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An exploration of patients' and professionals' experiences and perspectives.

Doctoral thesis

NTNU
Norwegian University of Science and Technology
Thesis for the Degree of
Philosophiae Doctor
Faculty of Medicine and Health Sciences
Department of Mental Health

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Sammendrag (summary in Norwegian)

Tittel: «Korttidsterapi for pasienter med moderate psykiske problemer – muligheter og utfordringer. En utforskning av pasienters og fagpersoners erfaringer og perspektiver»

Stadig flere mennesker søker hjelp for sine psykiske problemer, både internasjonalt og i Norge. Behovet for innovative behandlingsformer har økt tilsvarende, og målet er å tilby god og effektiv behandling til stadig flere pasienter. Ett eksempel, er et distriktspsykiatrisk senter (DPS) som har utviklet et tilbud om tidsavgrenset terapi for pasienter med moderate psykiske problemer, bl.a. for å redusere køene til poliklinisk behandling og for å kunne frigjøre tid og ressurser til pasienter med mer omfattende behov.

Tidsavgrenset «brief therapy» er en relativt ny behandlings-tilnærming i Norge, og vi har begrenset kunnskap om erfaringene med innføring av slike tilbud. For å undersøke muligheter og utfordringer knyttet til å tilby og motta behandlingstilbudet «brief therapy» for pasienter med moderate psykiske problemer, ble det derfor gjennomført tre studier med følgende mål:

I. Å utforske ansattes oppfatninger av hvordan etableringen av en spesialisert brief therapy enhet hadde påvirket organisasjonen, spesielt det daglige arbeidet i den polikliniske virksomheten ved DPS.

II. Å utforske pasienters og terapeuters erfaringer med brief therapy, spesielt hvordan tidsavgrensningen påvirket behandlingsprosessen.

III. Å utforske hvem som opplever å ha utbytte av brief therapy i et DPS, ved å utforske 1) pasientenes historier ca. ett år etter behandlingen avsluttes og 2) fastlegers erfaringer etter å ha henvist pasienter til brief therapy.

De tre kvalitative studiene ble gjennomført blant pasienter, fastleger og ansatte ved et DPS i Norge. Studie I avdekket en pågående diskusjon om korrekt ressursbruk og oppgavefordeling. Det var ulike oppfatninger om målrettet brief therapy til pasienter med moderate plager samtidig kunne ha som mål å løse andre vesentlige utfordringer i psykisk helsevern. Studie II synliggjorde brief therapy som gunstig for pasienter med moderate angst- og depresjonsproblemer. Tidsavgrensningen spilte en vesentlig rolle, og hjalp terapeutene med å strukturere den terapeutiske prosessen og styrket pasientenes motivasjon. Opplevelsen

av et felles behandlingsprosjekt med behandler, styrket pasientenes opplevelse av ansvar for - og forventning om - å nå individuelle mål. Studie III avdekket ulike erfaringer etter endt brief therapy. Flere pasienter opplevde behandlingen som gunstig, mens andre opplevde brief therapy som en vurderingsperiode før tilbud om mer passende behandling. Noen pasienter med alvorlige, komplekse eller tilbakevendende psykiske helseproblemer erfarte brief therapy som uegnet. Fastlegenes erfaringer bekreftet pasientenes opplevelse om at ikke alle som får tilbud om brief therapy har nytte av det.

Tilgangen til psykisk helsetjenester kan økes ved at flere pasienter får tilbud om brief therapy, men dette kan ha uønskede konsekvenser hvis tilbudet gis pasienter som ikke har nytte av behandlingen. Denne avhandlingen understreker behovet for forutsigbart samarbeid og kommunikasjon med og om pasientens individuelle behov før henvisning til brief therapy, og at det settes av tilstrekkelig tid til vurderingen. I tillegg ser det ut til å være behov for en bredere systemtilnærming til utvikling av forebygging, behandling og rehabilitering på tvers av tjenester og behandlingsnivå, inkludert en kontinuerlig vurdering av oppgavefordeling mellom behandlingsnivå. Fagpersoner fra ulike deler av spesialist- og primærhelsetjenesten kan med fordel inkluderes i innovasjonsarbeid i psykisk helsevern. Likedan bør pasienter og fagpersoner involveres mer i implementering og evaluering av nye behandlingstilbud.

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Most of all, I am grateful to all the participants who contributed to this thesis's three studies. The participants include all the patients who have taken part in two studies and professionals who have taken part in three studies. Professionals include GPs, therapists, and leaders/coordinators at DPC. Without their participation, this work would not have been possible. Thank you for sharing your experiences with me!

I would especially like to thank my supervisors, Marit By Rise, Lene Aasdahl, and Petter Viksveen, for their support and contributions to the work of this thesis. All three of you have enriched my path toward the goal in different ways. I also want to thank co-author Berith Hedberg for her contribution. I am very grateful to my primary supervisor, Professor Marit By Rise, for her knowledge, expertise, structured supervision, patience, and encouragement. You have meant more to me than you know.

Further, I thank my good colleagues in two research groups at NTNU, PEP (Patient Education and Participation - in the Department of Public Health and Nursing) and PHROSK (Mental Health in Relational and societal context - in the Department of Mental Health). This thesis would not have been possible without their support, refreshing discussions, and lively meetings. A special thanks to our informal group "ferske forskere" for nice and energetic lunch breaks and cafè visits. I am grateful that I had the opportunity to get to know you all. Throughout this thesis journey, they have been there for me in good and challenging times.

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Trondheim, October 2023
Hilde Våbenø Markussen

I dedicate this thesis to my dear father for his everlasting warmth, wisdom and for always believing in the potential for growth in every human being (Tore J. Markussen 1938 - 2012)

Prologue

We are constantly looking for improved treatment options to meet the needs of people with different mental challenges. However, highlighting and examining targeted therapies and different treatment options to improve the health sector may cause us to lose sight of the overall challenge picture. We live in a modern world characterised by volatility, uncertainty, complexity and ambiguity (VUCA) [1], which is an acronym used to advise society to maintain a greater awareness of and readiness for the unpredictable and complex when developing functioning and related services for people in need of mental services, for example. In addition to these challenges, the psychological and medical perceptions of good treatment change over time, and professional communities in different countries might have different professional views and conflicts of interest [1]. In addition, health authorities and insurers have an increasing influence on developing mental health services [2, 3] by encouraging more innovation to provide treatment to more patients within the resources at the healthcare service providers' disposal [2]. In recent decades, the user perspective has gained greater focus in planning innovation activities by giving users a clear and active role in providing input for improvements in mental health services, for example [4, 5]. Constantly changing norms and standards for treatment and courses of treatment within this complexity should challenge society to ask new questions, to doubt and to discuss issues with an open mind. My preconception was that insight into service providers' and patients' experiences might contribute to improved knowledge in assessing innovation and/or improvement work in mental health services.

In 2018, I had the opportunity to start my Ph.D. education, and I was happy to collaborate with St. Olav's Hospital, Division of Mental Health. After being away from mental health hospital planning for some years, I became particularly interested when I heard of a new treatment option that seemed to have better results for young adults with anxiety and depression than had been achieved with previous treatment programmes. Because many young people are struggling with anxiety and depression in our part of the world, I found that new and so-called innovative treatment options were exciting and valuable to explore. When the management of a district psychiatric centre (DPC) wanted to collaborate with me and my primary supervisor at NTNU on a research application to the Liaison Committee between the Central Norway Regional Health Authority and the Norwegian University of Science and Technology (NTNU), the start of the collaboration became a reality. We decided to develop three studies based on the newly established 'Brief Therapy' offered by one of Norway's largest DPCs. I am grateful that the Liaison Committee between the Central Norway Regional Health Authority and the Norwegian University of Science and Technology (NTNU) funded this work under Grant no. 22314.

~ Hilde V M

List of included papers

Paper I:

Hilde Våbenø Markussen, Lene Aasdahl, Marit By Rise.

Professionals' perceptions of the establishment of a specialized brief therapy unit in a district psychiatric centre - a qualitative study [6]

Published in BMC Health Services Research 2020. vol. 20 (1).

Paper II:

Hilde V Markussen, Lene Aasdahl, Petter Viksveen, Berith Hedberg, Marit By Rise

A treatment strategy for meeting life as it is. Patients' and therapists' experiences of brief therapy in a district psychiatric centre - a qualitative study [7]

Published in PLoS One. 2021. vol. 16 (10).

Paper III:

Hilde V Markussen, Lene Aasdahl, Petter Viksveen, Marit By Rise.

Who benefits from brief therapy treatment in a district psychiatric centre? A qualitative study investigating patients' stories and general practitioners' experiences

In review, BMC - International Journal of Mental Health Systems | Research article (biomedcentral.com).

Summary in English

Title: ‘Brief therapy for patients with moderate mental health problems – opportunities and challenges. An exploration of patients’ and professionals’ experiences and perspectives’.

Increasingly, more people are seeking help with their mental health problems, both internationally and in Norway. The need for innovative treatments has increased accordingly, and the goal is to offer effective treatment to more patients. One example is the district psychiatric centre (DPC), which has developed an offer of time-limited therapy for patients with moderate mental problems to reduce waiting time for outpatient treatment and to free up time and resources for patients with more extensive needs.

Time-limited ‘brief therapy’ is a relatively new treatment approach in Norway, and we have limited knowledge of the experiences arising from introducing such offers. To investigate opportunities and challenges related to offering and receiving ‘brief therapy’ for patients with moderate mental health problems, three studies were carried out with the following objectives:

I. To explore employees' perceptions of how the establishment of a specialized brief therapy unit had affected the organization, especially the daily work in the outpatient departments at DPC.

II. To explore patients' and therapists' experiences with brief therapy, especially how the time limit affected the treatment process.

III. To explore who experiences benefits from brief therapy in a DPC by exploring 1) the patients' stories approx. one year after treatment ends and 2) GPs' experiences after referring patients to brief therapy.

The three qualitative studies were conducted among patients, general practitioners and staff at a DPC in Norway. Study I revealed an ongoing discussion about the correct use of resources and the distribution of tasks. Opinions differed regarding whether targeted brief therapy for patients with moderate complaints could, at the same time, aim to solve other significant

challenges in mental health care. Study II highlighted brief therapy as beneficial for patients with moderate anxiety and depression problems. The time limit played a significant role, helping therapists to structure the therapeutic process and strengthening the patients' motivation. The experience of a joint treatment project with a therapist strengthened the patients' experience of responsibility for - and expectation of - reaching individual goals. Study III revealed different experiences after the end of brief therapy. Several patients felt the treatment was beneficial, while others experienced brief therapy as an assessment period before being offered more appropriate treatment. Some patients with severe, complex or recurrent mental health problems experienced brief therapy as unsuitable. The GPs' experiences confirmed the patients' experience that not everyone who is offered brief therapy benefits from it.

Access to mental health services can be increased by more patients being offered brief therapy, but this can have undesirable consequences if the offer is given to patients who do not benefit from the treatment. This thesis emphasises the need for predictable collaboration and communication with and about the patient's individual needs before referral to brief therapy and that sufficient time be set aside for the assessment. In addition, a need is apparent for a broader systems approach to the development of prevention, treatment and rehabilitation processes across services and levels of treatment, including a continuous assessment of the distribution of tasks between levels of treatment. Professionals from various parts of the specialist and primary healthcare services can be advantageously included in innovation work in mental healthcare. Likewise, patients and professionals should be more involved in implementing and evaluating new treatment options.

Abbreviations

CBT Cognitive Behavioral Therapy

DPC District psychiatric centre

GP General practitioner

STC Systematic Text Condensation

WHO World Health Organisation

TABLE OF CONTENTS

List of figures

List of tables

1 INTRODUCTION

This introduction presents topics and concepts central to the discussion of this thesis. Furthermore, when shedding light on the findings explored in the three studies through my lenses, the following sections contribute to accounting for my choice of perspectives in the thesis.

1.2 Rationale for conducting the study

The global burden of diseases related to mental problems has risen in all countries in the last decades [8], and mental problems contribute to poor health outcomes for affected people, their caregivers and society, as well as incurring global and national economic losses [9]. At the same time, the demand for mental health services is increasing globally [10]; in Europe alone, almost 40% of the population suffers from psychiatric disorders every year [8, 11]. The magnitude of the problem has led to a ubiquitous focus on mental health as a global health priority in the United Nations (Sustainable developmental goals), the World Health Organization (WHO) and Global Mental Health (movement and study field) [12]. Depressive and generalised anxiety problems are now among the most common psychiatric conditions globally [13, 14], and prevention and treatment of these conditions seem necessary for individuals and for society. In addition to the suffering of patients and their families, mild to moderate and severe mental problems cause significant challenges in health care and society in terms of healthcare and social care costs [11]. Individuals with anxiety and depression also have a higher risk of chronic somatic problems, leading to even higher health care expenditures [15].

Western countries have expanded their mental healthcare since the 70s, contributing to a substantial increase in the number of patients treated over the last decades. The prescription of antidepressants increased considerably between 1980 and 2010, and new brief trends in psychological treatments without medication have evolved [16]. In addition, the prevalence of depression is claimed to possibly be affected by changes in psychiatric practices and the availability of online mental health information in the past decades [17]. However, the expanded treatment offer has not been accompanied by reductions in the demand for depression treatment in countries that have implemented various changes in psychiatric

practice and have made online information available about mental health services [17]. Furthermore, the availability of services might have affected treatment-seeking behaviour and the availability of treatment in different parts of the health service [17]; therefore, the number of people seeking help might increase further in the years to come.

In the last few decades, investments in mental health care seem insufficient in all countries and disproportionate to the increasing burdens of mental health conditions [8]. Therefore, a need seems to exist for further research and funding to prevent and adequately treat various mental problems in mental health services. Furthermore, in the face of increasing mental health problems [8, 10], scarce treatment resources have pressured authorities and mental health services to innovate service provision, such as by developing differentiated services adapted to different needs [8, 11, 18]. However, a large worldwide gap remains between the number of people who suffer from anxiety and depression and those who seek and receive adequate treatment. This gap is visible in both low- and middle-income countries and high-income countries [19], and discussions have focused on implementing improved psychological treatments for these problems at the lowest adequate care level [20, 21]. Furthermore, several experts argue that innovative work processes in mental health services are necessary to reduce the burden on the individual and societal levels and meet the increasing need [8, 11, 18]. Investigating experiences with ongoing innovative methods, such as brief therapy, seems necessary to increase the knowledge basis.

The increasing burden of mental problems is an argument for starting effective treatment early to prevent exacerbation (e.g. anxiety and depression). Anxiety and depression are common problems that severely limit psychosocial functioning and diminish the quality of life in several phases of life. WHO ranked major depressive disorder as the third cause of disease worldwide in 2008 and projected that the disease will rank first by 2030 [22]. A systematic review from 2017 showed that a significant proportion of outpatients in different clinical specialties experience depression or depressive symptoms, which 15ecognized the importance of developing effective treatment strategies for the early identification and treatment of these conditions among outpatients in clinical practice [23]. Depression and anxiety often present simultaneously and are common mental health problems in adolescents and young adults worldwide [24]. At the personal level, these ailments can lead to feelings of guilt or low self-worth, disturbed sleep or appetite, tiredness and poor concentration [17]. Depression can lead to severe social and educational impairments, increased drug abuse and

severe obesity, and it is a significant risk factor for suicide [24]. Overall, these are arguments for early intervention to improve and maintain occupational performance for young adults and others at risk of mental problems.

1.2 Growing interest in brief therapies and CBT

The quest to find the optimal dosage of psychotherapy has become an increasingly popular research topic since the 1980s, and several attempts have been made to specify the number of therapy sessions required for most patients to experience improvement [25]. Brief therapy seems to provide good treatment outcomes for patients suffering from moderate depression and anxiety [26-28] and is a promising treatment for motivated persons who are able to develop skills and knowledge to take personal responsibility for their health [29]. Such skills and knowledge are related to the patient's capacity and readiness to change behaviour [30]. Overall, the terms 'time-limited', 'brief' or 'short-term' therapy also imply more than the application of a time limit and are often mentioned as the same [25]. In addition, few studies have investigated the effect of brief therapy and so-called low-intensity interventions for mental health problems, and the results are mixed [31]. A significant challenge in providing mental health interventions for young adults is making such interventions accessible and appeal to those most in need. In the last decade, several studies have investigated online and app-based forms of brief therapy and their effectiveness for mental health [32], but the evaluation of online services is beyond the scope of this thesis.

In recent decades, brief therapy has increasingly been introduced as part of mental health care globally, and a significant amount of research has attempted to estimate an adequate but sufficient number of therapy sessions for the larger public [25]. Brief therapy might be 16ecognized as a variety of interventions to reduce stress and moderate symptoms of depression and anxiety [33] and can serve as an example of a promising psychotherapeutic treatment. In brief therapy, the number of therapy sessions is decided before treatment starts [34]. The purpose of brief therapy might be to increase attention and resilience and thereby improve mood, anxiety, sleep and fatigue [33]. Brief therapy most often implies cognitive behavioural therapy (CBT), which can improve daily functioning and prevent a condition's worsening [35]. These are all important reasons for starting effective treatment early, but the detection, diagnosis and management of mental ailments often pose challenges for clinicians.

The problems occur because of the ailments' various presentations, the unpredictable course and prognosis and the patients' variable responses to treatment [22]. Therefore, we need more knowledge on whether a brief therapy offer hits the target group and whether this can potentially be an effective use of available resources in mental health care.

Scarce resources have led to a growing interest in evidence-based approaches in psychiatry and cost-effective psychotherapeutic treatments [2]. Brief therapy is known for its focus on efficiency through its use of several different techniques, focusing on the present ('here and now') and the patient's strengths and opportunities [25]. Brief therapy was initially developed as a reaction to long psychoanalytic treatment processes, but since then, it has been valued as a rapid and cost-effective treatment [36, 37]. In addition, several studies on improving mental health, well-being, physical health and lifestyle behaviours have shown that mindfulness and cognitive behavioural therapy-based brief interventions effectively reduce stress, anxiety and depression [33]. Brief therapy is a practical and structured form of psychotherapy that can suffice as a treatment for depression of moderate severity [14] and it might be beneficial for adults with common mental problems [38]. Furthermore, brief therapy and CBT positively affect depression and anxiety [26, 39, 40]. Therefore, researchers recommend that evidence-based psychotherapy, such as CBT, be offered first, although medication could be needed [22].

CBT has, for several years, been recommended as a primary treatment choice for anxiety and depression by the National Institute for Health and Care Excellence (NICE) in England [41, 42]. In 2004, NICE systematically reviewed the evidence for the effectiveness of various interventions for depression and anxiety problems, leading to a series of clinical guidelines supporting specific psychological therapies, and CBT was recommended for depression and anxiety problems [43]. Since then, CBT has been argued to have had political and cultural dominance as a recommended treatment in global mental health care [41].

Depression and anxiety problems are among the most common illnesses in the community and in primary care. Patients with depression often have anxiety problems, and those with anxiety problems often also have depression. Therefore, both problems may occur together, suggesting a necessity to identify and treat them, as they are associated with significant morbidity and mortality [44]. However, low-intensity interventions are not recommended for moderate to severe depression and other anxiety problems (such as post-traumatic stress

disorder). In addition, significant differences exist between patients regarding their response to treatment [45], and tailoring treatment length to individual patients is argued to be necessary [46].

In the literature, short-term, time-limited and brief therapy are discussed interchangeably [47], and most studies focus on specific psychological methods and diagnoses [47, 48]. Time limits are claimed to affect the therapeutic processes on several levels, but the use of time limits in psychotherapy research is rarely questioned [25], and researchers continue to regard a time limit as a neutral intervention that does not affect their studies or therapies [25]. Thus, since time limits are increasingly used in mental health treatment [25], more knowledge of the opportunities and challenges linked to brief therapy is needed.

1.3 Providing mental health care in Norway

Due to their high prevalence and early adulthood onset, anxiety and depression are estimated to be the fourth and third most important causes of nonfatal health loss in Norway [19, 49, 50]. Moderate to severe anxiety and depression present significant challenges in healthcare and society regarding health and social costs [11]. Moderate ailments therefore also have significant consequences for work–life participation and work functioning in Norway [51].

In Norway, the government is responsible for providing healthcare to the population, and the municipalities are responsible for providing primary health and social care. The mental health services in Norway are organised at two levels: the primary (general healthcare services) and secondary (specialist healthcare services) levels [52]. The responsibility for and supervision of most secondary services and hospitals lies with the Ministry of Health and Care Services, while the municipalities provide primary care services, as preventive services, and general practitioners (GPs) [53]. Municipalities also provide long-term care after specialised or hospital treatment [54].

The Ministry of Health mainly guides primary health, social care and specialist healthcare services through legislation and funding mechanisms. However, the Ministry plays a more direct role in specialist care through its ownership of hospitals and provision of directives to the boards of regional healthcare authorities [55], which assumedly affect both problem definitions and approaches in specialist healthcare services [3].

Hospitals and specialised mental health services are run by several health trusts owned and instructed by four regional health authorities on behalf of the state as the owner [52]. Psychiatric specialist care is organised as treatment wards in hospitals or DPCs, and the latter are often organised within a larger hospital. The regional health authorities' annual 'instruction letter' governs the regional DPC's activities [53], covering neighbouring municipalities. DPCs consist of different offers and services: day, 24-hour, outpatient and ambulatory services. In Norway, patients can contact their GP for help with general mental health problems, and the GP may refer them for specialised treatment at a DPC if needed. The treatment at a DPC is provided free of charge [55], but with a deductible paid by the patient. GPs function as gatekeepers, requiring a GP referral for specialist treatment at the DPC [54].

In Norway, the nationally managed and financed health system, providing between 90 and 100 percent of all healthcare, is built on the idea of universal coverage and equal access for all, regardless of socioeconomic status, ethnicity and area of residence. This scheme is financed through national and municipal taxes [55]. According to the health authorities in Norway, innovative therapy approaches are expected to help reduce waiting lists, fill gaps in current services, standardise information exchange and improve patient pathways [4, 56].

When trying to meet the increased demand for mental health services and to respond to demands for change, not only from politicians but also from those who provide and receive healthcare services [57], we need more knowledge on whether innovative efforts provide appropriate opportunities for patients needing help from mental health services. Therefore, exploring the opportunities and challenges of providing and receiving brief therapy seems necessary.

1.4 Need for more efficient utilisation of resources

In 2014, an OECD report urged Norway to address the weakness in care provision, focusing on treating patients with mild to moderate anxiety and depression [19, 58]. Further investment in research and innovation seemed necessary to prevent and treat various mental problems, and different innovative and effective preventive and therapeutic strategies were considered to reduce the burden of mental problems [59]. Researchers have argued for reducing the incidence of anxiety and depression by narrowing the treatment gap, providing

timely interventions and high-quality treatment, eradicating waiting lists, and providing more psychosocial treatment in primary healthcare [16]. In addition, research seemed necessary on the long-term results of various treatment modalities, such as brief interventions [14]. In this thesis, innovation in healthcare service delivery and organisation is defined as a novel set of behaviours, routines and ways of working directed at improving health outcomes, administrative efficiency, cost-effectiveness or users' experience and implemented by planned and coordinated actions [6, 60].

A distinct focus has been on implementing improved psychological treatments and innovative working processes in mental health services [11, 18], encouraging the health sector to invest in cost efficiency, quality of treatment, and continual improvement [39, 61], focusing on innovation and flexibility. Innovative and effective preventive and therapeutic strategies are being continuously assessed [59], and the development of innovative therapeutic approaches is believed to help standardise information exchange, fill gaps in current services, improve quality and provide better patient pathways [4]. In this thesis, a patient pathway is described as an intervention for the mutual decision-making and organization of care processes for a well-defined group of patients during a well-defined period [62, 63]. The intention underlying the establishment of patient pathways is to ensure that patients' needs will be met when they move across care and treatment levels and aims to support that the next level of care focuses on the patients' needs [64] (i.e., from secondary to primary care or vice versa).

The Norwegian Coordination Reform had its background in recognising that healthcare services had become too fragmented and were proving too expensive in 2008-2009 [65]. The reform aimed to promote holistic patient pathways, more prevention, better user co-determination and sustainable development [65]. Later, several reports have highlighted the need for further coordination and communication, particularly between the specialist and primary health care services [53]. The Care Coordination Reform evaluations showed that there was still some way to go before better communication was achieved [53]. It seems to be a challenge to create a 'balance' in communication between health trusts and municipalities in a comprehensive health service, and one may ask whether the weakest party is the patient. Therefore, investigating the patients' communication experiences becomes essential during brief therapy.

Nevertheless, improvement of work in and between complex health organisations involves various potential challenges, such as heterogeneous patient groups, organisational differences and different cultures [66]. Organizational culture is a set of shared norms, values, and beliefs that develop in an organisation as the members interact with each other and their environment and manifest through their behavior and attitudes at work [6, 67].

In addition, mental health care is claimed to be a complex service to manage in implementing change and innovations because the professional values and identities of professionals working in this field [52] encompass different schools of thought with different perspectives on how to explain and treat mental problems [2]. Therefore, ensuring that effective interventions are implemented has been identified as a priority task for mental health services [68], and several knowledge gaps in implementing innovation in healthcare systems have been pointed out [60]. One question is why the therapy has not been successfully implemented in practice [68, 69], when brief therapy has been confirmed efficient for several patient groups [26, 38-40]. It seems that implementation might encounter many potential barriers and facilitators embedded in the intervention, the external environment, the characteristics of the individuals involved, and the implementation process itself [69, 70]. Furthermore, other implementations of change show that implementation processes can be complicated, unpredictable and context sensitive [71]. The barriers appear at several levels, such as at the patient, treatment team, organisational and market or policy levels [70]. Investigating the experiences with implementation and the outcome of brief therapy therefore becomes essential in a 'real-world setting.'

1.5 Health, health inequalities and innovation processes

Good health is highly valued within society [72]. Health might be understood as a structural, functional and emotional state compatible with an effective life as an individual and a member of society [72]. From a public health standpoint, the goal is for everyone to have equivalent access to healthcare services and benefit equally from such services [73]. Health inequalities are described as the systematic, avoidable and unfair differences in health outcomes observed between populations and social groups within the same population [72]. A joint agreement exists whereby social inequalities in health comprise a public health

problem worldwide and should be reduced, but the challenges of the causes of health differences are complex [73].

Health differences and the social determinants of mental problems and illness have received increasing attention within public health research in recent decades. Attention is increasingly directed towards policy making and service development to make meaningful changes in the fair distribution of healthcare services [74]. I In recent decades, health authorities and insurers have had an increasing influence on the development of mental health services (e.g. time-limited treatment) [2, 3], and this has contributed to an understanding of how policy guidelines can affect innovation processes [3].

The implementation of innovative treatments, such as brief therapy, is, by nature, a social process intertwined with the context in which it takes place [70], and the interactions between innovation and the context influence the process and outcome [75]. Including different stakeholders in planning, preparing and implementing is thus recommended by applying a bottom-up approach and two-way communication in improvement work and innovations [76]. In addition, patient involvement is crucial to promoting equal healthcare services and ensuring quality [5], and the patient outcome seems to depend on only beginning work on the patients' mental health problems after establishing a goal consensus [77]. A goal consensus may depend on providing brief therapy to patients with moderate ailments who have the opportunity and ability to participate in working with defined issues [78].

The patient's level of education, work situation, social network, and the severity of depressive symptoms before treatment might be a predictor for the suitability of different types of treatment [79, 80]. A person's state of health varies greatly depending on where people are born, raised and have developed. Within countries, the differences in life chances are significant. At all income levels, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health [81]. For example, inequality in health between the employed and unemployed is explained by the difference in access to economic and social resources [82]. Therefore, greater attention to socioeconomic factors, such as unemployment and public health, is recommended to prevent inequality in mental health [82].

Caring for people with complex ailments seems to require a more complementary strategy in healthcare services that offer personal holistic continuity of care [83]. In addition, better coordination is needed between different treatment levels when choosing suitable treatment

for an individual patient [84]. This seems essential for the perceived treatment quality of people with extended problems moving between care settings [85]. Furthermore, coordination of mental health services to meet an individual's needs across different care levels is essential to ensure the quality of care for people with severe mental health ailments [85], and people with more complex mental health problems require multiple interventions and follow-up from multiple services [86]. Therefore, the healthcare system should overcome the challenges of coordinating continuity in care which is crucial for people with complex mental health challenges [85] and essential to benefit patients with moderate to severe ailments [87].

Nevertheless, developing and implementing possibly beneficial and customised services might be followed by imposition of different barriers and facilitators, and the change processes in healthcare services can be complicated, unpredictable and context sensitive [71]. Moreover, implementing new treatment offers involves various activities and stakeholders [88].

1.6 Participation and communication as interdependent concepts

Patient participation is a central concept in modern health care, and the patient's position in treatment situations has been strengthened in recent years [89]. Several positive effects of involving the patient in their care have been highlighted in research and are essential factors in theories/models, such as person-centred care, shared decision-making and recovery-oriented practice [89, 90]. Furthermore, the concept has manifested itself in human rights approaches, and patient involvement in healthcare improvement has attracted increased interest in recent decades [89, 91]. Many terms express patient involvement in the literature with diverse definitions, such as patient or user participation and engagement, co-creation, co-design and co-production [91]. Healthcare professionals not only have a responsibility to encourage patient participation, but equal communication between the patient and therapist also appears essential for delivering high-quality care[89, 92].

Patients can be proactive and engaged or passive and alienated, mainly due to the social conditions in which they develop and function [93]. Assessment of a patient's ability for self-determination has focused on the social-contextual conditions that facilitate versus hinder the natural processes of self-motivation and healthy psychological development [93]. In research

from Norway, patients have described that high-quality services should be flexible to adjust to their varying needs. Furthermore, the importance of predictable care in phases with stronger symptoms is highlighted, which increases the focus on empowerment, responsibility and decision-making in phases with fewer symptoms [92]. These findings are supported by qualitative and quantitative research showing that predictability and continuity of care are essential, especially among patients suffering from severe mental health problems [94].

Coordination of mental health services to meet an individual's needs across different care levels is needed when choosing suitable treatment [84], and communication between mental health services to meet an individual's needs across different care levels is an essential feature of the quality of care for people with mental health ailments [85]. Different types of services provide mental health care, and they may represent service sectors that vary in their level of specialisation and capacity to deliver the kinds of interventions appropriate for different types of problems and levels of need [95]. Comparing patients' experiences of receiving treatment across services may help in understanding the perceived quality of treatment and care and whether the treatment is perceived as adapted and coherent [95]. Therefore, exploring whether communication represents opportunities and challenges when providing and receiving brief therapy seems important.

2 AIMS OF THE THESIS AND STUDIES

The overall aim of this thesis is to investigate the opportunities and challenges of providing and receiving brief therapy for patients with moderate mental health problems. The different aims of the studies are summarised in Figure 1.

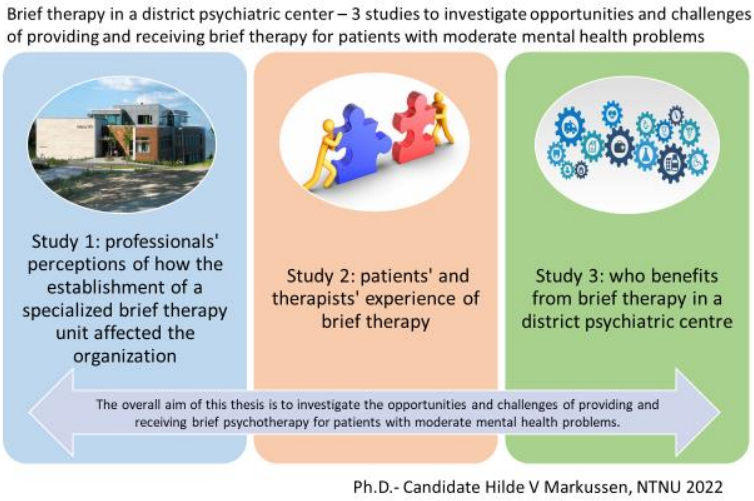

Figure 1: The overall aim of this thesis, including the aims of the three studies (Paper I-III)

The aims of the three studies included in this thesis are (Paper I-III):

1. *The first aim of the thesis was to explore the professionals' perceptions of how the establishment of a specialized brief therapy unit had affected the organization, especially the everyday work in the outpatient clinics (Paper I).*

2. *The second aim of the thesis was to explore patients' and therapists' experiences of brief therapy, especially how the time frame influences the treatment process (Paper II).*

3. *The third aim of the thesis was to explore who benefits from brief therapy in a district psychiatric centre, by investigating patients' stories after ending brief therapy, and the GPs' experiences with referrals for such treatment (Paper III).*

3 METHODS

The overall aim of this thesis is to investigate the opportunities and challenges of providing and receiving brief therapy for patients with moderate mental health problems. A qualitative approach was deemed suitable for addressing the aims of the three studies due to the ability of qualitative methods to explore different stakeholders' experiences [96, 97] of health care services. Our original idea was that human experiences could be recognised from different subject positions and thus could provide in-depth knowledge of various stakeholders' experiences of a newly established brief therapy service in mental health care. Therefore, the material in this thesis includes three qualitative interview studies that could help shed light on the overall research question from different points of view. The methods will be further elaborated in more detail later, but first, I will give an account of the study setting.

3.1 Study setting

The brief therapy that forms the basis for the studies was established in 2016 to target a growing group of patients with mild to moderate anxiety and/or depressive problems with previously good functioning and self-esteem, but with a sudden fall in function, reactive states or sudden life events [98]. A DPC aimed to provide treatment at the lowest adequate care level in the specialist health service and reduce waiting time for patients needing outpatient treatment.

This thesis includes three studies conducted mainly at one of the DPCs (mental health hospitals) in central Norway. The DPC was established in 2009 based on the hospital's strategy and guidelines for professional improvement of collaboration and patient flow [56]. The DPC consisted of different offers and services: day, 24-hour, outpatient, and ambulatory services.

Within a hospital trust in central Norway, this DPC covered a catchment area of 115,000 persons, with urban and semi-rural areas including parts of a large Norwegian city. The DPC had an increase of 42 % in referrals of patients needing outpatient treatment from 2009 to 2014. At the same time, the number of patients considered to need such treatment increased by over 43 % [98].

In 2016, this DPC established a specialised and method-specific outpatient unit to strengthen its general outpatient services and provide brief therapy. The main aims were to provide treatment at the lowest adequate care level in the specialist health service and reduce waiting time for patients needing outpatient treatment. In addition, the objective of establishing the new unit was to provide brief and effective therapy while freeing resources in general outpatient clinics for patient groups with more extensive treatment needs [98].

When our studies started in 2018, the unit encompassed 10.5 therapist positions specialising in short-term therapy, in contrast to the more generalist approach in other general outpatient clinics in the DPC. Treatment in the brief therapy unit was described as limited to approximately ten treatment sessions, individually or in groups, and included CBT, metacognitive therapy [99], mindfulness [100, 101] and acceptance and commitment therapy [100]. According to the head of the brief therapy unit (2021), brief therapy in recent years most often included CBT and metacognitive therapy [99] and was offered to adult patients (over 18 years of age in general), with moderate to severe anxiety and depression or other mental problems. The head of the unit also described the time-limited treatment as more flexible than only 10 treatment hours. Depending on the individual patient' s needs, it could be shorter or extended by a few hours.

The DPC's official information brochure on the offer (2018) refers to good experiences after a trial period from 2009 to 2010. In the brochure (Appendix 6), they envisioned a differentiated outpatient service with a method-specific (brief therapy) clinic 'at the front' of the DPC that should mainly provide metacognitive and cognitive behavioural therapy to patients with anxiety and depression as the leading cause of referral. In addition, the DPC describes in the brochure that the intention of improving the capacity at the general outpatient clinics was to enable longer treatment courses in more complex cases. Another essential point indicated in the brochure was that the DPC wanted to minimise the possible negative effects of psychotherapy, especially concerning the dangers of contributing to a possible institutionalisation of a very young patient population. Furthermore, the DPC wanted to develop a clear professional profile based on evidence-based treatment that would provide professional development and recruitment guidelines. Through this, they wanted to improve the quality of the treatment.

Further, the DPC also envisioned several opportunities ahead in the information brochure. For example, the short-term outpatient clinic (which offered brief therapy) wanted to become an outpatient laboratory for change work together with the general outpatient clinics (in the same DPC) and envisioned becoming an arena for developing and testing various treatment processes. In addition, the brochure described an ambition to provide input to the 'prioritisation debate' in Norway and be an example of the health service taking an active role in managing what should be the first treatment offered. Finally, the DPC envisioned developing a specialisation strategy as a counterweight to generalist thinking, where professionals engaged in the same methodology could gather for competence building in a professional team.

By this, I understand that establishing brief therapy was part of a broader strategy and represented the DPC's effort to improve several aspects of their outpatient mental health services.

3.2 Methodological positioning

Interpretative paradigm

Qualitative research is situated in an interpretative paradigm [102], and the thesis is placed in an interpretative paradigm that advocates notions about particular human experiences and their contexts from different subject positions [102]. Our research was co-constituted as a joint product of the participants, the researcher and their relationship. Inspired by the interpretive paradigm, we searched for new ways of understanding the different phenomena of interest as they appeared in the different studies. The thesis represents an interpretive paradigm and includes three studies inspired by phenomenology based on different qualitative research methods [103].

A phenomenological approach is common in psychology, sociology, public health and nursing [104] and is relevant to this thesis because it focuses on individual experience and how an individual assigns meaning to things and phenomena. The value of phenomenology lies in its sources of ideas on examining and comprehending lived experience, and the perceptions of lived experience are shaped by objectives, values and meaning [102, 103]. We sought to recognise subjectivity at an ontological level by how human beings experience

things and happenings and at an epistemological level by how researchers describe and reflect upon such experiences [102]. Inspired by social constructionism [102, 105], as described below, we chose an exploratory approach with a broad research question that allowed the informants to shed light on the aims of the studies.
Qualitative methods are recommended when exploring in-depth experiences and attitudes [84], and we focused on research approaches that could provide unique insights into perceptions, experiences and behaviours [106]. Studying human communication experiences, meaning, attitudes, motives and processes [96] within this part of specialised mental health services seemed valuable.

Below, some key points from the methodologies are highlighted to underpin how various aspects are understood and portrayed in this thesis. In studies I and II, an inductive thematic analysis approach called systematic text condensation was used to describe participants' experiences [103]. In study III, we chose an exploratory approach with inductive and thematic analysis of patient stories and GPs' experiences, which were contrasted.

Social constructionism

Social constructionism is concerned with explaining the processes by which people come to describe, explain or otherwise account for the world in which they live [107]. Our research approach was inspired by social constructionism and, in sum, an exploratory approach with broad research questions that allowed the informants to illuminate the aims of the studies. For example, people use symbols to communicate in an interview, representing their understanding of reality [108]. From a social constructionism perspective, our understanding of the results from the three studies is driven by a cooperative enterprise of persons in a relationship and not within the minds of independent persons. From such a perspective, the research results have emerged through relational interactions between the researchers and informants. Therefore, the researchers considered the local context in which the informants live and act, including the researchers' possible pre-understanding when analysing the results. Social constructionism has many forms and definitions, but a common understanding is that it reflects that all knowledge is negotiated between people within a given context and time [108]. Inspired by social constructionism, which has expanded the interpretative paradigm [102, 107], we emphasised the role of culture, narratives [109, 110], dialogue and context as

essential elements of understanding and gleaning knowledge of how people experience and deal with events, problems and solutions. Hence, the underlying theoretical foundations of social constructionism are that knowledge is situated and a temporary outcome of dynamic interpretations of several possible versions of reality [103]. We thus recognised participants' experiences of opportunities and challenges, relationships and interactions in our study context, and the knowledge we gained was an expression of constructions of the phenomena we found [111]. Lived experiences and human perceptions were thus understood as shaped by goals, values and meaning [102, 103].

Thematic analysis

Thematic analysis is a method for analysing qualitative data in many disciplines and fields and not a single method. Thematic analysis is an approach for analysing qualitative data that focuses on developing themes (meaning patterns) from qualitative data [112]. For example, the method has been widely used across the social, psychological, behavioural and health sciences [112]. We used thematic analysis to develop patterns of meaning or themes across the dataset in each study that addressed our research questions.

In thematic analysis, the researcher generates the patterns through a rigorous process of data familiarisation, data coding and theme development and revision [112]. The method can be applied in different ways and to different datasets to address different research questions, and within various theoretical frameworks. We combined thematic analysis with other methods in our three studies in this thesis. These approaches will be elaborated on further in the discussion of methods.

Inductive analysis of narratives

Narratives involve integrating events and human actions into a goal-directed story organised temporally, considering the past, present and future, and are presented within a specific setting [110]. In this section, my aim is not to provide exhaustive or prescriptive information about narrative analysis and techniques, which is a substantial methodological field [110].

However, we found that the patients' stories from the period after receiving brief therapy might be relevant for investigating and understanding the experiences, actions, motivations and life journeys of people challenged by health, trauma, change, loss or other life problems. Therefore, we were inspired by an 'inductive analysis of narratives' designed to compare and contrast various narratives (e.g. to identify key themes) [110]. 'Inductive' means that coding and theme development were directed by the content of the data we collected. The ability to tell a story is one of the strengths of qualitative research's strengths, mainly when it reflects the perspective of those directly involved [109]. Our inductive analysis of narratives [110] required a collection of stories during interviews as data, followed by an analysis that resulted in descriptions of themes that were held across the stories (study III). Each story included direct quotes from the participants' voices, offering depth to the data analysis and identifying the common and contrasting themes across stories. Understanding several people's narratives for an event or phenomenon could help to inform the researchers about the influences that helped shape that narrative. It is important to note that 'condensed stories' represent 'constructed narratives' in study III, which represent the researcher's construction of the participant's experiences [24]. The tension or conflict of differing narratives is claimed to be clarifying and to possibly represent 'opportunities for innovation' [109], and we found our differing results from patients' stories fruitful for the analysis.

3.3 Design and methodological approach

We achieved the research objectives by conducting three separate qualitative studies. We chose different qualitative methods according to the possibility of exploring and comparing the experiences of both individuals and groups. When investigating the opportunities and challenges of providing and receiving brief therapy in the specialist health service, we started by analysing individual interviews of professionals working in leading or coordinating positions in the DPC organisation on how the establishment of brief therapy might have affected other outpatient work (Paper 1). We also analysed individual interviews with patients and group interviews with therapists working in the brief therapy unit on whether and how time limitations influence treatment (Paper 2). Finally, we analysed individual interviews with the same patients conducted a year after completing brief therapy and

individual interviews with referring GPs, and we compared patient stories with GPs' experiences (Paper 3). In this way, we could study the patients' stories and experiences one year after receiving brief therapy and compare those with the GPs' experiences with several patients receiving brief therapy in recent years.

3.4 Participants and recruitment

From 2018 to 2022, we conducted three separate data collections for the three studies. All three studies included participants recruited from the same District Psychiatric Center (DPC). In addition, the third study included GPs recruited from the surrounding catchment area around the DPC.

A total of 48 participants were included in the three studies; all were participating in individual- and focus-group interviews. Overall, 12 participants were included in study I, 20 participants in study II and 17 participants in study III. Note that most of the same patients from study II (11 of the 12) were included in study III to examine patients' experiences during the year that passed after they had completed the brief therapy treatment, as presented in Figure 2:

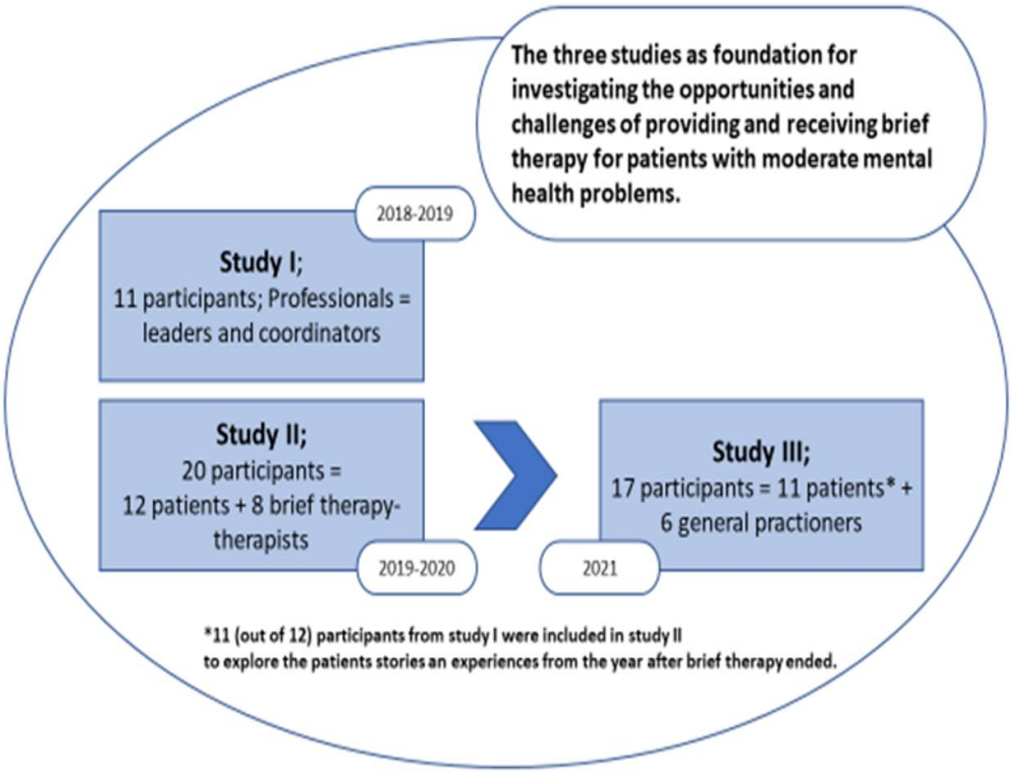

Figure 2: An overview of participants in the three studies combined with the year of data collection

The use of methods refers to specific procedures to operationalise the methodology in different parts of the study context. Data were generated through qualitative research interviews in all three studies. Therefore, we searched for common topics within an interview and across interviews [113], and the result of our studies was a detailed description of topics that aimed to capture the essential meaning of the participants' 'lived' experience.

Study I

Eligible participants were leaders, coordinators and key personnel (clinicians) at different levels in the outpatient clinics at the DPC, including the head clinic leader and leaders of the mental health services at the hospital. The aim of the sampling was to recruit participants with experience in the implementation and operation of the brief therapy unit and from

cooperation tasks within the DPC's outpatient services. Based on this sample strategy, initial study participants were suggested by the DPC's management. The participants in this study were then asked directly by me (the Ph.D. candidate) to participate in individual interviews. Subsequently, I recruited additional professionals to strengthen the diversity and representativeness of the sample. I sought to include professionals with different experiences and roles inside the brief therapy unit and in other parts of the outpatient services. Twelve participants were asked and consented to participate in the study. Unfortunately, one of the informants could not participate due to illness, so the final study sample included 11 professionals. All participants received oral and written information about the study and signed a written consent before participating in the interviews.

To summarise study I, all study participants were between 40 and 60 years old, and their professional backgrounds were in psychology, nursing and medicine. Most of them were specialists in their fields.

Study II

In study II, the eligible participants were patients currently receiving brief therapy and the therapists working at the brief therapy unit. The patients were informed by the therapists about the study while receiving treatment. The therapists provided the Ph.D. candidate's contact information for those who consented to participate. The Ph.D. candidate then contacted these patients and made appointments for interviews. Patients were thus recruited through purposeful criterion sampling [114], that is, those who met the study criteria. Sixteen patients consented to participate. One participant chose to leave the study before the interviews took place. After 12 interviews, the patient interviews were terminated when the authors considered that the study had sufficient information power [115]. The sample of 12 patients included seven men and five women, with a median age of 31 years (range 21 to 47 years), all receiving individual brief therapy at the unit. GPs from several GP offices diagnosed patients with depression and/or anxiety prior to referral for outpatient treatment at this DPC. Thus, although all patients were diagnosed with depression or anxiety, the sample included patients with different backgrounds and experiences. Therapists were recruited through purposeful criterion sampling [114], and the inclusion criterion was that they had

worked in the brief therapy unit for at least six months. Eight therapists, two women and six men, were eligible, and all consented to participate in focus-group interviews. Their ages ranged from 27 to 39 years (median 35 years), and their professional backgrounds included clinical psychologists (n = 4), psychologists (n = 3), and psychiatric nurses (n = 1). Half of the therapists had several years of experience working in specialist health services, while the others had some experience. Three focus-group interviews were conducted, one face-to-face and two using Skype technology, due to the pandemic outbreak in the spring of 2020.

To summarise study II, the patients participating in individual interviews were between 21 and 47, and the therapists participating in focus-group interviews were between 27 and 39 years old. The therapists had initially applied to work in the brief therapy unit. The patients had been diagnosed with depression or anxiety but had different backgrounds and experiences.

Study III

The eligible participants were patients who took part in study II and GPs who worked in a GP office and had personal experience referring several patients for outpatient treatment at this DPC.

The eligible participants were patients who had received brief therapy in the DPC during the last year and GPs who had referred patients to this brief therapy unit. The patients had participated in a qualitative study during treatment approximately one year ago [7] and were informed that they might be invited to participate in this second interview. They received verbal and written information about the study and signed a consent form before participating in the first interview. Patients were recruited through purposeful criterion sampling [114] and they confirmed their consent to participate before the second interview. Twelve participants initially agreed to participate, but one participant later answered that she could not participate in the second interview due to severe mental illness. The final sample of patients included four women and seven men, all between 20 and 50 years of age.

The patient characteristics presented below (Table 1) are valid for both study II and study III because the same patients participated in both studies one year apart.

Table 1: Patient characteristics, study III. Table retrieved from Markussen et al. (under review in International Journal of Mental Health Systems, 2022, p.11)

Variables and categories	N (%)
Gender	
Female	4 (36)
Male	7 (64)
Age	
20 – 25 years	5 (45)
26 – 35 years	3 (27)
36 – 50 years	3 (27)
Previous specialist mental health treatment	
Yes	8 (73)
No	3 (27)
Referred for further treatment after brief therapy	
Yes	5 (45)
No	6 (55)
Diagnoses (self-reported)	
Depression	8 (73)
Anxiety	5 (45)
Other[a]	7 (64)

a. Includes PTSD, personality disorder, bipolar disorder, neurological disorder, unresolved complex disorder.

GPs were recruited through purposeful criterion sampling [114], and the inclusion criterion was that they worked at a GP office that referred patients for brief therapy and had personal experience following the referral of patients for such treatment after 2016. Potential participants were informed about the study by the Ph.D. candidate (HVM) via e-mail to the receptionists at several GP offices in the geographical area near this DPC. Reminders were sent. The participants responded to the e-mail confirming that they would participate, and the Ph.D. candidate called them to make an appointment for an interview. The final sample of GPs included four men and two women aged 35 - 50 years.

To summarise study III, the patients participating in individual interviews were between 22 and 48, and the GPs participating in individual interviews were between 35 and 50 years old. The patients had received brief therapy a minimum of one year ago. The GPs have had several experiences referring patients to brief therapy since 2016.

3.5 Data collection

Qualitative research interviews

Qualitative research often involves collecting text-based data through, for example, relatively small numbers of semi-structured or unstructured interviews [116]. We prepared interview guides containing lists of questions and topic areas that should be covered in the specific study and chose semi-structured interviews as a qualitative approach to defining the area to be explored [117]. In all three studies, semi-structured interviews were conducted using interview guides [118] where the researchers had predefined questions or topics and then probed further as the participants responded. The Ph.D. candidate and her supervisors developed the interview guides, and representatives from the Competence Center for Lived Experience and Service Development in central Norway (https://kbtkompetanse.no/en/) provided helpful input. The interview guides were also adjusted after discussions in two research groups at the university. The Ph.D. candidate told all the participants that she was not a therapist and that if the patients needed to talk to a therapist after an individual interview, it was possible to arrange an appointment. However, no participants requested this.

Issues in the interview guide for study I were prepared to explore the professionals' experiences with innovation and new services, such as brief therapy in mental health care. In the interviews during study I, we intended to allow the professionals to reflect on and discuss how the establishment of the brief therapy unit had influenced their work and the overall work in the DPC. Important themes were how the work at the DPC had developed during and after establishing the brief therapy unit, the potential benefits and challenges herein, the overall quality of services and the organisational culture and environment. The interview guide for study 1 is attached (appendix).

In study II, a similar interview guide was developed and adapted to the study's two participant groups. Important topics were the participants' expectations before the treatment at DPC and their experiences during treatment. We included questions intended to allow both patients and therapists working in the brief therapy unit to reflect on the treatment process, including their possible responsibility throughout the treatment process and their thoughts concerning the time limits of the treatment. In addition, they were asked about their experiences with communication between therapists and patients and the role both groups had

played in the treatment process. Moreover, they were asked about their perspectives on the advantages and disadvantages of time-limited treatment. The interview guide for study II is attached (appendix).

In study III, two different semi-structured interview guides were adapted for patients and the GPs. An important topic in the interview guide for patients was the participants' experiences of outcomes one year after the end of treatment, whether they considered having experienced any changes due to brief therapy in the past year, and how they described their life situation after receiving brief therapy. When interviewing patients during study III, they were asked if they could tell their stories from the period after the end of brief therapy until the present interview (approximately one year after the first interview). They were also specifically asked how they experienced their state of health and whether they had received other mental health services after completing brief therapy. Essential topics in the interview guide for GPs from the surrounding area of the DPC were their general experiences with referring patients to brief therapy and any possible changes they observed in the patients following this treatment. In addition, the GPs were asked how they regarded brief therapy as part of the healthcare services for this patient group. Most of the topics in the interview guides remained constant, but one topic identified in the initial interviews with patients was incorporated into interviews with GPs, focusing on their perspectives on whether the treatment suited the patients who received brief therapy. The interview guide for study III is attached (appendix).

To summarise the interview process in the three studies, the Ph.D. candidate conducted all the interviews in study I. The participating professionals could choose whether to be interviewed in their own office or in a meeting room. In study II, the Ph.D. candidate conducted all the individual patient interviews. According to the patients' wishes, all interviews were conducted at the university. The Ph.D. candidate and her primary supervisor conducted the focus-group interviews with therapists at the clinic together (study II). When preparing interviews for study III, I needed to change our plan of face-to-face interviews. Due to the Covid-19 pandemic lockdown, the Ph.D. candidate conducted all interviews by telephone or Skype (video conversation), according to the participant's choice. All interviews in the three studies were audio-recorded and transcribed verbatim. The Ph.D. candidate checked the accuracy of the transcriptions by listening to all audio recordings several times. Notes on first impressions after each interview were logged by the interviewer(s), contributing further to the analytic process.

All the patients from study II who consented to participate in two studies were given a new choice of withdrawing from the following study when it started.

3.6 Data analysis

Data were analysed according to an inductive thematic analysis approach called systematic text condensation (STC) [103] (in studies I and II) and inductive analysis of patient narratives [110] combined with thematic analysis [119] of GPs' experiences in study III. For study III, data were collected from two groups of participants, and the GPs' experiences were thematically analysed to elaborate on the patients' stories.

Systematic text condensation (STC)

STC is a strategy for qualitative analysis recognised in medical and public health research [103]. The data analysis was conducted according to the four stages of STC [103] (studies I and II) according to these essential methodological steps; 1) getting a sense of the whole material (overall impressions - from chaos to themes), 2) identifying and sorting meaning units (from themes to codes), 3) making condensations – from code to meaning and 4) synthesising – from condensation to descriptions and concepts [103].

Initially, we chose an exploratory approach with broad research questions for studies I and II. First, the Ph.D. candidate (HVM) listened to all audio recordings when reading all transcripts several times to achieve an overall impression of the material. All interviews (study I and II) were initially read by HVM, whereas all interviews were divided among co-authors for reading and analysis. The first impressions resulted in preliminary themes discussed in the author group. Second, the unit of meanings [103] was identified and coded. The coding was conducted by systematically examining the text line by line, looking for meaning units that could shed light on the aims of both studies. Next, the codes from the interviews were grouped into categories representing the main themes in the interviews. In the third step, the main categories from the interviews were collected, collated and compared before condensing and summarising the main themes in the overall data material (study I and II). The themes

were then constructed and validated based on all categories through discussions in each study's author group. As a result, empirical dimensions were formed for each interview, and similarities across interviews were reflected in the themes. In the fourth step, descriptions and concepts reflecting the informants' most meaningful experiences were synthesised. This process continued until the data reached a point of convergence, resulting in themes encompassing the data material. Before agreeing, all the authors looked for alternative interpretations in several discussions.

The analysis was conducted in groups of three researchers (study I) and five researchers (study II) with different backgrounds (medicine, psychology, social sciences and health services research). In addition, HVM also presented preliminary findings in meetings with two different research groups at the university. The researchers in these groups had complementary experiences and provided fruitful feedback and input during the analytic processes. This feedback was shared with the other authors.

The analysis involved a process of de-contextualisation and re-contextualisation, which implied that parts from the transcript were lifted out and investigated more closely, along with other elements that highlighted similar issues. However, we were careful to ensure that the patterns still agreed with the context from which they were collected. The authors continuously looked for alternative interpretations in several meetings and critical discussions before agreeing on preliminary themes. Next, HVM summarised and decontextualised the text in the transcriptions that could illuminate the chosen codes and themes, focusing on the informant's experiences. Finally, the authors discussed whether the reduced text reflected the main topics in the data material. Together, we chose quotes from the data material to elaborate on and illustrate the results.

Mindjet MindManager

From the beginning, the central point was to present the results as close to the empirical data as possible, as the informants expressed themselves. In study I, Mindjet MindManager (2017) was used as a tool to visualise the codes in each interview and to sort meaning units in several mind maps. In addition, visualised mind maps (fig.3) for each interview were presented by the Ph.D. candidate and shared with the other authors to contribute to the analysis process.

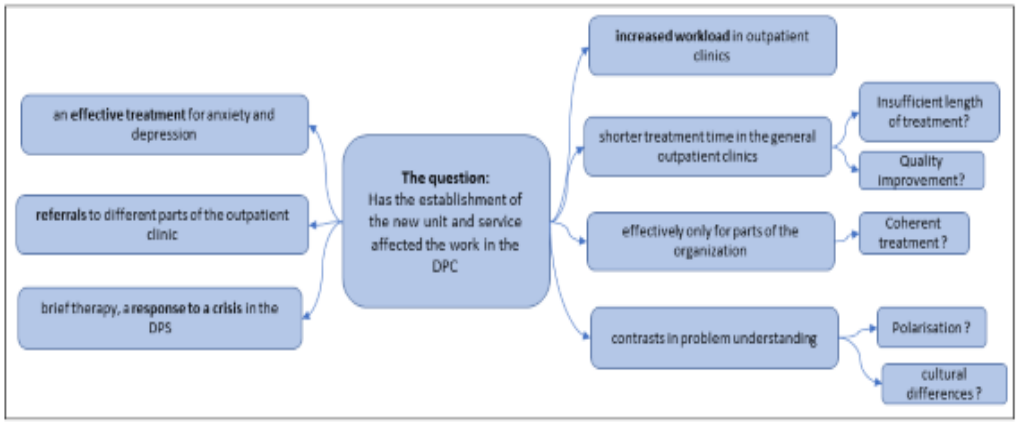

Figure 3: Illustration, a simplified example of the start of a mind mapping during analysis in study I

Empirical coding

From the beginning, in studies II and III, coding was conducted according to empirical coding [120], which means systematically examining the entire interview material 'line by line' as close to the empirical data as possible without analysing the content. The intention was to code the material as close to the empirical data as possible to contribute to the analysis process and look for common patterns across the patient narratives. The coding was then systematised in an overview, with colour codes representing preliminary themes (fig. 4). The purpose was to establish coded material that could contribute to the further analysis process and provide an opportunity to designate an exact quote within a specific interview when needed later in the analysis process. Furthermore, the authors discussed the coding list and sorted the material into code groups. Our further procedures during the analysis are described in more detail later. For studies I and II, the quotes were translated from Norwegian to English by one supervisor, checked and approved by another supervisor and the Ph.D. candidate.

Preliminary themes: color codes to systematize the empirical coding

(Ref interview guide: Experience of the treatment offer, communication and participation, and possible benefits)

CODE GROUP 1: Experience of the treatment offer?

TARGETED TOOLS TO HANDLE PSYCHOLOGICAL DISORDERS

THERAPISTS' COMPETENCE – and role

COMMUNICATION - and mutual trust

CODE GROUP 2: Experience of participation and activation?

INFLUENCE ON OWN TREATMENT - own role

ADAPTED TO ME AS INDIVIDUAL

THE RESPONSIBILITY IS ON ME

CODE GROUP 3: Benefits of treatment versus the need for more time?

BENEFITS OF TREATMENT

MORE TREATMENT IF I WANT versus INCONVENIENT TIME PRESSURE

Additional code, if necessary:

Other (if I find something that does not fit in the codes above but may still be important)

Figure 4: Illustration, color codes representing preliminary themes at an early stage in the analysis during study II

Inductive analysis of patient narratives and thematic analysis

In study III, the analysis was inspired by an inductive analysis of patient narratives [110], and our conceptualisation included an inductive discovery of categories or themes that emerged from the data. We obtained the patient stories during the semistructured interviews [116]. This required a collection of stories as data, followed by an analysis that resulted in themes across the stories. We intended to look beyond the collection and construction of stories, which were the focus of the storytellers/informants. The analysis was conducted in groups of four researchers (study III), and we analysed the stories further to extrapolate categories or themes. The most important advantage of such an analysis was to bring order to the experiences by seeing individual experiences in a story as belonging to a category or theme [110]. In addition, we were able to gain general knowledge about the overall stories and themes. Narrative inquiry methods are argued to have the capacity to reveal the complexity of

human experience and to understand how people make sense of their lives within social, cultural and historical contexts [110].

Our analysis of narratives required a collection of stories as data [110], and these stories of the patients' last year since brief therapy ended were collected through individual interviews. Inductive analysis was performed to explore whether categories or themes were present across the patient stories. The first impressions from the patients' interviews resulted in preliminary themes reflecting the patient stories, and all the authors then searched for alternative interpretations in several discussions. Second, all the GP interviews were assessed, and the authors suggested preliminary themes from the GPs' experiences.

Finally, descriptions of preliminary themes and categories across the patients' stories were contrasted with the preliminary themes from the GPs' interviews. Our analysis combined inductive analysis of patients' narratives [110] and comparative thematic analysis of the two groups of participants' experiences (themes from patients' stories and GPs' experiences) [112]. We used thematic analysis to develop patterns of meaning or themes that addressed our research questions and a combined approach to identify patterns across the datasets from patients and GPs to answer the research question. Meaning units were identified, condensed and coded based on conformity and differences. Similarities across interviews were reflected in the composite and condensed stories so that non-verbatim presentations of the participants' stories [121] became generally representative accounts of the participants' experiences. The 'condensed stories' represent 'constructed narratives' in the method of inductive analysis of patient narratives and represent our construction of the participant's experiences [24]. The GPs' experiences helped us to deepen the patients' stories [121] after patients' most meaningful experiences had been thematically grouped and presented. The GPs' experiences and perspectives were added to each story to elaborate on relevant findings in the three constructed narratives (condensed stories), but we chose to present the GPs' experiences separately after each condensed story (figure 5). We experienced that the tension or conflict between different patient narratives became clarifying [109] for analysis and that GPs' experiences helped to complete the picture. Finally, the authors discussed iwhether the condensed stories, combined with the GPs experiences, reflected the main topics in the data material and concluded that it did. Together, we chose quotes from the data material to elaborate on and illustrate the results. For study III, the quotes were translated from

Norwegian to English by the supervisors and then, checked and approved by the Ph.D. candidate.

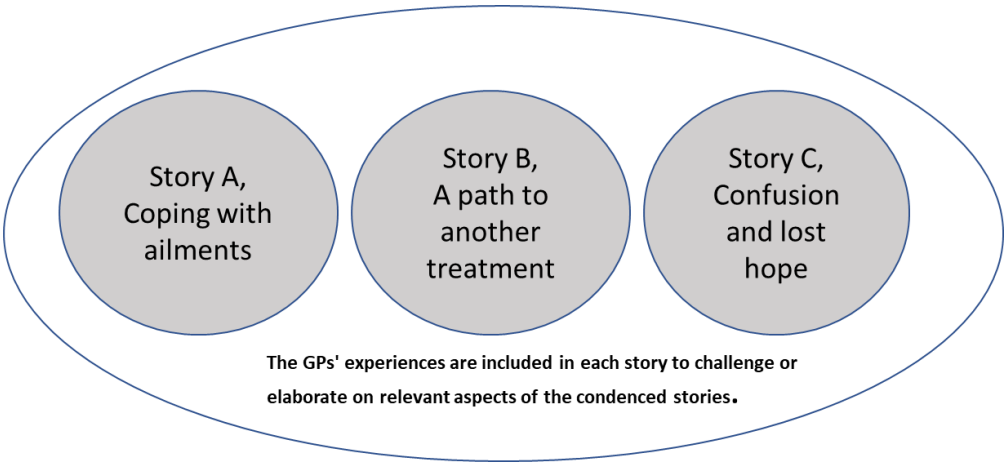

Figure 5: Illustration, condensed stories representing the results after analysis, study III

3.7 Ethical considerations

The studies were conducted in accordance with the Declaration of Helsinki (World Health Organization, 2010). Approval from the Regional Committee for Medical and Health Research Ethics (2018/49/REK Midt) was obtained. All the study participants in the three studies received oral and written information about the study and signed a consent form before taking part in the interviews.

Neither the Ph.D. candidate nor the co-authors of the three studies had any competing interests. The methods used in this thesis were carried out following relevant guidelines and regulations. The names or personal identifications were not registered in the condensed stories and summaries, the reflection memos or transcripts of interviews. Information about the participants was held to a minimum to secure anonymity, and all information in the papers was anonymised. The quotes used in the papers were anonymised.

We emphasise that our ambition to protect patients who participated in two studies (II and III) was necessary. Due to ethical considerations, we could not contact the patients directly, which limited the sample to those who wanted to participate. Instead, the therapists recruited

the patients from the brief therapy unit, and all the therapists recruited patients with some experience receiving the therapy.

The users of mental health services have different degrees of problems, and we made efforts to ensure that they felt safe and were not forced to participate or answer all questions. In addition, extra care was taken to ensure that all information was anonymised in the data material before the co-authors analysed the material. We also agreed that patients had the possibility of contacting specific therapists at the DPC should there be any need for personal support after the interviews in the two studies. Finally, the patients were informed that they could withdraw from the study at any time during the period in which it was in progress.

4 RESULTS

In the following, the results from three studies are presented separately before summarising the overall findings in this thesis.

4.1 Summary of results study I

Study I aimed to explore the professionals' perceptions of how the establishment of a specialised brief therapy unit had affected the organisation, especially the everyday work in the outpatient clinics.

The results in study I, 'professionals' experiences of the establishment of a specialised brief therapy unit in a district psychiatric centre', represented four main themes (fig.6): (1) The brief therapy unit was perceived as successful and celebrated. (2) The general outpatient clinics, on the other hand, were described as 'forgotten'. (3) The establishment process had elucidated different views on treatment in the outpatient clinics and had set off (4) a discussion regarding the criteria for prioritising in mental health services. According to the professionals, establishing brief therapy was the answer to a growing crisis in the DPC due to increased referrals without the supply of increased resources.

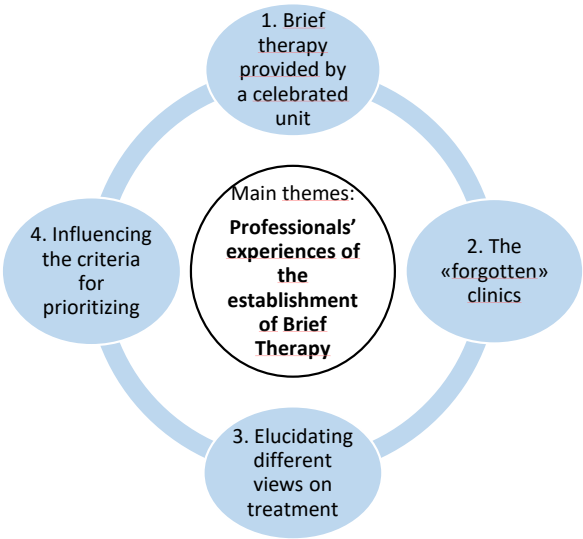

Figure 6: The results of study I, presented as four themes in the paper

Study I showed that, while being in line with health authorities' treatment guidelines, the trend of short-term treatment challenged the professionals' autonomy and judgement. Offering targeted treatment to patients with moderate mental health problems, while having a concurrent aim to solve broader problems in mental health services, entailed a discussion regarding resource use and the appropriate level of treatment provision. As contemporary mental health policy focuses on promotion, prevention and early intervention as innovative efforts, our study showed that professionals called for the authorities to focus on the ongoing needs of those with longer-term and more complex mental health problems. Thus, there might be a need for a complete system approach to prevention, treatment and rehabilitation for the heterogeneous patient population who need different mental health services. Professionals from different secondary and primary care levels could be more involved in improving the implementation processes in mental health care. The aims of innovative efforts are not always obvious, and success needs to be conceptualised and evaluated. Further research should include a longitudinal perspective on implementing innovative efforts in the services, including the perspectives of leaders, professionals and service users in various parts of the services.

4.2 Summary of results study II

Study II aimed to explore patients' and therapists' experiences of brief therapy, especially how the time limitation influences the treatment process.

The results in study II, 'A treatment strategy for meeting life as it is. Patients' and therapists' experiences of brief therapy in a district psychiatric centre', constituted five themes (table 2): (1) Time limit as a frame for targeted change, (2) Clarifying expectations and accountability, (3) Shared agreement on a defined treatment project, (4) Providing tools instead of searching for causes, and (5) Learning to cope—not being cured.

Table 2. Themes with key aspects, study II

Themes	Key aspects[1]
Time-limit as a frame for targeted change	Requirements: acceptance of time limitations; planning and closure skills; early termination if found unwanted/ineffective Consequences: clearer goals; increased structure and focus; stepwise assessment; increased predictability; signaling optimism concerning the duration of problems; strengthening optimism Challenges: insufficient time for both assessment and treatment
Clarifying expectations and accountability	Requirements: joint clarification of expectations; patients' assuming responsibility for and being actively involved in treatment, including between therapy sessions Consequences: increased self-efficacy after treatment; faster change Challenges: lack of motivation; concerns about relapse; more work after completion of therapy
Shared agreement on a defined treatment-project	Requirements: agreement on time-limitation; including a precise treatment plan aiming at concrete, realistic and limited goals; agreement on how to work as a therapist-patient team Consequences: more structured therapy; experiencing therapy as meaningful and time-efficient; aiming for patients to take ownership of their process; hope for improvement
Providing tools instead of searching for causes	Requirements: patients' awareness of their problems; active engagement in their therapy; using tools in between therapy sessions Consequences: increased active participation; learning to use self-management tools; dealing with negative thoughts and stress; improved mastering of life
Learning to cope – not being cured	Requirements: aiming to "master life as it is" and to support self-management; changing focus towards modifying previously unfortunate strategies Consequences: strengthened self-efficacy and coping ability Challenges: continuing the change-work on their own

1. The different key aspects describing themes could include requirements, consequences, and challenges. Table retrieved from Markussen et al. (2021, p. 8)

Study II showed that time limitations appeared to play a positive role in brief therapy, helping the therapists structure the therapeutic process and strengthening the patients' motivation. The experience of a shared treatment project and the opportunity for active participation in treatment might have reinforced patients' responsibility and positive expectations to achieve individual goals. These findings emphasise the importance of the patient's readiness and activation as prerequisites for brief therapy. In addition, brief therapy was perceived as the beginning of a longer recovery process that patients had to continue by themselves. The therapists' efforts to nurture the patients' hope for improvement during treatment can be

assumed to have contributed to increasing the motivation for further efforts and the recovery process after the end of treatment. The end of brief therapy can be viewed as a fragile and uncertain start to the patients' process towards 'mastering life as it is'. More research is needed to investigate patients' long-term outcomes after this treatment and to shed light on the potential for, and limitations of, mastering everyday life after ending brief therapy.

4.3 Summary of results study III

Study III aimed to explore who benefits from brief therapy in a DPC, by investigating patients' stories after ending brief therapy, and the GPs' experiences with referrals for such treatment.

The results in study III showed that some patients benefitted from brief therapy, whereas others did not. The results were presented as three constructed narratives [110] or condensed patient stories (table 3): A) coping with ailments; B) a path to another treatment; and C) confusion and lost hope. The GPs' experiences and perspectives were included in each story to elaborate on relevant findings in the constructed narratives.

Table 3. Condensed patient stories, study III

Condensed story	Number of patients represented in the story (n)*
A) Coping with ailments	5
B) A path to another treatment	6
C) Confusion and lost hope	3

*N=11, but patients could be represented in more than one condensed story. *Condensed patient stories, table retrieved from Markussen et al. (2022, p.12)*

Study III showed that brief therapy appeared beneficial for patients with moderate affective problems, anxiety problems or both. However, brief therapy served as an assessment period for other patients, leading to unnecessarily long pathways for accessing appropriate healthcare services and the unnecessary use of health resources. For other patients with severe, complex, or recurrent mental health problems, brief therapy was experienced as unsuitable, and some patients with chronic problems and severe problems experienced

deterioration in their mental health following brief therapy. Collaborative meetings between the GPs and the DPC seemed to have contributed to discussions and a shared learning process, resulting in more suitable referrals of patients to brief therapy. Therefore, the likelihood of success with brief therapy can probably be increased by establishing an improved system to provide adequate information to patients and GPs who can handle expectations and better ensure two-way communication in the referral phase. In addition, improved communication routines can probably contribute to more appropriate referrals, and more effective communication between patients, GPs and therapists should include information about assessment, treatment options, expectations and follow-up strategies. Such an approach may potentially increase the likelihood of successful treatment outcomes.

4.4 Main findings in this thesis

The overall aim of this thesis was to investigate the opportunities and challenges of providing and receiving brief therapy for patients with moderate mental health problems. In summary, brief therapy appeared beneficial for patients suffering moderately from depressive problems, anxiety problems or both (studies I, II and III). Furthermore, brief therapy contributed to young adults 'coming in contact with' mental health services early, receiving targeted and specialised treatment quickly, and potentially returning rapidly to society (study I). Brief therapy seemed suitable when contributing to patients accepting ailments as part of life; when the patients managed everyday life better after treatment, their self-image and self-confidence improved, they managed to return to school or work, improved close relationships and balanced the strains in life better (studies II and III).

While brief therapy appeared beneficial for several patients (studies II and III), it was experienced as an assessment period for other patients, leading to prolonged treatment courses and the potentially unnecessary use of health resources (studies I and III). In addition, some professionals were concerned that brief therapy had become a trend; that is, 'the quick and only option' to resolve mental problems, and they discussed the use of mental health resources and requested more customised treatment options at suitable treatment levels (studies I and III).

Brief therapy was experienced as unsuitable for patients with severe, complex or recurrent mental health problems, and GPs experienced some patients with chronic and severe problems deteriorating during and after brief therapy. They underlined that brief therapy was usually unsuccessful when provided to patients with extensive problems due to patients not being sufficiently examined or evaluated in advance (study III). While receiving brief therapy, patients with severe problems experienced a focus on 'coping with life as it is,' which ignited hope for recovery (study II), but after therapy ended, the same patients expressed confusion and lost hope of recovery (study III).

While the brief therapy unit was described as innovative and celebrated, the general outpatient clinics that provided treatment for the more severe conditions felt forgotten in the DPC's development efforts. In addition, some professionals expressed a lack of treatment integration between the new brief therapy unit and the rest of the mental health services needed to provide a coherent healthcare service for patients with varying needs (study I).

The GPs experienced that communication before, during and after patient referral was significant when offering brief therapy. Communication strengthens the opportunity for correct referrals and successful treatment results (study III). GPs elaborated that the contact established in regular collaborative meetings made asking for advice easier in follow-up on the patients without improvement after the end of brief therapy (study III).

5 DISCUSSION

The three papers shed light on what patients, therapists, GPs and other professionals value and find challenging when providing and receiving brief therapy. Based on their experiences and perspectives, this thesis investigates the opportunities and challenges of providing and receiving brief therapy for patients with moderate mental health problems.

First, I will discuss how the choice of perspective may influence the assessment of opportunities and challenges when providing and receiving brief therapy. Next, I discuss well-functioning communication as a prerequisite for successful brief therapy. Finally, I discuss whether offering brief therapy to an increasing number of people in DPC (specialist healthcare services) may have unwanted consequences for patients with more extensive psychological problems.

5.1 Discussion of main findings

Assessing success depends on what we are looking for

A significant distinction can be made between evaluating the effect of a single treatment method and assessing the treatment's consequences from a broader perspective. The results of this research project highlight different perspectives that affect the understanding of the opportunities and challenges of providing and receiving brief therapy. The choice of perspective may therefore be decisive for the assessment. I will first point out the difference between assessing brief therapy as a single intervention or as part of an innovative organisational effort with multiple goals.

This project showed that the opportunities and challenges of providing and receiving brief therapy depend on what you are looking for. An awareness of the choice of perspective when assessing innovations might expand the understanding of the scope of action in mental health development work. For example, it appears to be challenging to focus on targeted treatment for patients with moderate mental health problems while concurrently aiming to solve broader problems in the mental health service related to resource use and choice of the correct treatment level (study I). Conversely, if we only consider how a treatment works in isolation, we may lose sight of the big picture, not taking into account the possible adverse consequences of what we introduce as an opportunity to meet the growing demand for mental health services [10].

The establishment of brief therapy at DPC was built on the knowledge that innovative time-limited treatment options showed promising outcomes for adults with common mental problems [26, 38]. As a single intervention, brief therapy appeared to play a positive role, helping the therapists to structure the therapeutic process and strengthening patients' motivation and hope for recovery. Furthermore, shared understanding between patient and therapist and activation during brief therapy seemed to reinforce patients' responsibility and expectations to achieve individual goals. Various terms may describe individual goals, depending on patient participation and shared decision-making [122]. Different synonymous terms may describe the patient's active role during treatment, and user participation, collaboration, partnership and user involvement seem to align with a recovery-oriented approach [122]. Studies II and III show that experienced participation may lead to a personal

process toward ‘mastering life as it is’ (as shown in the poster presentation, Appendix 7). For patients who benefitted from the treatment, their hopeful expectations were nurtured by the therapists during brief therapy. This is in line with research showing that experiences of hope might support patients’ ability to change their perceptions and behaviours during their recovery process [123, 124]. Thus, the findings showed that many patients with moderate mental health problems seemed to benefit from brief therapy (Studies I, II and III). The new intervention seems to provide a better opportunity for many patients, successfully providing a beneficial outcome for them.

In addition, the possible success of an innovative effort should be understood as more than promising clinical treatment results within the context of a single treatment unit [88]. When assessing treatment success, an interpretive perspective on recovery has become increasingly in demand in recent years, and this involves, for example, an investigative and qualitative dialogue on subjective patient experiences and narratives [41]. An increased focus on an interpretive paradigm, which is concerned with understanding the world from the subjective experiences of individuals, can help shape service-based cultures by changing the way services are evaluated [41] and continuously improving. Moreover, neither clinical nor service-defined improvement is necessarily claimed to be included in a patient’s personal experience of recovery [90].

On the other hand, the implementation of brief therapy seemed like a response to a crisis, as an innovative move to solve broader challenges by providing treatment to more patients without increasing resources related to the health authorities’ guidelines (study I). This response aligns with improvement efforts, often focusing on identifying a problem, appropriate treatment, costs and waiting time [20]. Based on brief therapy as an innovative organisational effort with more goals, this research project shows the challenge of balancing conflicting guidelines provided by the health authorities (study I). Prioritising between patients and, at the same time, rejecting fewer patients was perceived as an impossible task. Further, the broader focus on assessing success might imply questions about whether policy guidelines influence which patient groups receive the most attention while developing mental health services (study I). Focusing on resolving mental problems quickly might contribute to an understanding that the authorities' perspectives affect both problem definition and approach during the development of treatment alternatives in mental health services [2, 3]. This understanding aligns with my results (study I), which demonstrate participants’ criticism

of the unintentional negative impact implementation of brief therapy may have, such as more pressure on the general outpatient units and insufficient focus on patients with more extensive treatment needs.

The establishment of brief therapy was experienced as an attempt to resolve mental problems or disorders as quickly as possible (study I). The improvement work in one part of the health service seemed to lead to other parts feeling low priority (study I). Other researchers argue that third parties, such as health authorities, have an increasing influence on mental health services, for example, by introducing time-limited treatment courses [2, 70]. The introduction of funding schemes and guidelines for mental health practice focusing on 'brief and efficient treatment' may negatively impact treatment provision for patients with extensive needs. Thus, a need might exist for a more holistic and complete system approach to prevention, treatment and rehabilitation for the heterogeneous patient population who need different mental health services.

Furthermore, I will focus on brief therapy as part of a coherent mental health service. In Norway, an innovation strategy for mental health in 2016-2020 was expected to help reduce waiting lists, fill gaps in current services, standardise information exchange, and improve clinical pathways [4]. Implementing a new treatment, such as brief therapy, involves various activities within and outside an organisation [88], and my findings suggest that other parts of the DPC should probably have received more attention during the implementation phase. For the implementation of brief therapy in similar settings in the future, establishing the innovative effort might be helpful as part of a broader strategy to improve treatment outcomes for several patient groups and thereby include more perspectives as fruitful contributions during development work (study I). Successful implementation of new treatment methods appears to depend on good interaction between the newly introduced treatment and the context or organisation in which it is implemented, and including all stakeholders in planning and development is thus recommended [70, 75, 125]. Conceptualising success within particular contexts seems essential for evaluating innovative efforts [88]. A broader focus might influence what opportunities and challenges the mental health services face when implementing treatment options for different patient groups in mental health care.

Finally, the targets and outcomes from improvement efforts like new treatment options are very much interwoven and complex [43], since innovations in mental health services are often expected to solve complex system challenges [4, 56], as seen in this research project. Assessing the opportunities and challenges of establishing brief therapy as a new treatment offer quickly becomes a simple assessment of whether the therapy works well for patients with moderate problems. Although brief therapy is efficient for several patient groups [26, 38-40], this does not guarantee that it is implemented successfully in practice [68, 69] or integrated within the context of a coherent service. Furthermore, people need different psychological approaches in real-world clinical settings involving heterogeneous patient groups [48], and an increasing focus on the patient perspective in treatment has contributed to a broader perspective on assessing treatment success in recent decades [5, 91]. A broader perspective might further affect what is supported, financed and developed. This research project encourages policymakers, service providers and mental health professionals to look for the different needs of the patient population when facilitating innovational change in specialist healthcare services, such as DPC. Considering different perspectives seems needed when assessing innovations in mental health services and making the chosen perspective transparent might contribute to a more open debate about success criteria before solutions in mental health services are spread.

Well-functioning communication is a prerequisite for successful brief therapy

The opportunities for brief therapy to be beneficial for patients seemed linked to the possibility of well-functioning communication at various levels. The results of this research project highlight the importance of good communication between patients, GPs and therapists for the treatment to be beneficial and meaningful for the patient.

Brief therapy appeared suitable for relatively well-functioning patients with recently started mental problems (study III). These patients emphasised that trust between therapists and patients was established early in the communication process, potentially positively influencing patients' hopes for recovery and reaching the agreed goal of brief therapy (study II). Our results align with research recommending treating patients' mental health problems only after adequate communication and consensus about the treatment goals have been

reached [77]. The patient's preferences and desires for involvement should therefore be assessed before starting the treatment [5]. In this project, a contract between the patient and therapist was described, committing both parties during brief therapy (study II). Talking about expectations engaged both parties and helped patients take responsibility for their parts in the treatment process, aiming to learn ways to 'master life as it is' (study II). Meta-analyses have demonstrated links between goal consensus, communication, collaboration and patient outcomes in individual psychotherapy [126]. The findings indicate that patients experienced brief therapy as beneficial when they understood the treatment''s purpose and felt able to communicate and participate in the treatment. The goal agreement depended on this ability (studies II and III), and this project suggests that the ability for goal agreement should be an indicator before providing brief therapy. It, tTherefore, seems appropriate to pointing out that brief therapy is a good option for several patients with moderate problems seems appropriate, but it should not be presented as a standardiszed treatment offer for the growing number of young people with various mental health challenges.

Based on the assumptions that brief therapy is not suitable for all patients and that GPs know their patients quite well, this project points to two-way communication during the referral processes contributing to more appropriate referrals of patients to brief therapy (study III). A reasonable question to ask is whether the assessment of brief therapy as beneficial was favourably influenced by whether GPs, together with patients, had the opportunity to provide input before the DPC's choice of treatment approach. Communication to meet the needs of individual patients across different care levels seems to be an essential feature of the quality of care [85]. The GPs who participated in collaborative meetings with the DPC described discussions as fruitful and as a shared learning process that might have led to more suitable referrals for brief therapy. The findings align with research calling for interventions for shared decision-making to ensure that patients' needs will be met [62-64] and other research suggesting a closer integration and collaboration on referrals [127]. In cases of poor communication in the referral phase, the consequence may be an offer of brief therapy that is not beneficial to the patient. The results from this project encourage further collaboration on communication routines between GPs and therapists at DPC to improve the accuracy of referrals and treatment courses during and after brief therapy.

Further, the findings showed that most patients (and some GPs) did not know what treatment they would receive before their first meeting with the therapist at DPC and thus only started

communication with the therapist when the treatment sessions started. However, it was underlined that therapists assessed patients at the first treatment sessions to prepare those who felt ready for brief therapy. Those who expressed that they did not believe the treatment would work for them were advised to wait until they felt ready or to seek treatment elsewhere (study II). By contrast, some patients described not communicating their uncertainty about readiness for brief therapy to the therapist due to fear of losing the treatment offer (study III). Recently published research emphasises the importance of patients experiencing short-term treatment as relevant to them and their situation and that scepticism can arise because patients initially do not expect the treatment to be long enough for them to get better [128]. The involvement of patients is considered crucial to improve the health of patients and healthcare services, and therapists need to assess each service user's desires and abilities for involvement and consider how these can be met [5]. Because some of the patients with extensive complaints perceived the offer of short-term treatment as giving them a feeling of 'not being taken seriously', this also suggests a need for improved dialogue in the preparation phase of brief therapy [128]. The findings showed that conducting an assessment and providing adequate treatment within the limit of 10 therapy sessions was challenging, potentially compromising the quality of one or the other (study II). The consequence might be that brief therapy is offered to some patients, who probably will benefit more from other treatments. Therefore, suggesting separating assessment and treatment processes more clearly seems adequate.

Although brief therapy seems associated with an overall reduction in symptoms [3, 129], recent research shows that most patients are rarely asked whether they perceive their treatment as helpful [95]. Existing studies often focus on outcomes clinicians consider essential in evaluating treatments, while patients' perceptions may differ. The patient's perspective is increasingly seen as an essential independent perspective on treatment [95]. In this project, the patients focused on quality of life, e.g. restoring functioning beyond symptom reduction when describing outcomes (studies II-III). The patients described that hope for recovery increased motivation to engage in the recovery process and strengthened their optimism about the future (study II), and nurturing hope seems an essential factor that therapists can help promote and strengthen [123, 124]. Patients' responses corresponded with the severity of their self-reported health condition before the treatment started, i.e. patients who were mentally more severely ill reported poorer outcomes and vice versa (study III).

People with more complex mental health problems seem to require multiple interventions and follow-ups from multiple services [86] before, during and after the ongoing therapy. In this project, patients with the most extensive complaints expressed the least benefit from brief therapy and probably should have had other treatments or follow-ups.

This research project revealed a discussion on the future of the DPC and how the system could handle the increasing number of patients in need of treatment, and some professionals at the DPC were worried that treating more patients with less severe diagnoses implied doing the work for primary care (study I). When trying to improve treatment processes in mental health care, professionals from different levels of the DPC and the primary care level could be more involved, and collaboration and communication between primary and secondary healthcare services are emphasised and advised [20, 42]. Closer integration and collaboration between service providers are suggested for consultation before patient referrals [127]. Furthermore, the patient perspective should be considered in planning, implementing and evaluating interventions to improve patient participation in these processes [89], including procedures to ensure responsibility between treatment levels and transparency at every stage of the treatment course [130]. In any case, the different treatment levels should ensure continuity of treatment between treatment levels, especially for patients who need long-term treatment and follow-up.

In summary, well-functioning communication at various levels appears to be a prerequisite for brief therapy to be successful. A reasonable suggestion is that extended communication between patients, GPs and practitioners should include information on assessment criteria, different treatment options, mutual expectations, and follow-up strategies. Future studies could investigate sufficient levels of treatment for patients with mild to moderate anxiety and depression. It may seem equally important to research suitable treatments at adequate treatment levels for patients with more extensive complaints.

Challenges when providing brief therapy to more patients

Although Norway is a high-income country with a comprehensive welfare system [54] all political parties agree that social inequalities in health constitute a public health problem and should be reduced [73]. From a public health standpoint, every patient should have equal

access to healthcare services and benefit equally from them [73], regardless of the cause of their problems. For example, access to mental health services can be increased by more patients being offered brief therapy, but this may have undesirable consequences if brief therapy is provided to patients who would benefit more from other treatment options.

The findings showed that brief therapy did not work for all, even though all patients were initially diagnosed with depression or anxiety (studies II and III). Research has shown that a patient's level of education, work situation, social network and the severity of depressive symptoms before treatment might affect the suitability of brief therapy [78, 80]. In this project, patients and GPs described brief therapy as suitable for 'relatively resourceful' patients with the ability to establish or reconnect with 'structures in life' such as studies or work (studies II-III). These findings can be seen in conjunction with research showing that more people with severe mental health problems seem to lose touch with everyday routines and social networks that contribute to stability in their lives [131]. Research describes brief therapy as suitable for patients who can cope with thoughts, feelings and events and can anticipate when and how they may use the skills learned in therapy in future situations [80]. This research project, therefore, suggests that DPC should target brief therapy to patients with moderate mental health problems.

The patient's belief and hope that the therapy will help contribute positively to the individual outcome, and a lack of hope can affect the possibility of symptom relief and other positive changes in the patient's life [123, 132]. In this research project, some patients with chronic or severe problems experienced 'losing hope' and deterioration of their mental health following brief therapy (study III). In case brief therapy is expected to increase access for patients and cost-effectiveness for society [34], it is vital to point out that differences in health status before the start of treatment influenced the individual patient's experience of brief therapy as an opportunity or a challenge in their recovery process.

A challenge for mental health services appears to arise when several patients are offered brief therapy, but the patients have very different needs (study I and III). Moreover, this development might have unintended consequences for patients with more extensive psychological problems (study III). Mental health services research has focused on the gap between what is known about effective treatment and what is provided to different patients in routine care [68], and the claim has been made that risk factors for many common mental

disorders are strongly associated with inequality in health [133]. As health differences and social determinants of mental health problems have received increasing attention within public health research, greater attention should be paid to socioeconomic factors, such as the consequences of drop-out from education and unemployment [82]. Since health can be understood as a structural, functional and emotional state that is compatible with an 'effective' life as an individual and as a member of society [72], the findings call for an extended focus on suitable treatment for long-term and complex psychiatric needs (studies I and III). These findings highlight the importance of providing differentiated, beneficial and appropriate treatment to the growing number of people with various needs.

Furthermore, in a situation with an increasing number of referrals to psychiatry, it might be tempting for the authorities to create 'short and effective' treatment courses because it is possible to reach more patients. However, this research project indicates that more patients receive help due to the brief therapy offered, but those with severe or complex ailments benefitted least from the therapy (study III). Therefore, one may wonder whether providing brief therapy might be an improper and unnecessary use of health resources for portions of the patient group in this study. Furthermore, some patients who did not receive a suitable treatment but received brief therapy as the only alternative seemed to be the most disadvantaged (study III). The health authorities should be aware that offering brief therapy to a broader target group than those benefitting from it may result in a possible systematic avoidable and unfair difference in health outcomes between social groups in the same population [72]. The health authorities should therefore support further research into whether health differences persist or increase through the development of mental health services.

In this research project, some experienced brief therapy treating more patients with moderate problems and perceived this as DPC doing the job of the primary healthcare service. Some professionals were concerned that development work for patients with more complex problems was affected and thus not prioritised in DPC (study I). This finding aligns with the WHO statement that common mental health treatment should occur in primary care [21] and is in line with one of the main aims of the Norwegian Coordination Reform requires a transfer of tasks and responsibilities to primary healthcare services [65]. In addition, previous research has claimed a need for a change in the balance of resources between the levels of care to provide care across systems [134]. Cooperation between primary and secondary healthcare services should be emphasised to meet the needs of different patients [20, 42].

Mental health services are focusing on the increasing number of young adults with anxiety and depression in developing new services at the DPC's treatment level (study I), but this research project questions at which level of care the increasing number of referrals of young adults with anxiety and depression should be treated. Thus, more patients with moderate problems should be offered mental health services in the first-line service (e.g. in the municipality).

This research project calls for prioritising suitable treatment for long-term and complex psychiatric needs and scaling up treatment where it seems needed in the specialist healthcare service (studies I and III). Brief therapy is an opportunity for many patients if health authorities ensure a fair distribution of health resources and access to adapted treatments. A more apparent division of roles between first- and second-line services could contribute to better prioritising and cooperation between the treatment levels. Equal access to adequate mental health treatment and care at the appropriate level of healthcare services might create opportunities and remove factors that prevent patients from achieving their health potential.

Tasks and responsibilities might be transferred between health services and levels. However, irrespective of future role distribution, DPC should limit short-term treatment to the patient group that benefits the most from it and invest innovative efforts in further developing the treatment within the specialist healthcare service for patients with more extensive needs. In any case, the collaboration between the patient, GP and therapist appears decisive for brief therapy to be experienced as beneficial.

5.2 Discussion of methods

This thesis includes three study aims for which different qualitative data collection and analysis methods have been used. Two qualitative methods were combined and used to investigate participants' different perceptions and experiences. This approach made it possible to illuminate a limited field of clinical practice from different perspectives that could contribute to an expanded understanding of content and context. Further, the approach focused on communication, meaning, attitudes and processes [96]. In addition, the follow-up study (study III) also provided an opportunity to explore the same patients' (study II) stories and experiences from the period after therapy ended. Therefore, we found the qualitative approach appropriate for the aims of the three studies.

Qualitative studies are recognised as essential to understanding health care with all of its richness and complexities [135]. Therefore, our choice of qualitative research methods from an interpretative paradigm constituted reflexive methodologies concerned with the systematic collection, organisation and interpretation of textual material drawn from interviews suited for exploring the meanings of social phenomena as experienced by the participants within their natural context [102].

In this research project, the enquiry focused in depth on relatively small samples selected purposefully [114]. The rationale, logic and power of purposeful sampling lie in choosing information-rich cases for an in-depth study. Furthermore, information richness could teach us a lot about issues of central importance to the purpose of the research, thus the concept of purposeful sampling [114]. For example, when our purpose of the study was to explore the different stakeholders' experiences of a specific treatment programme, we thought we would learn much more by carefully focusing on understanding the needs, interests and incentives of a small number of participants than by collecting standardised information from a large, statistically representative sample.

KBT - the Competence Center for Lived Experience and Service Development supported the project application from the start. Representatives from the centre provided substantial input to the interview guides used during the qualitative studies but could not participate in the analysis process due to capacity reasons. Additional service users' involvement as representatives or co-researchers during the planning, data collection, and analysis could have

strengthened users' perspectives in our research. Such expanded collaboration could have contributed to increased reflexivity in our research [136].

The three papers accounted for reflexivity, contributing to transparency and intersubjectivity by acknowledging the researchers' roles and the different parts of the research context. While the positivist notion of objectivity assumes that the researcher takes a view from nowhere and observes a fact, reflexivity implies that different versions of the same phenomenon are perceived and interpreted from different angles [102].

In study I, the sample consisted of leaders, coordinators and other key personnel and had good gender representation and diversity of experiences from different parts of the outpatient clinics in the DPC. When asking leaders to recruit study participants, they could possibly influence the choice of information sources and bring about potential bias. However, the study depended on professionals with first-hand experience of the new unit from different perspectives and positions within the organisation. In addition, participants were added to include a variety of perspectives until the sample was considered to have sufficient information power [115].

In study II, the sample consisted of both patients and therapists, and variation in age and gender constituted a strength. A potential limitation was the management's initial choice of staff (those who 'believed in' brief therapy) when recruiting professionals working in the brief therapy unit. Those interested in brief therapy were encouraged to apply for work in the brief therapy unit. Thus, they were likely to be dedicated to brief therapy. However, we did not consider this as a methodological weakness because the unit was composed this way. Another potential bias is that the therapists recruited the patients as study participants, and their participation may have been affected by how the therapists presented the study alongside the information sheet. However, our study depended on participants with first-hand experience receiving brief therapy, and we found this recruitment process effective in reaching relevant participants. Afterward, we found a breadth of patient experiences in the sample.

In study III, the same patients were interviewed anew. The changes in conducting interviews in study III due to the Covid-19 lockdown did not affect the number of participants in the study. However, it is worth mentioning that interviews with the same patients were conducted face-to-face in study II and that the establishment of this first contact probably made it easier

to conduct the most recent interviews by Skype or telephone by the same interviewer. In addition, GPs were included in study III, working in five different GP offices around the DPC's catchment area. The inclusion criterion was that they worked at a GP office that referred patients for brief therapy and had personal experience following the referral of patients for such treatment since 2017. Potential participants were informed about the study by the Ph.D. candidate via e-mail sent to several GP offices in the geographical area around this DPC. In addition, reminders were sent to four offices. The participants responded to the e-mail confirming that they would participate, and the Ph.D. candidate called them to make an appointment for an interview. We found this recruitment adequate because the sample of GPs included diversity in experiences of referring several patients to the DPC since 2016 and diversity in whether the GPs had attended collaboration meetings with the DPC or not.

Asking participants about their past experiences also introduced a risk of recall bias. Data collected at different time points in the implementation process could have strengthened the long-term perspectives of professionals and patients' experiences. In studies II and III, we conducted interviews with patients during therapy and one year after the brief therapy ended. Encompassing an even longer longitudinal approach would have strengthened the long-term perspective of this thesis. On the other hand, our interviews with a limited number of GPs represented their overall experiences of referring patients for brief therapy at this specific DPC, and these GPs' experiences were related to several patients over the past five years. We conducted an exploratory study (study III) as a combined inductive and thematic analysis of patient stories and GPs' experiences, which we contrasted.

Our choice of a qualitative health research design helped logically and pragmatically determine the appropriate methods to use when 1) defining a purposeful sample; 2) identifying appropriate strategies for data collection; 3) rigorously applying analytic techniques to the gathered data; and 4) presenting valid findings [137]. In addition, we noticed that qualitative studies often had been an integral component of programme evaluations to identify and describe contextual factors related to individuals, teams, organisations or social structures that inhibit or facilitate the successful adoption, implementation and delivery of an intervention [137], such as during the introduction of a new treatment offer in an existing treatment system.

In study I, Mindjet MindManager (2017) was used to visualise the codes in each interview and to sort meaning units. The coding in studies II and III was conducted by systematically examining the text line by line, looking for meaning units that could shed light on the aim of the studies. The methods used to do so according to empirical coding [120] strengthened the process of analysing data as close to the empirical material as possible. When reporting on this qualitative research, we included descriptions of the setting involved, quotes from participants, and the patient stories in study III, including 'rich descriptions.' This may be considered a strength of validity or credibility in our qualitative research [96, 109]. In addition, during analysis in this thesis, the patients' treatment experiences have been listened to, included and compared with the professionals' experiences, thereby providing trustworthiness.

Opportunities and challenges are presented and expressed as the participants' experiences and perceptions. Therefore, there is reason to emphasize that this thesis provides insight into the opportunities and challenges of providing and receiving brief therapy by focusing on patients' and professionals' experiences and perspectives.

The influence of researchers' backgrounds on the research project

When articulating the aim of the thesis, my choices were guided by some of my preconceptions. The measure of validity should be reflected as an honest reflection of the researcher's abilities and effects on the research [96]. The validity is often reported when considering the trustworthiness of research [138]. Reflexivity refers to the researcher's background and position and how it influences the choice of subject for investigation, the angle of investigation and the use of methods. Decisions regarding analytical samples or interpretations of findings and the framing and communication of conclusions are considered the most adequate [96].

Reflexivity is essential for quality control in qualitative research, and understanding the researcher's characteristics and experiences might be essential [139]. Before becoming a Ph.D. candidate, I was a trained Community Planner with additional education. Throughout my education and professional career over the last 30 years, I have been concerned that social and healthcare services should be developed based on the best available knowledge,

including human experience, participation, and shared learning. As a result, I have been explicitly concerned with how healthcare services can best be developed according to patients' needs, which may have affected my focus during the choice of study design. In addition, I have several years of experience in development work in the public sector, including as a consultant, process supervisor, and project manager in mental health care, (e.g. mental hospital planning). In this context, I have led several development projects in specialist health services (including DPCs) and collaborated with authorities, leaders, employees, patients, relatives and other partners. However, I have never been involved in planning or assessing brief therapy or the like at DPC.

I have previous experience promoting the participation of individuals and groups in service and community development, and I am used to communicating with different people in different contexts. My background has guided me in the direction of a research project exploring experiences of the services in mental health care which might have influenced my framing and communication of conclusions in this thesis. I became particularly interested when I heard of a new treatment option, brief therapy, that seemed to have better treatment results for young adults with anxiety and depression than previous treatment programmes. Because many young people are struggling with anxiety and depression in our part of the world, I found that new, so-called innovative treatment options were exciting and valuable to explore. Therefore, this research project aimed to investigate the opportunities and challenges of providing and receiving brief therapy for patients with moderate mental health problems. Choosing the aim of the study was a prerequisite for selecting the research method. The method includes data analysis, and my preconceptions could have influenced the results. However, my preconceptions were balanced because the chosen aim and methods were made in consultation with the supervisors and my two research groups and after input from KBT.

Therefore, when articulating the aim of this thesis, my choices were guided by some of my preconceptions, and the interpreted data were already constructed by the participants and supervisors. Furthermore, we aimed to perform intersubjectivity while writing the articles, which means that the analysis was conducted and presented so that others could read about the procedure and progress and understand the conclusions [103]. This thorough procedure based on dialogue strengthens the thesis's communicative validity [96, 97].

The analysis was conducted in a group of five researchers with different backgrounds (medicine, psychology, social sciences and health services research), and the diversity in backgrounds and experience was a strength of the three studies. HVM is a doctoral candidate in medicine with a professional background in medical sociology and community planning at the MA level and several years of experience in mental health hospital planning, including service innovation tasks from this area of Norway. LA is a researcher and physician (specialist in physical medicine and rehabilitation), and PV is an associate professor in health sciences and health services research. BH is a researcher and associate professor in Health and Care Science. Finally, MBR is a professor in mental health work with a Ph.D. in public health and psychology background. Two authors (HVM and MBR) also discussed and adjusted the guides' content in meetings in a research group on patient education and participation where both are members. Discussions in two interprofessional research groups strengthened the study by providing alternative considerations and invaluable feedback in the analytic process, increasing credibility and investigating the dependability of the results and discussion.

Preconceptions are part of all the participating researchers 'lived life' in meeting the topic before starting and during the work. Pre-understanding can be understood as experiences, hypotheses, professional perspectives and a theoretical basis [96]. An assumption in qualitative research is the belief that knowledge is embedded in individuals' lives and experiences [140]. The three studies developed knowledge through a collaborative process involving in-depth interviews between researchers and participants with experience with the treatment.

Reflexivity linked to preconception may be described as 'the luggage we bring with us in the backpack' at the start of a research project (e.g. what questions we ask and how we interpret and follow up the answers in an interview). The research appears as a systematic and reflective process for developing knowledge, and the co-authors' preconceptions were part of this [96]. For example, when preparing for semi-structured interviews, the co-authors discussed the predefined questions and topics from different angles to facilitate robust data that could provide insight into the participants' experiences, perceptions, or opinions [118]. Five authors with different professional backgrounds conducted the analysis, so their complementary experiences strengthened the analytic processes. The analysis was a collaborative process among the authors in all three studies. Themes were constructed and

validated through discussions in the entire author group and were based on common patterns and categories following the chosen methods for analysis.

External validity

The validity of this thesis has to do with the extent to which the scientific methods examine what it is intended to examine [97] and whether our analyses actually reflect the phenomenon we described in the analysis and discussions. The thorough description of the researchers' methods used in the data gathering and analysis (Chapter 3) helps make our findings transparent in this thesis.

Extern validity can refer to the results' relevance and generalisability in similar mental health care settings [96]. Our results were based on stakeholders' experiences from different points of view in the same DPC context. When studying experiences from one single DPC and several GP offices in the surrounding area, our results are not necessarily directly transferable to other DPCs' or mental health systems. Nevertheless, this thesis can contribute to a developed understanding and expanded knowledge base within this field of research due to the analysis of our findings that provided insight into experiences with innovation and service development in mental health care.

6. CONCLUSIONS

The overall aim of this thesis was to investigate the opportunities and challenges of providing and receiving brief therapy for patients with moderate mental health problems. The three studies examined different aspects of providing and receiving brief therapy and showed that a conscious choice of perspective when assessing outcomes might affect the conclusions. Assessing success after implementing brief therapy seems to depend on what we are looking for.

Brief therapy appeared beneficial for relatively well-functioning patients with recently started and moderate mental problems. In addition, trust between therapists and patients seemed to positively influence patients' hope for recovery and reaching the agreed goal of brief therapy. Furthermore, time limitations appeared as a cornerstone in brief therapy, supporting a shared focus on the patients' change and maintaining structure and focus during the treatment. Finally, brief therapy seemed suitable when contributing to patients accepting ailments as part of life and managing everyday life better after treatment.

Moreover, the findings emphasise the importance of mapping the patient's readiness and activation before offering brief therapy. Brief therapy appeared beneficial for patients with moderate depression, anxiety problems, or both and less beneficial for patients with severe, complex or recurrent mental health problems. Predictable cooperation and communication between patients, GPs and therapists can improve referral processes and customised treatment. Therefore, well-functioning communication appears to be a prerequisite for successful brief therapy. This research project also emphasises the importance of communication between these stakeholders before, during and after brief therapy.

When trying to solve broader challenges in mental health services, the suitability for the patients' various needs should be assessed. Offering brief therapy to a growing number of patients seems to challenge the mental health system, because the treatment is, in some cases, offered to people needing other types of treatment. Prolonged or incorrect treatment is not a good use of health resources, nor does it serve the patients' best interests. In addition, this research project raises questions about whether brief therapy should be offered in the first-line service, cf. the intention of the lowest possible adequate level of treatment (e.g. as a municipal offer). Differentiated offers for patients with extensive and complex needs should

be developed further in mental health services. Increased cooperation and role clarification between the levels of treatment might support and coordinate the follow-up of patients with different needs.

7 IMPLICATIONS FOR PRACTICE AND RESEARCH

Access to mental health services can be increased by more patients being offered brief therapy, but this may have undesirable consequences when brief therapy is provided to patients who would benefit better from other treatment options. This research project highlighted the importance of providing beneficial and appropriate treatment and follow-up to the growing number of people with various needs seeking mental health services.

Although brief therapy seems beneficial for several patients, it should not be presented as a standardized treatment for the growing number of young people with various mental health challenges. Instead, there is a need for a complete system approach to prevention, treatment, and rehabilitation.

Providing transparent and predictable information about brief therapy from DPC to patients and GPs can contribute to a better clarification of expectations and improved two-way communication, which can contribute to appropriate referrals for brief therapy. The communication between patients, GPs, and therapists should include information about assessments, treatment options, expectations, and follow-up strategies. In addition, collaboration meetings may potentially increase the likelihood of successful treatment outcomes.

The patients who perceived brief therapy as beneficial expressed treatment as a fragile beginning of an improvement process and personal recovery. More research is needed to investigate the patients' long-term outcomes after brief therapy and to shed light on the potential for and limitations of mastering everyday life after ending therapy.

This research project recommends including professionals from different parts of the specialist and primary health services in innovation work in mental healthcare services. In addition, patients and professionals should be more involved when implementing innovative efforts, and the criteria for success should be conceptualized and evaluated.

Further research should include a longitudinal perspective on implementing innovative efforts in the services, including the perspectives of leaders, professionals, caregivers, service users, and relatives in various parts of the services.

References

1. Unnikrishnan MK: **Eminence or Evidence? The Volatility, Uncertainty, Complexity, and Ambiguity in Healthcare**. *J Pharmacol Pharmacother* 2017, **8**(1):1-2.
2. Berghmans R, Berg M, van den Burg M, ter Meulen R: **Ethical issues of cost effectiveness analysis and guideline setting in mental health care**. *J Med Ethics* 2004, **30**(2):146-150.
3. Wright T, Simpson-Young V, Lennings C: **Therapeutic process in the context of third party determined time limits**. *Clin Psychol* 2012, **16**(2):82-92.
4. **Strategi for innovasjon i Helse Midt-Norge (2016–2020).** [https://helse-midt.no/Documents/Strategi/Strategi%20for%20innovasjon%20Helse%20Midt-Norge%20for%20perioden%202016-2020.pdf]
5. Sagsveen E, Rise MB, Grønning K, Westerlund H, Bratås O: **Respect, trust and continuity: A qualitative study exploring service users' experience of involvement at a Healthy Life Centre in Norway**. *Health Expect* 2019, **22**(2):226-234.
6. Markussen HV, Aasdahl L, Rise MB: **Professionals' perceptions of the establishment of a specialized brief therapy unit in a district psychiatric centre - a qualitative study**. *BMC Health Serv Res* 2020.
7. Markussen HV, Aasdahl L, Viksveen P, Hedberg B, Rise MB: **A treatment strategy for meeting life as it is. Patients' and therapists' experiences of brief therapy in a district psychiatric centre: A qualitative study**. *PLoS One* 2021, **16**(10):e0258990.
8. Patel V, Saxena S, Lund C, Thornicroft G, Baingana F, Bolton P, Chisholm D, Collins PY, Cooper JL, Eaton J *et al*: **The Lancet Commission on global mental health and sustainable development**. *Lancet* 2018, **392**(10157):1553-1598.
9. Patel V, Saxena S, Frankish H, Boyce N: **Sustainable development and global mental health--a Lancet Commission**. *Lancet* 2016, **387**(10024):1143-1145.
10. Wittchen HU, Jacobi F, Rehm J, Gustavsson A, Svensson M, Jonsson B, Olesen J, Allgulander C, Alonso J, Faravelli C *et al*: **The size and burden of mental disorders and other disorders of the brain in Europe 2010**. *Eur Neuropsychopharmacol* 2011, **21**(9):655-679.
11. Holmes EA, Ghaderi A, Harmer CJ, Ramchandani PG, Cuijpers P, Morrison AP, Roiser JP, Bockting CLH, O'Connor RC, Shafran R *et al*: **The Lancet Psychiatry Commission on psychological treatments research in tomorrow's science**. *The lancet Psychiatry* 2018, **5**(3):237-286.
12. Knizek BL, Mugisha J, Kinyanda E, Hjelmeland H: **A Patchwork of Good Intentions: A Critical Look at Different Perspectives Regarding Ethics-Based Mental Health Care in Under-Resourced Settings**. In: *Foundation of Ethics-Based Practices: Annals of Theoretical Psychology Vol 18.* edn. Edited by Knizek BL, Klempe SH. Cham: Springer International Publishing; 2021: 135-150.
13. Craner JR, Sawchuk CN, Smyth KT: **Outcomes of a 6-week cognitive-behavioral and mindfulness group intervention in primary care**. *Fam Syst Health* 2016, **34**(3):250-259.
14. Wolgensinger L: **Cognitive behavioral group therapy for anxiety: recent developments**. *Dialogues Clin Neurosci* 2015, **17**(3):347-351.
15. Tiemens B, Kloos M, Spijker J, Ingenhoven T, Kampman M, Hendriks GJ: **Lower versus higher frequency of sessions in starting outpatient mental health care and the risk of a chronic course; a naturalistic cohort study**. *BMC Psychiatry* 2019, **19**(1):228.
16. Ormel J, Kessler RC, Schoevers R: **Depression: more treatment but no drop in prevalence: how effective is treatment? And can we do better?** *Curr Opin Psychiatry* 2019, **32**(4):348-354.

17. Lim GY, Tam WW, Lu Y, Ho CS, Zhang MW, Ho RC: **Prevalence of Depression in the Community from 30 Countries between 1994 and 2014**. *Sci Rep* 2018, **8**(1):2861.
18. Aarons GA, Sommerfeld DH, Walrath-Greene CM: **Evidence-based practice implementation: The impact of public versus private sector organization type on organizational support, provider attitudes, and adoption of evidence-based practice**. *Implement Sci* 2009, **4**(1):83-83.
19. Knapstad M, Lervik LV, Saether SMM, Aaro LE, Smith ORF: **Effectiveness of Prompt Mental Health Care, the Norwegian Version of Improving Access to Psychological Therapies: A Randomized Controlled Trial**. *Psychother Psychosom* 2019:1-16.
20. Clark DM: **Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: the IAPT experience**. *Int Rev Psychiatry* 2011, **23**(4):318-327.
21. World Health Organization: **The world health report 2001—Mental health: new understanding, new hope**. Geneva: World Health Organization; 2001.
22. Malhi GS, Mann JJ: **Depression**. *Lancet* 2018, **392**(10161):2299-2312.
23. Wang J, Wu X, Lai W, Long E, Zhang X, Li W, Zhu Y, Chen C, Zhong X, Liu Z *et al*: **Prevalence of depression and depressive symptoms among outpatients: a systematic review and meta-analysis**. *BMJ Open* 2017, **7**(8):e017173.
24. Thapar A, Collishaw S, Pine DS, Thapar AK: **Depression in adolescence**. *Lancet* 2012, **379**(9820):1056-1067.
25. De Geest RM, Meganck R: **How Do Time Limits Affect Our Psychotherapies? A Literature Review**. *Psychol Belg* 2019, **59**(1):206-226.
26. Zhang A, Franklin C, Currin-McCulloch J, Park S, Kim J: **The effectiveness of strength-based, solution-focused brief therapy in medical settings: a systematic review and meta-analysis of randomized controlled trials**. *J Behav Med* 2018, **41**(2):139-151.
27. Driessen E, Van HL, Peen J, Don FJ, Twisk JWR, Cuijpers P, Dekker JJM: **Cognitive-behavioral versus psychodynamic therapy for major depression: Secondary outcomes of a randomized clinical trial**. *J Consult Clin Psychol* 2017, **85**(7):653-663.
28. Borza L: **Cognitive-behavioral therapy for generalized anxiety**. *Dialogues Clin Neurosci* 2017, **19**(2):203-208.
29. Lloyd C, Waghorn G, Williams PL: **Conceptualising recovery in mental health rehabilitation**. *Br J Occup Ther* 2008, **71**(8):321-328.
30. Krebs P, Norcross JC, Nicholson JM, Prochaska JO: **Stages of change and psychotherapy outcomes: A review and meta-analysis**. *J Clin Psychol* 2018, **74**(11):1964-1979.
31. Kramer J, Conijn B, Oijevaar P, Riper H: **Effectiveness of a web-based solution-focused brief chat treatment for depressed adolescents and young adults: randomized controlled trial**. *J Med Internet Res* 2014, **16**(5):e141.
32. Garrido S, Millington C, Cheers D, Boydell K, Schubert E, Meade T, Nguyen QV: **What Works and What Doesn't Work? A Systematic Review of Digital Mental Health Interventions for Depression and Anxiety in Young People**. *Front Psychiatry* 2019, **10**:759.
33. Melnyk BM, Kelly SA, Stephens J, Dhakal K, McGovern C, Tucker S, Hoying J, McRae K, Ault S, Spurlock E *et al*: **Interventions to Improve Mental Health, Well-Being, Physical Health, and Lifestyle Behaviors in Physicians and Nurses: A Systematic Review**. *Am J Health Promot* 2020, **34**(8):929-941.
34. Migone P: **What does "brief" mean? A theoretical critique of the concept of brief therapy from a psychoanalytic viewpoint**. *J Am Psychoanal Assoc* 2014, **62**(4):631-656.
35. Read H, Roush S, Downing D: **Early Intervention in Mental Health for Adolescents and Young Adults: A Systematic Review**. *Am J Occup Ther* 2018, **72**(5):7205190040p7205190041-7205190040p7205190048.
36. Eckert PA: **Acceleration of change: Catalysts in brief therapy**. *Clin Psychol Rev* 1993, **13**(3):241-253.

37. Koss MP, Shiang J: **Research on brief psychotherapy**. 1994.
38. Abbass AA, Kisely SR, Town JM, Leichsenring F, Driessen E, De Maat S, Gerber A, Dekker J, Rabung S, Rusalovska S *et al*: **Short-term psychodynamic psychotherapies for common mental disorders**. *Cochrane Database Syst Rev* 2014(7):Cd004687.
39. Shapiro DA, Barkham M, Stiles WB, Hardy GE, Rees A, Reynolds S, Startup M: **Time is of the essence: A selective review of the fall and rise of brief therapy research**. *Psychol Psychother* 2003, **76**(Pt 3):211-235.
40. Dekker J, Molenaar PJ, Kool S, Van Aalst G, Peen J, de Jonghe F: **Dose-effect relations in time-limited combined psycho-pharmacological treatment for depression**. *Psychol Med* 2005, **35**(1):47-58.
41. Williams CH: **Improving access to psychological therapies (IAPT) and treatment outcomes: epistemological assumptions and controversies**. *J Psychiatr Ment Health Nurs* 2015, **22**(5):344-351.
42. National Institute for Health and Clinical Excellence: **Commonmental health disorders: identification and pathways to care (CG123)**. London: NICE; 2011.
43. Cuijpers P: **Targets and outcomes of psychotherapies for mental disorders: an overview**. *World Psychiatry* 2019, **18**(3):276-285.
44. Tiller JW: **Depression and anxiety**. *Med J Aust* 2013, **199**(S6):S28-31.
45. Barkham M, Connell J, Stiles WB, Miles JN, Margison F, Evans C, Mellor-Clark J: **Dose-effect relations and responsive regulation of treatment duration: the good enough level**. *J Consult Clin Psychol* 2006, **74**(1):160-167.
46. Ewen V, Mushquash AR, Bailey K, Haggarty JM, Dama S, Mushquash CJ: **Same-Day Counseling: Study Protocol for the Evaluation of a New Mental Health Service**. *JMIR Res Protoc* 2016, **5**(1):e22.
47. Roth A, Fonagy P: **What works for whom?: a critical review of psychotherapy research**: Guilford Press; 2006.
48. Hersen M, Biaggio M: **Effective brief therapies: A clinician's guide**: Elsevier; 2000.
49. Haagsma JA, Graetz N, Bolliger I, Naghavi M, Higashi H, Mullany EC, Abera SF, Abraham JP, Adofo K, Alsharif U *et al*: **The global burden of injury: incidence, mortality, disability-adjusted life years and time trends from the Global Burden of Disease study 2013**. *Inj Prev* 2016, **22**(1):3-18.
50. Kessler RC, Amminger GP, Aguilar-Gaxiola S, Alonso J, Lee S, Ustün TB: **Age of onset of mental disorders: a review of recent literature**. *Curr Opin Psychiatry* 2007, **20**(4):359-364.
51. Knudsen AK, Øverland S, Hotopf M, Mykletun A: **Lost working years due to mental disorders: an analysis of the Norwegian disability pension registry**. *PLoS One* 2012, **7**(8):e42567.
52. Tørseth TN, Ådnanes M: **Trust in pathways? Professionals' sensemaking of care pathways in the Norwegian mental health services system**. *BMC Health Serv Res* 2022, **22**(1):33.
53. Grimsmo A, Lohre A, Rosstad T, Gjerde I, Heiberg I, Steinsbekk A: **Disease-specific clinical pathways - are they feasible in primary care? A mixed-methods study**. *Scand J Prim Health Care* 2018, **36**(2):152-160.
54. Tikkanen R, Osborn R, Mossialos E, Djordjevic A, Wharton G: **International profiles of health care systems**. *The Commonwealth Fund* 2020.
55. Mossialos E, Wenzl M, Osborn R, Sarnak D: **2015 international profiles of health care systems**: Canadian Agency for Drugs and Technologies in Health Ottawa, ON, Canada; 2016.
56. **Strategy 2020** [https://helse-midt.no/helsefaglig/helsefaglig/mal-og-strategier]
57. Roberts JP, Fisher TR, Trowbridge MJ, Bent C: **A design thinking framework for healthcare management and innovation**. *Healthc (Amst)* 2016, **4**(1):11-14.
58. OECD: **OECD Reviews of Health Care Quality: Norway 2014; Raising Standards**; 2014.

59. Gianfredi V, Blandi L, Cacitti S, Minelli M, Signorelli C, Amerio A, Odone A: **Depression and Objectively Measured Physical Activity: A Systematic Review and Meta-Analysis**. *Int J Environ Res Public Health* 2020, **17**(10).
60. Greenhalgh T, Robert G, Macfarlane F, Bate P, Kyriakidou O: **Diffusion of innovations in service organizations: systematic review and recommendations**. *Milbank Q* 2004, **82**(4):581-629.
61. Altmann U, Thielemann D, Zimmermann A, Steffanowski A, Bruckmeier E, Pfaffinger I, Fembacher A, Strauss B: **Outpatient Psychotherapy Improves Symptoms and Reduces Health Care Costs in Regularly and Prematurely Terminated Therapies**. *Front Psychol* 2018, **9**:748.
62. Vanhaecht K: **The impact of clinical pathways on the organisation of care processes**. 2007.
63. Vanhaecht K, Panella M, Van Zelm R, Sermeus W: **An overview on the history and concept of care pathways as complex interventions**. *International Journal of Care Pathways* 2010, **14**(3):117-123.
64. Bauer M, Fitzgerald L, Haesler E, Manfrin M: **Hospital discharge planning for frail older people and their family. Are we delivering best practice? A review of the evidence**. *J Clin Nurs* 2009, **18**(18):2539-2546.
65. Norwegian Ministry of Health and Care Services: **The Coordination Reform. Proper treatment – at the right place and right time (English summary of the white paper). Report no. 47 (2008–2009) to the Storting**. Oslo: Norwegian Ministry of Health and Care Services; 2009.
66. Martin GP, Kocman D, Stephens T, Peden CJ, Pearse RM: **Pathways to professionalism? Quality improvement, care pathways, and the interplay of standardisation and clinical autonomy**. *Sociol Health Illn* 2017, **39**(8):1314-1329.
67. Bang H: **Organisasjonskultur: en begrepsavklaring**. *Tidsskrift for norsk psykologforening* 2013, **50**(4):326-336.
68. Proctor EK, Landsverk J, Aarons G, Chambers D, Glisson C, Mittman B: **Implementation research in mental health services: an emerging science with conceptual, methodological, and training challenges**. *Adm Policy Ment Health* 2009, **36**(1):24-34.
69. Dryden-Palmer KD, Parshuram CS, Berta WB: **Context, complexity and process in the implementation of evidence-based innovation: a realist informed review**. *BMC Health Serv Res* 2020, **20**(1):81.
70. Damschroder LJ, Aron DC, Keith RE, Kirsh SR, Alexander JA, Lowery JC: **Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science**. *Implement Sci* 2009, **4**:50.
71. Kimberly J, Cook JM: **Organizational measurement and the implementation of innovations in mental health services**. *Adm Policy Ment Health* 2008, **35**(1-2):11-20.
72. McCartney G, Popham F, McMaster R, Cumbers A: **Defining health and health inequalities**. *Public Health* 2019, **172**:22-30.
73. Arntzen A, Bøe T, Dahl E, Drange N, Eikemo TA, Elstad JI, Fosse E, Krokstad S, Syse A, Sletten MA *et al*: **29 recommendations to combat social inequalities in health. The Norwegian Council on Social Inequalities in Health**. *Scand J Public Health* 2019, **47**(6):598-605.
74. Rich E, Miah A, Lewis S: **Is digital health care more equitable? The framing of health inequalities within England's digital health policy 2010–2017**. *Sociol Health Illn* 2019, **41**:31-49.
75. Thakur R, Hsu SHY, Fontenot G: **Innovation in healthcare: Issues and future trends**. In. [New York, NY] :; 2012: 562-569.
76. May CR, Mair F, Finch T, MacFarlane A, Dowrick C, Treweek S, Rapley T, Ballini L, Ong BN, Rogers A *et al*: **Development of a theory of implementation and integration: Normalization Process Theory**. *Implement Sci* 2009, **4**:29.

77. Tryon GS, Winograd G: **Goal consensus and collaboration**. 2011.
78. Davidson L: **The recovery movement: Implications for mental health care and enabling people to participate fully in life**. *Health Aff (Millwood)* 2016, **35**(6):1091-1097.
79. Knekt P, Grandell L, Sares-Jäske L, Lindfors O: **Poor suitability for psychotherapy - a risk factor for treatment non-attendance?** *J Affect Disord* 2021.
80. Dos Santos É N, Molina ML, Mondin T, Cardoso TA, Silva R, Souza L, Jansen K: **Long-term effectiveness of two models of brief psychotherapy for depression: A three-year follow-up randomized clinical trial**. *Psychiatry Res* 2020, **286**:112804.
81. Marmot M, Friel S, Bell R, Houweling TA, Taylor S: **Closing the gap in a generation: health equity through action on the social determinants of health**. *Lancet* 2008, **372**(9650):1661-1669.
82. Brydsten A, Hammarström A, San Sebastian M: **Health inequalities between employed and unemployed in northern Sweden: a decomposition analysis of social determinants for mental health**. *Int J Equity Health* 2018, **17**(1):59.
83. Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B: **Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study**. *Lancet* 2012, **380**(9836):37-43.
84. Scaioli G, Schäfer WLA, Boerma WGW, Spreeuwenberg PMM, Schellevis FG, Groenewegen PP: **Communication between general practitioners and medical specialists in the referral process: a cross-sectional survey in 34 countries**. *BMC Fam Pract* 2020, **21**(1):54.
85. Storm M, Husebø AML, Thomas EC, Elwyn G, Zisman-Ilani Y: **Coordinating Mental Health Services for People with Serious Mental Illness: A Scoping Review of Transitions from Psychiatric Hospital to Community**. *Adm Policy Ment Health* 2019, **46**(3):352-367.
86. Killaspy H: **Improving the quality of global mental health care requires universal agreement on minimum national investment**. *World Psychiatry* 2018, **17**(1):40-41.
87. Ose SO, Kaspersen SL, Pettersen I: **Transferring psychiatric specialist services to local authorities-Characteristics of the patients involved**. *Nord J Psychiatry* 2016, **70**(8):633-640.
88. Proctor E, Silmere H, Raghavan R, Hovmand P, Aarons G, Bunger A, Griffey R, Hensley M: **Outcomes for implementation research: conceptual distinctions, measurement challenges, and research agenda**. *Adm Policy Ment Health* 2011, **38**(2):65-76.
89. Selvin M, Almqvist K, Kjellin L, Schröder A: **Patient participation in forensic psychiatric care: Mental health professionals' perspective**. *Int J Ment Health Nurs* 2021, **30**(2):461-468.
90. Chester P, Ehrlich C, Warburton L, Baker D, Kendall E, Crompton D: **What is the work of recovery oriented practice? A systematic literature review**. *Int J Ment Health Nurs* 2016, **25**(4):270-285.
91. Bergerum C, Thor J, Josefsson K, Wolmesjö M: **How might patient involvement in healthcare quality improvement efforts work-A realist literature review**. *Health Expect* 2019, **22**(5):952-964.
92. Rise MB, Westerlund H, Bjørgen D, Steinsbekk A: **Safely cared for or empowered in mental health care? Yes, please**. *Int J Soc Psychiatry* 2014, **60**(2):134-138.
93. Ryan RM, Deci EL: **Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being**. *Am Psychol* 2000, **55**(1):68-78.
94. Lester H, Tritter JQ, Sorohan H: **Patients' and health professionals' views on primary care for people with serious mental illness: focus group study**. *BMJ* 2005, **330**(7500):1122.
95. Harris MG, Kazdin AE, Munthali RJ, Vigo DV, Hwang I, Sampson NA, Al-Hamzawi A, Alonso J, Andrade LH, Borges G *et al*: **Perceived helpfulness of service sectors used for mental and substance use disorders: Findings from the WHO World Mental Health Surveys**. *Int J Ment Health Syst* 2022, **16**(1):6.
96. Malterud K: **Qualitative research: standards, challenges, and guidelines**. *Lancet* 2001, **358**(9280):483-488.

97. Brinkmann S, Kvale S: **Interviews: Learning the craft of qualitative research interviewing**. In.: Thousand Oaks, CA: Sage; 2015.
98. Hopsø JE, Ulleberg E: **An Evaluation of Brief Psychotherapy for Outpatients in a Naturalistic Setting**. *Journal of Brief Therapy* 2016.
99. Wells A: **Emotional Disorders and Metacognition: Innovative Cognitive Therapy**. University of Manchester: Wiley; 2002.
100. Hayes SC, Luoma JB, Bond FW, Masuda A, Lillis J: **Acceptance and commitment therapy: model, processes and outcomes**. *Behav Res Ther* 2006, **44**(1):1-25.
101. Segal ZV, Williams M, Teasdale JD: **Mindfulness-based cognitive therapy for depression: a new approach to preventing relapse**. New York (NY): Guilford Press; 2002.
102. Malterud K: **Theory and interpretation in qualitative studies from general practice: Why and how?** *Scand J Public Health* 2016, **44**(2):120-129.
103. Malterud K: **Systematic text condensation: a strategy for qualitative analysis**. *Scand J Public Health* 2012, **40**(8):795-805.
104. Berner-Rodoreda A, Bärnighausen T, Kennedy C, Brinkmann S, Sarker M, Wikler D, Eyal N, McMahon SA: **From Doxastic to Epistemic: A Typology and Critique of Qualitative Interview Styles**. *Qual Inq* 2020, **26**(3-4):291-305.
105. Crotty M: **The foundations of social research: Meaning and perspective in the research process**. 2020.
106. Cuthbertson LM, Robb YA, Blair S: **Theory and application of research principles and philosophical underpinning for a study utilising interpretative phenomenological analysis**. *Radiography (Lond)* 2020, **26**(2):e94-e102.
107. Gergen KJ: **The social constructionist movement in modern psychology**. 1992.
108. Raskin JD: **Constructivism in psychology: Personal construct psychology, radical constructivism, and social constructionism**. *American communication journal* 2002, **5**(3):1-25.
109. Tenny S, Brannan GD, Brannan JM, Sharts-Hopko NC: **Qualitative Study**. In: *StatPearls.* edn. Treasure Island (FL): StatPearls Publishing; 2022.
110. Sharp NL, Bye RA, Cusick A: **Narrative analysis**. 2019.
111. Hersted L, Ness O, Frimann S: **Tradition and renewal**. *Action research in a relational perspective: Dialogue, reflexivity, power and ethics* 2019.
112. Braun V, Clarke V: **What can "thematic analysis" offer health and wellbeing researchers?** *Int J Qual Stud Health Well-being* 2014, **9**:26152.
113. Moser A, Korstjens I: **Series: Practical guidance to qualitative research. Part 3: Sampling, data collection and analysis**. *Eur J Gen Pract* 2018, **24**(1):9-18.
114. Patton MQ: **Qualitative evaluation and research methods**: SAGE Publications, inc; 1990.
115. Malterud K, Siersma VD, Guassora AD: **Sample Size in Qualitative Interview Studies: Guided by Information Power**. *Qual Health Res* 2016, **26**(13):1753-1760.
116. Langdridge D, Hagger-Johnson G: **Introduction to research methods and data analysis in psychology**: Pearson Education; 2009.
117. Britten N: **Qualitative interviews in medical research**. *BMJ* 1995, **311**(6999):251-253.
118. Peters K, Halcomb E: **Interviews in qualitative research**. *Nurse Res* 2015, **22**(4):6-7.
119. Braun V, Clarke V: **Using thematic analysis in psychology**. *Qualitative research in psychology* 2006, **3**(2):77-101.
120. Tjora A: **Qualitative research as stepwise-deductive induction**: Routledge; 2018.
121. Willis R: **The use of composite narratives to present interview findings**. *Qualitative Research* 2018, **19**(4):471-480.
122. Jørgensen K, Rendtorff JD: **Patient participation in mental health care - perspectives of healthcare professionals: an integrative review**. *Scand J Caring Sci* 2018, **32**(2):490-501.

123. Reiter MD: **Hope and expectancy in solution-focused brief therapy**. *J Fam Psychother* 2010, **21**(2):132-148.
124. Leamy M, Bird V, Le Boutillier C, Williams J, Slade M: **Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis**. *Br J Psychiatry* 2011, **199**(6):445-452.
125. May CR, Cummings A, Girling M, Bracher M, Mair FS, May CM, Murray E, Myall M, Rapley T, Finch T: **Using Normalization Process Theory in feasibility studies and process evaluations of complex healthcare interventions: a systematic review**. *Implement Sci* 2018, **13**(1):80.
126. Tryon GS, Birch SE, Verkuilen J: **Meta-analyses of the relation of goal consensus and collaboration to psychotherapy outcome**. *Psychotherapy (Chic)* 2018, **55**(4):372-383.
127. Bower P, Gilbody S: **Managing common mental health disorders in primary care: conceptual models and evidence base**. *BMJ* 2005, **330**(7495):839-842.
128. Hestbæk E, Hasselby-Andersen M, Juul S, Beier N, Simonsen S: **Mentalizing the patient-Patient experiences with short-term mentalization-based therapy for borderline personality disorder: A qualitative study**. *Front Psychiatry* 2022, **13**:1088872.
129. Cushman P, Gilford P: **Will managed care change our way of being?** *Am Psychol* 2000, **55**(9):985.
130. Sather EW, Svindseth MF, Crawford P, Iversen VC: **Care pathways in the transition of patients between district psychiatric hospital centres (DPCs) and community mental health services**. *Health Sci Rep* 2018, **1**(5):e37.
131. Horghagen S, Fostvedt B, Alsaker S: **Craft activities in groups at meeting places: supporting mental health users' everyday occupations**. *Scand J Occup Ther* 2014, **21**(2):145-152.
132. Park J, Chen RK: **Positive psychology and hope as means to recovery from mental illness**. *Journal of Applied Rehabilitation Counseling* 2016, **47**(2):34-42.
133. Allen J, Balfour R, Bell R, Marmot M: **Social determinants of mental health**. *Int Rev Psychiatry* 2014, **26**(4):392-407.
134. Sadeniemi M, Pirkola S, Pankakoski M, Joffe G, Kontio R, Malin M, Ala-Nikkola T, Wahlbeck K: **Does primary care mental health resourcing affect the use and costs of secondary psychiatric services?** *Int J Environ Res Public Health* 2014, **11**(9):8743-8754.
135. McKibbon KA, Gadd CS: **A quantitative analysis of qualitative studies in clinical journals for the 2000 publishing year**. *BMC Med Inform Decis Mak* 2004, **4**:11.
136. Veseth M, Binder P-E, Borg M, Davidson L: **Collaborating to stay open and aware: Service user involvement in mental health research as an aid in reflexivity**. *Nordic Psychology* 2017, **69**(4):256-263.
137. Luciani M, Jack SM, Campbell K, Orr E, Durepos P, Li L, Strachan P, Di Mauro S: **An Introduction to Qualitative Health Research**. *Prof Inferm* 2019, **72**(1):60-68.
138. Rodwell MK, Byers KV: **Auditing constructivist inquiry: Perspectives of two stakeholders**. *Qualitative Inquiry* 1997, **3**(1):116-134.
139. Berger R: **Now I see it, now I don't: Researcher's position and reflexivity in qualitative research**. *Qualitative research* 2015, **15**(2):219-234.
140. Borg M, Karlsson B, Kim HS, McCormack B: **Opening up for many voices in knowledge construction**. In: *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research: 2012*; 2012.

Paper I

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RESEARCH ARTICLE Open Access

Professionals' perceptions of the establishment of a specialized brief therapy unit in a district psychiatric centre - a qualitative study

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Abstract

Background: Increasing mental health problems and scarce treatment resources put pressure on mental health services to make innovations in service provision, such as developing differentiated services adapted to different needs. One innovation in differentiated service provision is brief or short-term treatment to patients with moderate mental health problems. Implementing a new unit in an organization usually faces many potential barriers and facilitators, and knowledge on how the professionals providing the services perceive the implementation of innovative approaches in mental health services is scarce. The aim of this study was therefore to explore the professionals' perceptions of how the establishment of a specialized brief therapy unit had affected the organization, especially the everyday work in the outpatient clinics.

Methods: Eleven professionals, five men and six women, took part in individual interviews. All participants were between 40 and 60 years old and had leading or coordinating positions in the organization. Their professional backgrounds were within psychology, nursing and medicine, most of them specialists in their field. Data was analyzed according to Systematic text condensation.

Results: The professionals' experiences represented four main themes: (1) The brief therapy unit was perceived as successful and celebrated. (2) The general outpatient clinics, on the other hand, were described as "forgotten". (3) The establishment process had elucidated different views on treatment in the outpatient clinics - and had set off (4) a discussion regarding the criteria for prioritizing in mental health services.

Conclusion: Providing targeted treatment to patients with moderate mental health problems, while having a concurrent aim to solve broader problems in mental health services, entails a discussion regarding resource use and the appropriate level of treatment provision. Professionals should be more involved when innovative efforts are implemented, and the criteria for success must be conceptualized and evaluated. Longitudinal research on the implementation of innovative efforts in the services should include professionals' and service users' perspectives.

Keywords: Mental health services, Short-term therapy, Health personnel, Organisational innovation, Mental health professionals, Implementation, Qualitative research

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Background

Mental health problems and the demand on mental health services are increasing globally [1]. Yearly, almost 40% of the European population suffers from a psychiatric disorder [2, 3]. Implementing improved psychological treatments and innovative working processes in mental health services are needed to reduce the burden of mental illness [2–4], calling on the health sector to increase cost efficiency, quality of treatment and continual improvement [5, 6]. Scarce resources have led to a growing interest in evidence-based approaches in psychiatric and psychotherapeutic treatments that are cost-effective [7], contributing to a focus on innovation and flexibility. The development of innovative therapy approaches is expected to help reducing waiting lists, filling gaps in current services, standardizing information exchange and improving clinical pathways [8, 9]. Nevertheless, research has shown that there is little evidence that evidence-based treatments are adopted or successfully implemented in a context in an optimal way [10]. Research has pointed out several knowledge gaps in studies of implementing innovation in health care systems [11]. Improvement work in complex health organizations involves various potential challenges, such as heterogeneous patient groups, organizational differences and different cultures in the organization [12]. Ensuring that effective interventions are implemented has been identified as a priority task for mental health services [10]. Researchers have argued that the concept of "implementation results" depends on context and must be understood as different from the clinical treatment results following an intervention or a new treatment method [13].

In order to meet the increased demand for mental health services, a District Psychiatric Center (DPC) in Central Norway set an example of service innovation. This DPC was the setting for this study. From 2009 to 2014 the center had an increase of 42% in referrals of patients in need for outpatient treatment, and the number of patients who needed such treatment increased with over 43%. To respond to this challenge, the DPC in 2016 added a specialized outpatient unit to strengthen its general outpatient services. The objective of the establishment of the new unit was to provide brief and effective therapy for patients diagnosed with moderate affective and/or anxiety disorders, while also freeing resources in the general outpatient clinics for the patient groups with more extensive treatment needs [14].

Brief therapy is defined as an efficient mental health therapy approach, focusing on the present ("here and now") and the patient's strengths, and having a decisive approach [15]. Studies have shown that short-term psychotherapy is beneficial for adults with common mental disorders [16], and that short-term cognitive behavioral treatment (CBT) has a good effect on depression and anxiety [5, 17, 18]. Studies exploring the therapists' perspectives show, on the other hand, skepticism regarding limitation of treatment, fearing that therapy becomes superficial and less client-centered [19, 20].

Although brief therapy is shown to be efficient for several patient groups [5, 16–18] this does not guarantee that knowledge will be successfully implemented in practice [10, 21]. Implementing a new service or unit in an organization usually faces many potential barriers and facilitators embedded in the characteristics of the new effort; the characteristics of the intervention, the external conditions, the internal environment, the characteristics of the individuals involved, and the implementation process [21, 22]. In health services, barriers to implementation seems to arise at several levels, such as at the patient level, at the treatment team level, at the organizational level and at the market or policy level [22]. In fact, one of the most critical issues in mental health services research is the gap between what is known about effective treatment and what is provided to consumers in routine care [10]. Context, complexity and process have been described as aspects that influence the outcomes from implementation efforts [13, 21]. Some studies infer implementation success by measuring clinical outcomes at the client or patient level, while other studies measure the actual targets of the implementation [13]. Researchers from different academic traditions generally conceptualize their topic for research of innovations in health service organizations in different ways [11]. In the present study, the conceptualizing of innovative efforts in a health organization was as follows: Innovation in health care service delivery and organization is defined as a novel set of behaviors, routines, and ways of working that are directed at improving health outcomes, administrative efficiency, cost effectiveness, or users' experience and that are implemented by planned and coordinated actions [11]. Organizational culture is defined as sets of shared norms, values and beliefs that develop in an organization as the members interact with each other and their environment, and that are manifested through the members' behavior and attitudes at work [23]. The establishment of a new treatment unit providing a specialized service, such as brief therapy, to a specific patient group, might thus influence the organization in several ways. Exploring the professional's perceptions of what contributes to a successful implementation of new practices in a traditional organization is important [24], and studies of change and implementation show that implementation processes can be complicated and unpredictable and that they should be context-sensitive [24]. The aim of this study was therefore to explore the professionals' perceptions of how the establishment of a specialized brief

therapy unit had affected the organization, especially the everyday work in the outpatient clinics.

Methods

This was a qualitative study including individual semi-structured interviews with professionals in a DPC. The study was conducted from October 2018 to February 2019.

Study setting

In Norway, health care is organized at two levels, in the primary or secondary health services. The responsibility and supervision for most secondary services and the hospitals lies with Ministry of Health and Care Services, while the municipalities provide primary care services such as preventive services and general practitioners (GPs) [25]. Psychiatric care is organized as treatment wards in hospitals and as DPCs, the latter can be organized within a larger hospital. The Ministry of Health governs the DPC's activities through the Regional Health Authorities in annual "letters of instruction" [26].

The DPC in the present study was part of a university hospital in Central Norway, producing 260 man-years (full-time equivalents) and being one of three similar DPCs in the hospital trust. The catchment area included approximately 110.000 persons in urban and semirural areas and parts of a large city. The DPC provided inpatient treatment, ambulatory services, and different types of outpatient treatment. Patients were mainly referred to the DPC from their GP, or by psychologists or psychiatrists in private practice. The DPC determined whether treatment was needed and offered a right to treatment within a specific time period (a waiting period guarantee). Before 2016, the DPC's outpatient services was organized in three outpatient clinics, all with a generalist focus. In 2016, one of the general outpatient clinics was selected to provide brief (short-term) therapy in a delimited unit [14]. The unit encompassed 10.5 therapist positions specializing in short-term therapy, in contrast to the more generalist approach in the other general outpatient clinics in DPC. The unit's target group was patients with anxiety and/or depressive disorders who previously had good functioning and self-esteem, but with a sudden fall in function, reactive states or sudden life events [14]. Treatment in the brief therapy unit was limited up to ten treatment sessions, individually or in groups, and included CBT, meta-cognitive therapy [27], mindfulness [28, 29] and Acceptance and commitment therapy [28].

Participants and recruitment

Eligible participants in this study were leaders, coordinators and key personnel on different levels in the outpatient clinics at the DPC, as well as the head clinic leader and leaders of the mental health services at the hospital. The sampling aimed at recruiting participants that had experience with the implementation and operation of the brief therapy unit, and from cooperation tasks within the DPC's outpatient services. Based on this sample strategy, initial study participants were suggested by the DPC's management. The participants in this study were then asked directly by the first author (HVM) to participate in individual interviews. Subsequently, HVM recruited additional professionals to strengthen the diversity and representativeness of the sample. Here, we sought to include professionals with different experiences and roles, both inside the brief therapy unit and in the other parts of the outpatient services. Twelve participants were asked and consented to participate in the study. Due to illness, one of the informants was unable to participate, and the final study sample included 11 professionals. All participants received oral and written information about the study and signed a written consent before taking part in interviews.

Data collection

Interviews were conducted using a semi-structured interview guide [30] where the researcher has some predefined questions or topics but then probes further as the participant responds. The interview guide was developed by HVM and MBR and contained a list of questions and topic areas that should be covered in the interviews. Representatives from the Competence Center for Lived Experience and Service Development in Central Norway provided useful input. The issues in the interview guide were prepared to explore the professionals' experiences with innovation and new services in mental health care. When a district psychiatric center presented a new practice as an innovative effort, we found it interesting to gain insight into the practice's impact on the organization and the extent to which the impact was consistent with the intentional change in the organization. The interview guide included topics and questions intended to allow the professionals to reflect on and discuss how the establishment of the brief therapy unit had influenced their work and the overall work in the DPC. Important themes were how the work at the DPC had developed during and after the establishment of the brief therapy unit, potential benefits and challenges herein, the overall quality of services, and the organizational culture and environment. The first author (HVM) conducted all interviews, either in the professional's office or in a meeting room, according to the professional's wish. The interviews lasted between 50 min to 1 h and 20 min. The interviewer (HVM) made notes during and after each interview. All interviews were audio recorded and transcribed verbatim by the first author (HVM).

As the aim was to explore the professionals' experiences, we were cautious not to put up too strict boundaries for themes that came up in the interviews. While some topics identified in the first interviews were incorporated into the interview guide, the main issues remained constant. A new topic that was incorporated was the resource situation in the other outpatient units, and how the establishment had influenced the overall workload in the outpatient services.

Data analysis

Data was analyzed according to Systematic text condensation (STC) [31]. The analysis was conducted in a group of three researchers with different backgrounds. HVM is a doctoral candidate in medicine with a professional background from medical sociology and community planning at MA-level. She has several years of experience from mental health hospital planning, including service innovation tasks within from this area of Norway. LA is a researcher and physician (specialist in physical medicine and rehabilitation). MBR is a professor in mental health work with a background from psychology and public health.

The data analysis was conducted according to the four steps in STC [31]. Firstly, the first author (HVM) listened to all audio recordings and read all transcripts several times to achieve an overall impression of the material. Each researcher then read the same three interviews and suggested preliminary codes for a coding list. The authors discussed codes and made a final coding list which was used in the next step. Examples of preliminary codes were "Better classification between patients needing short-term and long-term treatment", "A good and delimited service for anxiety and depression", "The general outpatient clinics were forgotten in this process", and "Polarization in the professional environment – them and us". Secondly, Mindjet MindManager (2017) was used by HVM as a tool to visualize the codes in each interview and for sorting meaning units. This was presented as a visualized mind map for each interview and shared with the other authors. After discussion of preliminary themes, all the interviews were coded by HVM and sorted in code-groups, such as "Prioritization of patients for two different services", "New and celebrated treatment services in the brief therapy unit", "Culture - working environment", "Treatment length and coherent treatment" and "Quality of treatment". Thirdly, the authors narrowed the code groups to fewer subgroups after several discussions. HVM formulated text condensations as texts amalgamating the meaning units of these subgroups [31]. In the fourth and final step themes were constructed, synthesized and validated through discussions in the author group. Empirical dimensions were formed for each interview and similarities across interviews were reflected in the themes and quotations.

The iterative analysis process continued until data reached a point of convergence, where four themes encompassed the most prominent of the material. The first author (HVM) also presented preliminary findings in meetings with two different research groups at NTNU. The researchers in these groups had complementary experiences and gave fruitful feedback and input during the analytic processes - input which was shared with the other authors. All three authors were continuously looking for alternative interpretations in several meetings and critical discussions, before agreeing on preliminary themes. The first author (HVM) summarized and decontextualized the text from the interviews that could illuminate the chosen codes and themes, focusing on the informant's experiences. Finally, the authors discussed if the reduced text reflected the main topics in the data material. Quotes from the data material were chosen to elaborate and illustrate the results. They were translated by the third author (MBR) and checked and approved by the first (HVM) and second author (LA).

Ethics

This study was approved by the Regional Committees for Medical and Health Research Ethics in Central Norway (2018/49/REK Midt). The participants in this study received oral and written information about the study and signed a consent form before taking part in interviews. The project was conducted in line with the Helsinki declaration (World Health Organization, 2010).

Results

Eleven professionals took part in interviews, five men and six women, all between 40 and 60 years old and with more than 3 years of college/university education. All worked on different levels in the outpatient clinics at the DPC, five of them as leaders, while six had responsibility as coordinators. Their professional backgrounds were within psychology (8), nursing (2) and medicine (1), most of them specialists in their field.

According to the professionals, the establishment of the brief therapy unit was the answer to a growing crisis in the DPC, a crisis due to an increase in referrals but not in resources. They described that the DPC would not have tolerated this much longer, and something had to be done to relieve the pressure.

The results are presented as four themes: 1) Brief therapy provided by a celebrated unit, 2) The "forgotten" clinics, 3) Elucidating different views on treatment and 4) Influencing the criteria for prioritizing.

Brief therapy provided by a celebrated unit

The brief therapy unit was described as a most welcome innovative effort, and many portrayed the brief therapy unit as successful and celebrated. Soon after the establishment, the brief therapy unit had also become an arena for trying out further innovative means, such as online-therapy. The professionals described that leaders and professionals from hospitals across the country came to visit and to learn from their creation of the unit. They elaborated that visitors were told about the beneficial changes in the DPC, such as the structured number of treatment hours, research-based and structured treatment methods, and shorter waiting times. The professionals described no doubt that the DPC treated far more patients after the implementation of the brief therapy unit, and that young patients with less severe diagnoses seemed to profit from this treatment approach. They also told about an internal evaluation report measuring clinical outcomes at the patient level, showing that patients could achieve good results with brief therapy. The results were so good that the management wanted to expand and develop the service further.

> *I have noticed that the brief therapy unit is held up as a good example of success. Something excellent and good that we should be proud of.* (HP2)

Professionals within the brief therapy unit described a unique "team-feeling" among the staff, and a specialization of treatment approaches, compared to the general outpatient clinics. They elaborated that the unit had gathered a team of professionals who were interested in the same treatment approach and that the environment was inspiring, motivating, and energizing. The professionals who worked in the brief therapy unit described this as positive and beneficial, appreciating the possibility to specialize together with other professionals with the same interest. They also expressed feeling safe as fellow professionals in the team and said they helped and supported each other.

> *It is an advantage to work in a similar manner and to have a shared professional profile. It gives us the opportunity to develop a specialist environment and be good at that specific service.* (HP4)

Several of the professionals working in other parts of the organization were more critical to the establishment of the brief therapy unit. They highlighted that the new unit was in a different building, geographically separated from the rest of the DPC, and that the unit had evolved into a separate unit without contact or collaboration with the other outpatient clinics. External research funding had also made possible more professional development in the new unit, compared to the general outpatient clinics. Several voiced a lack of integration between the new unit and the rest of the outpatient services.

The "forgotten" clinics

While the brief therapy unit was described as an innovative and celebrated part of the DPC, the general outpatient clinics were described by several as "forgotten". Professionals working here said that they had expected the implementation of the brief therapy unit to give them more room for working with the more complex patient cases. According to them, this had not happened. The work pressure had instead increased, and the establishment of the new unit had not led to the expected ease in workload. Several expressed that increasing referral volume had led to the brief therapy unit now treated the "easiest" cases, while the far more complicated and complex cases were allocated to the general outpatient clinics. The latter group demanded extra resources and time, and only a slow positive improvement could be expected. Many described that this led to fewer positive stories and experiences of success, leading to frustration among the professionals.

> *We don't see the success stories anymore. The stories that held us up … that we sometimes discharged a patient as recovered … we hardly see that anymore. Now we are overloaded […] we don't have the success stories and we report it as a personal work environment problem. [The professionals] feel that they are not competent anymore.* (HP6)

Some of the professionals working in the general outpatient clinics said that the increased workload neither was anticipated nor acknowledged by the DPC's management. In their view, the delimited treatment focus in the new unit had resulted in a more distinct focus on prioritization between demanding patients in the general outpatient services. In their view, "the rest of the organization" had not been properly involved in the innovative approaches and development of better services. They missed that the management focused on the work and increased effort in the general outpatient clinics. The professionals pointed to the wide range of tasks in the general outpatient clinics and said that it was nearly impossible to keep updated, professionally and methodically, to handle the different and complex diagnoses. Several said that they missed consideration and recognition of the various disciplinary approaches, and that they had too little time to meet the needs of different patient groups. Some described a fear of having to schedule more infrequent treatment sessions for patients and to terminate treatment too early.

I think the reason is that we cannot influence how many patients we receive […] and to manage [the case load] we "dilute" [the treatment]. This is against professional advice … and I think that professionals from different traditions experience this as a problem. Individual professional has too many patients on the list … more than they can manage. (HP7)

Elucidating different views on treatment

The establishment of the brief therapy unit also seemed to have highlighted the existence of different views on treatment within the DPC, namely on what constitutes good treatment. While some professionals highlighted short-term treatment as a success and a promising approach for the future, others voiced concerns about how focusing on short-term therapy could result in poorer treatment for patients with more complex needs. The professionals who were most positive to the short-term approach emphasized that the brief therapy unit was a positive addition to the outpatient treatment, providing targeted treatment to a large and increasing patient group. They attributed this to the DPC's young patient population and said that targeting the youngest adults could have significant long-term benefits for the DPC. According to them, the implementation had provided a possibility for young adults to come early in contact with the mental health services, receiving targeted treatment quickly and, potentially, returning rapidly to society.

The more critical professionals said that young adults with mental health problems potentially received too limited treatment in their first meeting with psychiatry. They were concerned that all new patients struggling with anxiety and depression now received the same treatment approach, and that short-term treatment had become "the quick and only option" for a large group of young adults. Several stated that the establishment of brief therapy in the DPC was an expression of a trend towards attempting to resolve mental problems or disorders as quickly as possible.

[Brief therapy] can be at the expense of thoroughness … making you lose eye with the underlying … and if you are focused on quick improvement, it governs the way we view a person, view the patient, understand the patient … In my opinion, it could be a risk. (HP7)

According to some, the brief therapy unit had cultivated a standardized working method in "a one-sided manner", describing this as an expression of a "quick fix". Others said that while the management tried to handle the increased volume of referral, they forgot the patients with complex needs. In their view, the short-term approach was not sufficient to provide good treatment to the general patient population, since many patients would not benefit from standardized or time limited treatment.

[The development of time limited treatment] has an unintended effect. The development I am talking about here is that we are expected to provide good services to more people with fewer resources. It is not possible to give good therapy to all in so short time. When this is presented as the solution to a much bigger problem, I become doubtful. We use internal resources to focus more on time limited treatment, resources that could have been used for patients with more complex needs. (HP6)

Influencing the criteria for prioritizing?

Many of the professionals discussed whether the development towards more short-term approaches influenced the criteria for prioritizing in the mental health services. The focus on young adults with anxiety and depression, was described as a potential driver for lowering the threshold for treatment in the DPC. Some said that the threshold had already been lowered after the implementation of brief therapy, resulting in more referrals of patients with less severe diagnoses. Others claimed that the patient population in the DPC had changed over two decades, and that an increasing group of younger patients with moderate problems demanded a larger share of the resources. Some said that society was responsible for handling and normalizing some of the mild mental challenges the patients experienced, and that referring and providing treatment to all types of mental problems was neither sustainable nor appropriate.

We tend to "therapeuticize" needs in people. I think this is part of the explanation for the large group we shall manage. That we over-use therapy. (HP5)

The professionals also attributed a potential lowering of the threshold for treatment in the specialized services to the current priority guidelines in the mental health services. Some said that they had to balance what they perceived as conflicting guidelines: To prioritize between patients and at the same time reject fewer, describing this as an impossible task. Many emphasized that the government's guidelines, stating that youth should be prioritized, probably resulted in more young people with moderate diagnoses being offered treatment in the DPC.

One the one hand we are supposed to prioritize. On the other hand, we have a minister of health that gets a tummy ache thinking of someone who will be rejected. So, we should meet everybody and be

available, but we also must prioritize. It does not add up. (HP1)

Professionals discussed the future of the DPC and how the system could handle the increasing number of patients in need of treatment. According to some, treating more patients with less severe diagnoses implied doing the work for primary care, thus affecting the treatment of patients with more complex problems who should be the most important group for the DPC. Several were concerned that the resources were used incorrectly, and that moderate mental problems should have been treated elsewhere. In their view, the general increase in mental health problems, particularly among young people, should have resulted in more responsibility for these patients within other parts of the health care system, such as the student health services and the municipal health services. Some said that a general patient admission across service levels could improve this situation. They advocated the establishment of an interdisciplinary team for improving the prioritization of patients between different levels of mental health services.

The more we establish frontline services like this, the more we undermine the expectations that the municipality ... primary care, should be managing these patient groups. (HP6)

Some stated that it was a misconception that the brief therapy unit treated only moderate problems. In their opinion, the patients were too sick to receive treatment at the primary care level and that the brief therapy approach mainly had contributed to more differentiation of the services and thus more targeted treatment in DPC.

The cases are not mild, that is a myth. When we look at the diagnoses they have [...] not only anxiety and depressions. They have other types of problems as well. They have recurrent depressions; they have personality problems. I don't know whether they are very different from the patient population in the general outpatient clinics, except for the comprehensive and complex cases where it is obvious that ten sessions are not sufficient. [...] Besides that, I do not think the patient population is very different. (HP9)

Discussion

The shift towards short-term treatment

In the present study, the establishment of a brief therapy unit was described as complying with treatment guidelines provided by the health authorities, encouraging more innovation to provide treatment to a larger number of patients without any increase in resources. The establishment of the new unit was therefore perceived as an important signal that the DPC recognized and followed up the expectations from health authorities. Authors have argued that third parties, such as health authorities and insurers have an increasing influence on mental health services, for example in limiting the amount of treatment [7, 20]. In the present study, the health authorities were understood as such a third party, strongly influencing the treatment provided in the outpatient services. This finding contributes to an understanding of how policy guidelines can affect both problem definition and approach [20] during the implementation of innovation tasks and the development of treatment alternatives in mental health services. The trend of short-term treatment was also viewed differently within the DPC. For some, shorter treatment represented a positive influence by drawing attention to effective and adequate treatment. Others argued that brief therapy represented a somewhat superficial approach to complex patient needs. Both previous and current mental health care encompass different schools of thought with different perspectives on how to explain and treat mental illness [7]. Different views in the present study might thus be an expression of a complex organizational culture [23] encompassing therapists with different professional training and backgrounds. Implementation of innovative treatment offers is by nature a social process that is intertwined with the context in which it takes place [22] and our findings according to the internal environment in the DPC might shed light on a possible organizational barrier to implementation.

The described trend of short-term treatment also seemed to challenge the autonomy, independence and judgement of some of the professionals, as well as inducing a risk of burnout for the professionals working in the general outpatient services. This is in line with previous research, suggesting that the regulation that lies within bureaucratization and national governance weakens medical professionals' autonomy [32]. Standardization of services, such as time limitations, can lead to professionals' skepticism and resistance [7, 12]. Burnout in doctors and other health professionals results in negative effects on patient care, professionalism, therapists' self-care, and the health care system's viability [33] Research indicates that both individual-focused and structural or organizational strategies can result in reductions in the experience of burnout [34] and such strategies can facilitate a more successful implementation of service innovation. Further research should examine the complex ways in which organizational culture and different strategies

can influence professionals' attitudes to innovation efforts in health organizations and how this can possibly be better accommodated in practice.

Several have described prerequisites for successful implementation of new efforts [22, 34]. Different perceptions of the benefits of the innovation, the consensus among professionals and the interactions between innovation and the context influences the innovative process [35]. One aspect is the importance of collective action; that all participants agree on the implementation of the new effort and are willing to contribute in the work [36]. Including all stakeholders in planning and preparing is thus recommended before implementing changes [36]. In addition, management has an important role in innovation processes, especially in maintaining a positive relationship with employees [35]. To provide interaction between professionals at different levels in the organization, management should engage in extensive information sharing across organizational levels by applying a bottom-up approach, two-way communication and feedback, including evaluation, modification and improvement of innovative efforts [35]. Investing more in securing the staff's commitment before and during implementation of new efforts would thus be useful. This includes asking for input from the staff and using this information to adjust the course during the implementation process. Another important role in implementation processes is the middle manager. In the present study, some of the leaders and coordinators at different levels expressed that they had not been properly involved in the innovation process. Middle managers might influence the implementation of healthcare innovation by disseminating information, synthesizing information, communicating between strategy and daily activities among employees [37]. Involving the professionals on different levels in larger part of the organization in the implementation process might thus have been helpful. Further studies should investigate the middle managers role in improving the implementation of mental healthcare innovation.

Success depends on what you are looking for

In the present study, the brief therapy unit was established to target a growing patient group, namely young adult patients with anxiety and/or depression. However, an additional aim was to free up resources in the general outpatient clinics for the patient groups with more extensive treatment needs. The results reflected this two-fold aim, showing two different views on whether the innovative effort was a success or not. While most agreed that the brief therapy unit provided good treatment outcomes for the targeted patient group, an outcome that encouraged the management to expand and develop further the brief therapy service, the more critical voices put emphasis on other influences from the implementation, such as more pressure on the general outpatient units and not enough focus on patients with more extensive treatment needs. An important issue in implementation of innovative efforts is how to conceptualize and evaluate success [13]. The concept of "implementation results" depends on context and must be understood as different from the clinical treatment results following an intervention or a new treatment method [13]. A distinction should thus be made between considering a new measure as a limited intervention or as an organizational innovative effort with more goals. It is therefore reasonable to ask whether patients with complex mental health problems and associated services in the DPC received sufficient attention in the innovation work that took place. In this context, it is important that policymakers, service providers, and mental health professionals to understand the very different needs in the patient population when facilitating innovational change in specialist health care such as DPC.

Studies of implementation have used varying approaches [13]; some measuring clinical outcomes at the patient level, while others have measured the organizational or broader targets of the implementation [10]. However, implementation of any new treatment or service is recognized as a process that involves a variety of activities in an organization [13]. In the DPC investigated in the present study, it might have been useful to visualize the establishment of the new unit as part of a broader strategy demonstrating the organization's effort to improve broader aspects of the mental health services.

Providing mental health care on the appropriate level

On what care level common mental health problems should be treated is an ongoing discussion regarding accurate identification of problem, appropriate treatment, costs, and waiting time [38]. Providing mental health treatment in primary care should secure treatment that is effective, efficient, accessible, and equitable [38]. The present study showed that several of the professionals meant that young adults with moderate mental health problems such as anxiety and depression, should not be treated in the DPC, but rather be the responsibility of primary care services. This is in line with one of the main aims of the Norwegian Coordination Reform [39] requiring a transferal of tasks and responsibility to the primary health services. Similarly, The World Health Organization has stated that mental health treatment should take place in primary care [40].

Whether mental health care is provided mainly at the primary or secondary care level varies a lot in Europe [41]. Researchers have claimed that collaboration between the primary and secondary mental health services

is needed to provide care across systems [42], and that a shift in resource balance between the care levels is needed [43]. Collaboration between primary and secondary health services is also emphasized and advised in treatment guidelines for common mental health treatment [38, 44], and several models have been suggested for closer integration and collaboration [45]. Such models include training of primary care professionals, consultation-liaison collaboration (where a secondary care specialist provides support during care whenever needed), collaborative care (where appointed care managers secure a collaboration between primary and secondary care professionals), and referral (where the patient is referred to secondary care for treatment) [45]. Collaborative models for treatment of depression and anxiety disorders in primary health care have shown to be effective and providing mental health care at this level is cost-effective [42, 46, 47].

Similarly, treatment in primary care with a permanent care manager can be positive and represent continuity for patients who need long-term treatment and follow-up [48]. In addition, brief psychological treatment approaches (CBT, counselling and problem-solving therapy) can be provided effectively in primary health care [49]. Although the present study showed disagreement between the professionals about the severity of the patients' illness, patients with moderate anxiety and/or depression could thus be successfully treated in or in some type of collaboration with primary care. Future studies should thus investigate on what treatment level young adults with moderate anxiety and/or depression could be provided short-term treatment in the most cost-effective way and with the best treatment outcome. Studies comparing similar treatment in primary or secondary care level, respectively, could answer this question.

Strengths and limitations

The study sample consisted of leaders, coordinators and other key personnel. The sample had good gender representation and diversity of experiences from different parts of the outpatient clinics in the DPC. This provided data material that reflected the width of professionals' experiences and strengthens this study. The first participants were identified and suggested by the DPC's management. Subsequently, HVM recruited more participants to include various perspectives. Asking leaders to recruit study participants brings about potential bias, since they influence the choice of information sources. Nevertheless, the study depended on interviewing professionals who had first-hand experience with the establishment of the new unit, and who could view this from different positions in the organization. We therefore found the recruitment process adequate.

A qualitative semi-structured interview approach made it possible to explore the professionals' individual experiences without setting boundaries for the themes brought up during interviews. This strengthened the exploratory approach. While an exploratory approach allows for all types of experiences and perceptions, this also imply limitations. Most of the results convey the professionals' personal experiences and points of view and are not confirmed by any other types of data. Many of the findings must therefore be interpreted with caution. One example is the statement that the general outpatient clinics were forgotten and not acknowledged by the DPC's management. We have no other data material confirming these statements. Conducting interviews at a single time point also includes the risk of recall bias. Data collected on different time points in the implementation process would have strengthened the long-term perspective. Encompassing the longitudinal approach should be pursued in further research on innovative efforts in mental health settings.

The analysis was conducted by three authors with backgrounds in social science/public health, medicine and psychology. The first author (HVM) is educated as community planner with several years of experiential knowledge from mental health hospital planning including service innovation tasks. The 3rd author (MBR) has extensive experience with qualitative analyses, and the 2nd author (LA) has some experience. The diversity in backgrounds and experience is a strength in this study. The author group had several meetings, continuously looking for alterative interpretations before agreeing on every step in the analysis process. To allow for alternative understandings and perspectives on the data material, preliminary results were discussed several times in two separate research groups, one group with an exclusively qualitative methods approach, and one with a more comprehensive methodological focus. This helped provide alternative points of view in the analysis process and strengthens the study.

The Norwegian socio-cultural context, such as the organization of mental health care and the comprehensiveness of the welfare system, somewhat limits the transferability to other countries. The present study did not measure treatment outcome or patients' experiences. Neither can we be certain whether the professionals' perception of increasing time constraints was a result of the establishment of brief therapy or part of a general development in the mental health services. Other types of studies are needed to investigate this.

Conclusion

This study explored professionals' experiences with the establishment of a new unit providing short-term therapy in the outpatient services of a DPC. The results

showed that, while being in line with health authorities' treatment guidelines, the trend of short-term treatment challenged the professionals' autonomy and judgment. Offering targeted treatment to patients with moderate mental health problems, while having a concurrent aim to solve broader problems in mental health services, entails a discussion regarding resource use and the appropriate level of treatment provision. As contemporary mental health policy focuses on promotion, prevention and early intervention as innovative efforts, our study shows that professionals call for the authorities' focus on the ongoing needs of those with longer-term and more complex mental health problems. Choice of focus during innovation and implementation processes might influence what is given attention. There might thus be a need for a more complete system approach to prevention, treatment and rehabilitation for the heterogeneous patient population who need different mental health services.

To improve implementation processes in mental health care, professionals from different levels of the organization, as well as the primary care level, could be more involved. The aims of innovative efforts are not always clear-cut, and success needs to be conceptualized and evaluated. Further research should include a longitudinal perspective on the implementation of innovative efforts in the services, including the perspectives from leaders, professionals and service users in various parts of the services.

Abbreviations

DPC: District Psychiatric Center; GP: General Practitioner; NTNU: Norwegian University of Science and Technology

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Authors' contributions

HVM collected all data and was in charge of the analysis process. All authors (HVM, LA and MBR) took part in the planning and design of the study, data analysis and writing of the manuscript. All authors (HVM, LA and MBR) approved the final manuscript.

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Availability of data and materials

The datasets generated and analyzed during the current study are not publicly available due to ethical approval but are available from the corresponding author on reasonable request.

Ethics approval and consent to participate

This study was approved by the Regional Committees for Medical and Health Research Ethics in Central Norway (2018/49/REK Midt). The participants in this study received oral and written information about the study and signed a consent form before taking part in interviews. The project was conducted in line with the Helsinki declaration (World Health Organization, 2010).

Consent for publication

Not applicable.

Competing interests

The authors declare that they have no competing interests.

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References

1. Wittchen HU, Jacobi F, Rehm J, Gustavsson A, Svensson M, Jonsson B, Olesen J, Allgulander C, Alonso J, Faravelli C, et al. The size and burden of mental disorders and other disorders of the brain in Europe 2010. Eur Neuropsychopharmacol. 2011;21(9):655–79.
2. Holmes EA, Ghaderi A, Harmer CJ, Ramchandani PG, Cuijpers P, Morrison AP, Roiser JP, Bockting CLH, O'Connor RC, Shafran R, et al. The lancet psychiatry commission on psychological treatments research in tomorrow's science. Lancet Psychiatry. 2018;5(3):237–86.
3. Patel V, Saxena S, Lund C, Thornicroft G, Baingana F, Bolton P, Chisholm D, Collins PY, Cooper JL, Eaton J, et al. The lancet commission on global mental health and sustainable development. Lancet. 2018;392(10157):1553–98.
4. Aarons GA, Sommerfeld DH, Walrath-Greene CM. Evidence-based practice implementation: The impact of public versus private sector organization type on organizational support, provider attitudes, and adoption of evidence-based practice. Implement Sci. 2009;4(1):83.
5. Shapiro DA, Barkham M, Stiles WB, Hardy GE, Rees A, Reynolds S, Startup M. Time is of the essence: a selective review of the fall and rise of brief therapy research. Psychol Psychother. 2003;76(Pt 3):211–35.
6. Altmann U, Thielemann D, Zimmermann A, Steffanowski A, Bruckmeier E, Pfaffinger I, Fembacher A, Strauss B. Outpatient psychotherapy improves symptoms and reduces health care costs in regularly and prematurely terminated therapies. Front Psychol. 2018;9:748.
7. Berghmans R, Berg M, van den Burg M, ter Meulen R. Ethical issues of cost effectiveness analysis and guideline setting in mental health care. J Med Ethics. 2004;30(2):146–50.
8. Helse Midt-Norge. Strategi for innovasjon i Helse Midt-Norge (2016–2020). Trondheim: Helse Midt-Norge; 2015. https://helse-midt.no/Documents/Strategi/Strategi%20for%20innovasjon%20Helse%20Midt-Norge%20for%20perioden%202016-2020.pdf. Accessed 10 Mar 2020.
9. Helse Midt-Norge. Strategy 2020. Trondheim: Helse Midt-Norge; 2016. https://helse-midt.no/helsefaglig/helsefaglig/mal-og-strategier. Accessed 10 Mar 2020.
10. Proctor EK, Landsverk J, Aarons G, Chambers D, Glisson C, Mittman B. Implementation research in mental health services: an emerging science with conceptual, methodological, and training challenges. Admin Pol Ment Health. 2009;36(1):24–34.
11. Greenhalgh T, Robert G, Macfarlane F, Bate P, Kyriakidou O. Diffusion of innovations in service organizations: systematic review and recommendations. Milbank Q. 2004;82(4):581–629.
12. Martin GP, Kocman D, Stephens T, Peden CJ, Pearse RM. Pathways to professionalism? Quality improvement, care pathways, and the interplay of standardisation and clinical autonomy. Sociol Health Illn. 2017;39(8):1314–29.
13. Proctor E, Silmere H, Raghavan R, Hovmand P, Aarons G, Bunger A, Griffey R, Hensley M. Outcomes for implementation research: conceptual distinctions, measurement challenges, and research agenda. Admin Pol Ment Health. 2011;38(2):65–76.
14. Hopsø JE, Ulleberg E. An Evaluation of Brief Psychotherapy for Outpatients in a Naturalistic Setting. J Brief Therapy. 2016.
15. De Geest RM, Meganck R. How do time limits affect our psychotherapies? A Literature Review. Psychol Belg. 2019;59(1):206–26.

16. Abbass AA, Kisely SR, Town JM, Leichsenring F, Driessen E, De Maat S, Gerber A, Dekker J, Rabung S, Rusalovska S, et al. Short-term psychodynamic psychotherapies for common mental disorders. Cochrane Database Syst Rev. 2014;(7):Cd004687. https://doi.org/10.1002/14651858.CD004687.pub4.
17. Zhang A, Franklin C, Currin-McCulloch J, Park S, Kim J. The effectiveness of strength-based, solution-focused brief therapy in medical settings: a systematic review and meta-analysis of randomized controlled trials. J Behav Med. 2018;41(2):139–51.
18. Dekker J, Molenaar PJ, Kool S, Van Aalst G, Peen J, de Jonghe F. Dose-effect relations in time-limited combined psycho-pharmacological treatment for depression. Psychol Med. 2005;35(1):47–58.
19. Cohen J, Marecek J, Gillham J. Is three a crowd? Clients, clinicians, and managed care. Am J Orthop. 2006;76(2):251–9.
20. Wright T, Simpson-Young V, Lennings C. Therapeutic process in the context of third party determined time limits. Clin Psychol. 2012; 16(2):82–92.
21. Dryden-Palmer KD, Parshuram CS, Berta WB. Context, complexity and process in the implementation of evidence-based innovation: a realist informed review. BMC Health Serv Res. 2020;20(1):81.
22. Damschroder LJ, Aron DC, Keith RE, Kirsh SR, Alexander JA, Lowery JC. Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. Implement Sci. 2009;4:50.
23. Bang H. Organisasjonskultur: en begrepsavklaring. Tidsskrift for norsk psykologforening. 2013;50(4):326–36.
24. Kimberly J, Cook JM. Organizational measurement and the implementation of innovations in mental health services. Admin Pol Ment Health. 2008; 35(1–2):11–20.
25. Grimsmo A, Lohre A, Rosstad T, Gjerde I, Heiberg I, Steinsbekk A. Disease-specific clinical pathways - are they feasible in primary care? A mixed-methods study. Scand J Prim Health Care. 2018;36(2):152–60.
26. Ringard A, Saunes IS, Sagan A. The 2015 hospital treatment choice reform in Norway: continuity or change? Health Policy. 2016;120(4):350–5.
27. Wells A. Emotional disorders and metacognition: innovative cognitive therapy: University of Manchester. Chichester: Wiley; 2002.
28. Hayes SC, Luoma JB, Bond FW, Masuda A, Lillis J. Acceptance and commitment therapy: model, processes and outcomes. Behav Res Ther. 2006;44(1):1–25.
29. Segal ZV, Williams M, Teasdale JD. Mindfulness-based cognitive therapy for depression: a new approach to preventing relapse. New York: Guilford Press; 2002.
30. Peters K, Halcomb E. Interviews in qualitative research. Nurse Res. 2015;22(4): 6–7.
31. Malterud K. Systematic text condensation: a strategy for qualitative analysis. Scand J Public Health. 2012;40(8):795–805.
32. Racko G. Bureaucratization and medical professionals' values: a cross-national analysis. Soc Sci Med. 2017;180:76–84.
33. West CP, Dyrbye LN, Erwin PJ, Shanafelt TD. Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. Lancet. 2016;388(10057):2272–81.
34. May CR, Cummings A, Girling M, Bracher M, Mair FS, May CM, Murray E, Myall M, Rapley T, Finch T. Using normalization process theory in feasibility studies and process evaluations of complex healthcare interventions: a systematic review. Implement Sci. 2018;13(1):80.
35. Thakur R, Hsu SHY, Fontenot G. Innovation in healthcare: Issues and future trends. J Bus Res. 2012;65:562–9.
36. May CR, Mair F, Finch T, MacFarlane A, Dowrick C, Treweek S, Rapley T, Ballini L, Ong BN, Rogers A, et al. Development of a theory of implementation and integration: normalization process theory. Implement Sci. 2009;4:29.
37. Birken SA, Lee S-YD, Weiner BJ. Uncovering middle managers' role in healthcare innovation implementation. Implement Sci. 2012;7(1):28.
38. Clark DM. Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: the IAPT experience. Int Rev Psychiatry. 2011;23(4):318–27.
39. Norwegian Ministry of Health and Care Services. The Coordination Reform. Proper treatment – at the right place and right time (English summary of the white paper). Report no. 47 (2008–2009) to the Storting. Oslo: Norwegian Ministry of Health and Care Services; 2009.
40. World Health Organization. The world health report 2001—mental health: new understanding, new hope. Geneva: World Health Organization; 2001.
41. Gutierrez-Colosia MR, Salvador-Carulla L, Salinas-Perez JA, Garcia-Alonso CR, Cid J, Salazzari D, Montagni I, Tedeschi F, Cetrano G, Chevreul K, et al. Standard comparison of local mental health care systems in eight European countries. Epidemiol Psychiatr Sci. 2019;28(2):210–23.
42. Sadeniemi M, Pirkola S, Pankakoski M, Joffe G, Kontio R, Malin M, Ala-Nikkola T, Wahlbeck K. Does primary care mental health resourcing affect the use and costs of secondary psychiatric services? Int J Environ Res Public Health. 2014;11(9):8743–54.
43. Ala-Nikkola T, Pirkola S, Kaila M, Joffe G, Kontio R, Oranta O, Sadeniemi M, Wahlbeck K, Saarni SI. Identifying Local and Centralized Mental Health Services-The Development of a New Categorizing Variable. Int J Environ Res Public Health. 2018;15(6):1131.
44. National Institute for Health and Clinical Excellence. Commonmental health disorders: identification and pathways to care (CG123). London: NICE; 2011.
45. Bower P, Gilbody S. Managing common mental health disorders in primary care: conceptual models and evidence base. BMJ. 2005;330(7495):839–42.
46. van Mens K, Lokkerbol J, Janssen R, van Orden ML, Kloos M, Tiemens B. A cost-effectiveness analysis to evaluate a system change in mental healthcare in the Netherlands for patients with depression or anxiety. Admin Pol Ment Health. 2018;45(4):530–7.
47. Kroenke K, Unutzer J. Closing the false divide: sustainable approaches to integrating mental health services into primary care. J Gen Intern Med. 2017;32(4):404–10.
48. Griswold KS, Zayas LE, Pastore PA, Smith SJ, Wagner CM, Servoss TJ. Primary care after psychiatric crisis: a qualitative analysis. Ann Fam Med. 2008;6(1): 38–43.
49. Cape J, Whittington C, Buszewicz M, Wallace P, Underwood L. Brief psychological therapies for anxiety and depression in primary care: meta-analysis and meta-regression. BMC Med. 2010;8:38.

Publisher's Note

Paper II

PLOS ONE

RESEARCH ARTICLE

A treatment strategy for meeting life as it is. Patients' and therapists' experiences of brief therapy in a district psychiatric centre: A qualitative study

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Abstract

Background

Young adults increasingly seek help for mental health problems. In 2016, a district psychiatric centre in Norway started a brief treatment program to provide early and effective help for moderate depression and anxiety.

Aim

Exploring patients' and therapists' experiences of brief therapy, especially how the time limitation influences the treatment process.

Methods

Individual interviews with 12 patients and focus group interviews with eight therapists analyzed using systematic text condensation.

Results

The results constitute five themes: (1) Time-limit as a frame for targeted change, (2) Clarifying expectations and accountability, (3) Shared agreement on a defined treatment-project, (4) Providing tools instead of searching for causes, and (5) Learning to cope—not being cured.

Conclusion

Time-limitation in brief therapy appeared to play a positive role, helping the therapists to structure the therapeutic process and strengthening patients' motivation. Shared

the original data as participants were guaranteed that their interviews would not be made publicly available. Therefore, data publication would violate their privacy rights and conflict with the General Data Protection Regulation (GDPR). The approved information letter to participants in the present study stated; The researchers have a duty of confidentiality, and information from the interviews will not be given to employees at the DPC nor anyone else. This study was approved by the "Regional Committee for Medical and Health Research Ethics" (REK) in central Norway (2018/49). REK approved the information letter before we used it in the study. Email: rek-midt@mh.ntnu.no The committee secretariats can also be contacted by telephone or office address which can be found at the online portal: https://rekportalen.no.

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Abbreviations: DPC, District Psychiatric Centre; CBT, Cognitive Behavioral Treatment.

understanding and activation during brief therapy may reinforce patients' responsibility and expectations to achieve individual goals. Brief therapy can be viewed as the start of a personal process towards "mastering life as it is". More research is needed to investigate the patients' long-term outcomes after treatment and to shed light on the potential for, and limitations of, mastering everyday-life.

Introduction

The demand for mental health services is growing worldwide [1]. In addition to the suffering of patients and their families, mental illness causes major challenges in health care and society in terms of health and social care costs [2]. Despite substantial research advances showing what can be done to prevent and treat mental disorders and to promote mental health, the global burden of disease attributable to mental disorders has risen in all countries the last decades [3]. Different innovative and effective preventive and therapeutic strategies have been considered to reduce the burden of mental illness [4]. Still, investments in mental health care have shown to be insufficient in all countries, and disproportionate to the burden of mental health conditions the last decades [3]. Thus, there may be a need for further research on and financing of prevention and adequate treatment of various mental disorders in mental health services.

As early as the 1980s, time-limited therapies were presented as a possible solution for mental health services to deal with an increasing number of patients seeking help [5]. Based on the relationship between dose and treatment effect, a time-limit in outpatient treatment was both recommended and introduced into clinical practice in several countries in the following years [6]. Studies investigating the relationship between treatment length and improvement rate have shown that small treatment doses are associated with rapid change, and that improvement often takes place very early in the treatment course [7]. However, some studies have shown that there are large differences between patients with regards to their response to treatment, indicating that a fixed duration of treatment is inappropriate [8] and that a tailoring of treatment length to individual patients is necessary [9]. This means that a larger number of treatment sessions does not necessarily give better results than shorter treatment programs [8, 10]. It has been argued that treatment should end when the patient has improved to a "sufficient" degree, which is determined by the patient's ability to manage life outside therapy [7, 8].

Brief therapy is defined as an innovative and efficient mental health therapy approach, focusing on the present ("here and now") and the patient's strengths [11]. The words short-term, time-limited, and brief therapy are used interchangeably in the literature [11]. Limitation of therapy processes was initially developed as a contrast to long and comprehensive psychoanalytic treatment [11]. Short-term psychodynamic psychotherapy has shown promising benefits for adults with common mental disorders [12], and short-term cognitive behavioral treatment (CBT) may be effective in treating depression and anxiety [13]. While the real-world clinical setting involves a heterogeneous patient group where patients are in need of different psychological approaches, most studies focus on specific psychological methods and specific diagnoses [14, 15]. Studies investigating the experiences of brief therapy provided in a real-world setting are thus lacking.

Studies have found that therapists are skeptical about time-limited therapy, fearing that therapy becomes superficial and less client-centered [16, 17]. Some research suggests that time-limited adaptations in therapeutic context involve greater focus on symptoms, increased

directivity, stronger containment of problems, and limitations in therapeutic approaches [17]. Therapists have reported that providing treatment within a time-limit often made them adapt their approach to the time-frame [17]. Approaches such as CBT and solution-focused approaches in time-limited treatment have been recommended due to their focus on symptom reduction [18]. Such claims suggest that treatment deadlines affect the therapeutic process in several ways, but shed little light on how this may be the case [17]. There might thus be a need for investigating how time-limitations influence the treatment processes.

Some therapists may prefer open ended treatment because of its opportunities to facilitate insight and personality reconstruction, while patients may be more content with limited treatment when they experience that it helps them feel better rapidly [11]. There still seems to be an under-researched, potential contradiction between the fixed number of therapy sessions and the possibility of involvement and activation of patients during brief therapy. The clinical practice involving customized and time-limited treatment within the context of specialized mental health services brings attention to how therapists and patients experience the new services.

Research has shown that treatment outcomes improve when patients and therapists agree on treatment goals and collaborate during treatment [19]. Since many patients have been passive recipients of treatment in the past, therapists needs to encourage them to actively participate part in their treatment by asking for feedback and to discuss treatment goals [19]. Patient activation during treatment is related to self-efficacy and self-management, as well as changes in behavior [20]. Activating patients during treatment could thus be helpful to enable them to cope with their mental health problems. Similarly, the active involving of patients in treatment is described as important to incorporate their wishes and needs, to add therapeutic value [21, 22] and to achieve efficient and effective health services [23]. The present article helps to shed light on whether patients and therapists experience the time-limit as a spur to activation and involvement, or whether it constitutes a barrier to adequate treatment. The aim of this study was therefore to explore patients' and therapists' experience of brief therapy, especially how the time frame influences the treatment process.

Methods

This was a qualitative interview study involving patients receiving and therapists providing brief therapy in an outpatient unit in a district psychiatric centre (DPC). Inspired by phenomenology [24], we chose an exploratory approach with a broad research question that gave the informants an opportunity to shed light on the topic. This method was chosen because of the opportunity it offers in exploring both individuals' and groups' experiences. We aimed to present the results as close to the empirical data as possible, as the informants expressed themselves.

Study setting

This study took place in a DPC in Central Norway. To provide customized treatment to young adults with anxiety and/or depression disorders, the DPC in 2016 added a specialized outpatient unit to their general outpatient services. The time-limited brief treatment program was started after a short trial-period of brief therapy provided in the general outpatient services at the DPC. The trial-period had strengthened the management's belief that brief therapy could be helpful to a larger proportion of patients if it was offered by specialized therapists working in a separate treatment unit. The DPC therefore introduced brief therapy in a new treatment unit, intending to provide early and effective help to young adults. In this study, brief therapy was defined as time-limited cognitive psychotherapy with a time restriction set at the beginning of treatment [11].

During 2019, 10 therapists provided brief therapy for 459 patients. Brief therapy was offered through up to 10 individual therapy sessions, each lasting 45 minutes. The treatment approach included CBT and metacognitive therapy [25], mindfulness [26, 27], and acceptance and commitment therapy [26]. Brief therapy was primarily aimed at patients with moderate and specific ailments, who were thought to need an effective and limited therapy approach focusing on the present. In addition to this, patients with more extensive mental health disorders could be referred to brief therapy if they could benefit from a limited focus on some of their ailments.

Participants and recruitment

A total of 20 informants, 12 patients and 8 therapists, took part in the study, participating in individual or focus group interviews. Eligible participants were patients who were currently receiving brief therapy, and therapists who worked at the brief therapy unit. Patients were informed by the therapists about the study while receiving treatment. The therapists provided the first author's contact information for those who consented to take part. The first author then contacted these patients and made appointments for interviews. Patients were thus recruited through purposeful criterion sampling [28], i.e. those who met the study criteria. Sixteen patients consented to participate. One participant chose to leave the study before the interview took place. Patient interviews were terminated when the authors considered that the study had sufficient information power [29], after twelve interviews. The sample of twelve patients included seven men and five women, median age 31 years (range 21 to 47 years), all receiving individual brief therapy at the unit. They had been diagnosed with depression and/or anxiety by their GP prior to referral for outpatient treatment at DPC. Additionally, three patients reported also suffering from post-traumatic stress disorder. Half had been diagnosed with more than one condition, and nine out of 12 had previously received specialized psychiatric treatment. Some reported their first episode of mental ailments, whereas others had suffered from mental health problems over several decades. Thus, although all were diagnosed with depression or anxiety, the sample included patients with different backgrounds and experiences.

Therapists were recruited through purposeful criterion sampling [28], and the inclusion criterion was that they had worked in the brief therapy unit for at least six months. Eight therapists, two women and six men were eligible, and all consented to participate in focus group interviews. Their age ranged from 27 to 39 years (median 35 years), and their professional background included clinical psychologists (n = 4), psychologists (n = 3), and psychiatric nurse (n = 1). Half of the therapists had several years of experience working in the specialist health service, while the others had some experience. A total of three focus group interviews were conducted, one face-to-face and two by using Skype technology due to the worldwide pandemic outbreak in the spring of 2020.

Data collection

Data was collected between July 2019 and May 2020. Interviews were conducted by using a semi-structured interview guide [30] where the researcher had predefined topics and then probed further as the participants responded. Representatives from the Competence center for lived experience and service development in Central Norway provided useful input to the draft interview guide, together with three of the authors (HVM, PV, MBR). The interview guide was adapted to the two participant groups, as described in the guide for interviews with patients and therapists (Fig 1). Important topics were the participants' expectations before the treatment at DPC and their experiences during treatment. The guide included questions intended to allow both patients and therapists to reflect on the

Interview guide for patients	Interview guide for therapists
What did you know about brief therapy before receiving the offer?	What are your experiences with providing brief therapy for this patient group?
What were your expectations of the treatment in the clinic?	What are the advantages and challenges of limiting brief therapy to 10 sessions?
What do you think about the communication with the therapist(s)?	What does this limitation mean for whether patients take responsibility in their treatment?
To what extent has there been room for adapting the treatment over time?	What does this limitation mean for how and to what extent patients are actively involved in their treatment?
How did you experience your role in the treatment process?	To what extent can patients be involved in decision-making processes or influence the treatment they receive?
In what ways did you experience you were given responsibility in your treatment?	How does brief therapy compare to regular psychotherapy regarding patients' role, responsibility, and possibilities to influence the treatment?
What was the benefit of the treatment?	Based on your experience, what benefits do patients have from brief therapy?
What were the most important experiences with this time-limited treatment offer?	

Fig 1. Guide for interviews with patients and therapists. A treatment strategy for meeting life as it is. Patients' and therapists' experiences of brief therapy in a district psychiatric centre—a qualitative study.

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treatment process including their responsibility throughout the treatment process, and thoughts concerning time-limits of the treatment. They were asked about their experiences with communication between therapists and patients and what role both groups had played in the treatment process. Moreover, they were asked about their perspectives on the advantages and disadvantages of time limited treatment.

The first author (HVM) conducted all the individual patient interviews. All interviews were conducted at the university, according to the patients' wishes. Interviews with patients lasted from 40 to 60 minutes. The first (HVM) and last author (MBR) conducted the focus group interviews with therapists at the clinic together. The Skype-interviews were led by the first author (HVM) from her home-office, and the participants attended from their home offices due to Covid-19 government restrictions. Due to illness, one of the therapists was interviewed individually over Skype a few days later. Interviews with therapists lasted from 40 to 80 minutes.

The interview-guide remained unchanged, with the exception of questions to explore whether patients were familiar with this type of treatment beforehand; whether it was possible to adjust the treatment program during treatment; and whether any part of the therapy had been different compared to what they had expected. All interviews were audio recorded and transcribed verbatim. The accuracy of the transcriptions was checked by the first author by listening to all audio recordings several times. Notes on first impressions after each interview were also logged by the interviewer(s) and contributed to the analytic process.

Data analysis

Data analysis was conducted using the method of Systematic Text Condensation (STC) [24]. STC is a phenomenological methodological approach that aims to describe the informants' experiences, as expressed by themselves. The analysis was conducted in a group of five researchers with different backgrounds (medicine, psychology, social sciences, health services research). HVM is a doctoral candidate in medicine with a professional background from medical sociology and community planning at MA-level and several years of experience from mental health hospital planning including service innovation tasks from this area of Norway. LA is a researcher and physician (specialist in physical medicine and rehabilitation). PV is an associate professor in health sciences and health services researcher. BH is a researcher and associate professor in Health and Care Science. MBR is a researcher and professor in mental health work with a background from psychology and public health.

The data analysis was conducted according to the four stages of STC [24]. All interviews were initially read by the first author (HMV), all therapist interviews were also read by MBR, whereas patient interviews were divided between MBR and PV. First impressions resulted in preliminary themes which were discussed. Examples of preliminary themes at the first step were "tools to deal with mental illness and not focus on emotions", "influence on own treatment", and "the responsibility lies with me".

Secondly, unit of meanings [24] were identified and coded. The coding was conducted by systematically examining the text line by line, looking for meaning units that could shed light on the aim of the study. All codes were collected in a coding list by HVM, according to empirical coding [31], as close to the empirical material as possible [24]. The coding list was discussed by the authors, sorted in code-groups and grouped into categories, representing the main themes in the material. The code groups appeared, for example, as "experience of the treatment offer", "experience of participation and activation" and "advantage of the treatment versus need for more time". The focus group interviews with the therapists were coded [31] by HVM. The codes from these interviews were grouped into categories, representing the main themes in the interviews with the therapists. Examples of categories from therapists were "patients' benefits", "termination competence and limited focus" and "activation".

Thirdly, the main categories from the interviews with the patients and therapists, respectively, were collected, compared and collated, before condensing and summarizing the main themes in the overall data material. Based on all categories, themes were constructed and validated through discussions in the complete author group. Empirical dimensions were formed for each interview and similarities across interviews were reflected in the themes. In the fourth step, descriptions and concepts reflecting the informants' most important experiences were synthesized. The process continued until data reached a point of convergence, resulting in five themes that encompassed the data material. Before agreeing, all the authors looked for alternative interpretations in discussions.

Preliminary findings were also presented and discussed in meetings in a research group on patient education and participation where HVM and MBR are members. Quotes from the

data material were chosen to elaborate and illustrate the results. They were translated by LA and checked and approved by MBR and HVM.

Ethics

This study was approved by the Regional Committee for Medical and Health Research Ethics (REK) in Central Norway (2018/49). REK are composed of persons with different professional backgrounds, lay representatives and representatives of patient associations. The seven regional committees are appointed by the Ministry of Education and Research in Norway for four years at a time. Patients received oral and written information about the study at the clinic and their signed consent was obtained. The first author received the therapists' contact information from the clinic manager before interviews took place. Therapists received oral and written information about the study at the clinic and signed a written consent. This project was conducted in line with the Helsinki declaration (World Health Organization, 2010).

Results

A total of 20 informants, 12 patients and eight therapists, took part in individual or focus group interviews. The patients were currently receiving brief therapy, and the therapists worked at the brief therapy unit.

The main results constitute five themes; 1) Time-limit as a frame for targeted change, 2) Clarifying expectations and accountability, 3) Shared agreement on a defined treatment-project, 4) Providing tools instead of searching for causes, and 5) Learning to cope—not being cured.

The main findings of the five themes are summarized in the figure Themes with key aspects (Fig 2).

Time-limit as a frame for targeted change

Time-limitation was described by the therapists as a cornerstone in brief therapy. According to them, the time frame helped them to stay focused on the patients' change and maintain structure and focus during treatment. The patients' acceptance of the time-limit was described by the therapists as crucial to benefit from treatment. When starting treatment, they informed the patients that they had to accept and trust that sufficient treatment was possible within this time frame. Although most patients said they had not been aware of the time-limits before starting treatment, they accepted it and did not see it as problematic. They perceived the time-limit for the treatment as adequate and said it helped them look differently at their mental problems, describing it as a signal to them that their mental illness did not have to last a lifetime.

> *[. . .] it gives the picture that mental illness doesn't have to be an eternity project. That it is possible to succeed [. . .]The time-limitation contributes to thinking of [my problems] as a normal illness.* (Female patient no. 6)

Several therapists experienced that the predefined time-limit for treatment made it easier for them to focus on providing structured treatment. The time frame forced them to evaluate each step during treatment. When comparing brief therapy to regular outpatient treatment, the therapists described the brief therapy process as more focused and thereby more predictable. The time- limitation enforced clearly defined treatment goals.

> *[The time-limitation] makes it easier for me to be structured. It is important for me not to waste time. . . I would rather not waste a minute of any session. Fifteen minutes passing without me knowing how I used them [. . .] for the direction I am going in, that is not good. So,*

Themes	Key aspects[1]
Time-limit as a frame for targeted change	Requirements: acceptance of time-limitations; planning and closure skills; early termination if found unwanted/ineffective Consequences: clearer goals; increased structure and focus; stepwise assessment; increased predictability; signaling optimism concerning the duration of problems; strengthening optimism Challenges: insufficient time for both assessment and treatment
Clarifying expectations and accountability	Requirements: joint clarification of expectations; patients' assuming responsibility for and being actively involved in treatment, including between therapy sessions Consequences: increased self-efficacy after treatment; faster change Challenges: lack of motivation; concerns about relapse; more work after completion of therapy
Shared agreement on a defined treatment-project	Requirements: agreement on time-limitation; including a clear treatment plan aiming at concrete, realistic and limited goals; agreement on how to work as a therapist-patient team Consequences: more structured therapy; experiencing therapy as meaningful and time-efficient; aiming for patients to take ownership of their process; hope for improvement
Providing tools instead of searching for causes	Requirements: patients' awareness of their problems; active engagement in own therapy; using tools in between therapy sessions Consequences: increased active participation; learning to use self-management tools; dealing with negative thoughts and stress; improved mastering of life
Learning to cope – not being cured	Requirements: aiming to "master life as it is" and to support self-management; changing focus towards modifying previously unfortunate strategies Consequences: strengthened self-efficacy and coping ability Challenges: continuing the change-work on their own

Fig 2. Themes with key aspects. 1. The different key aspects describing themes could include requirements, consequences, and challenges.

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you need to focus all the time. Know that what you are doing is useful for where you are, and where you are going. We must evaluate continuously, to know that we are on the right track. (Therapist no. 1, group no. 3)

The therapists described that the time-limitation entailed focusing on closure when starting treatment, and that closure was a theme discussed with patients throughout the sessions. Several therapists compared brief therapy to ordinary outpatient treatment and pointed out that brief therapy to a greater extent required good "closure skills". Having termination in sight during treatment was described as crucial to stay focused.

[. . .] closure competence is about what I say when the patient arrives. It makes it much easier for me to repeat if I realize that we are at that point [treatment approaching conclusion]. In addition, it makes it much easier for the patient to accept when I say: Do you remember that we spoke about this during the first session? (Therapist no. 1, group no. 3)

Several patients found that therapists were good at explaining the time-limited treatment process and therapists' expectations of them when starting treatment. They said they understood early on that the treatment might be challenging but efficient, and they felt motivated to undergo the treatment.

Yes, [time-limited] treatment is challenging, but at the same time I feel. . . there is no coercion, I don't feel like having to do anything. I do this because I want to achieve something. It is challenging, but that is what I need. (Male patient no. 9)

If the therapists later in the process saw that treatment was ineffective, they could also terminate treatment early (after 3–4 sessions). They said that it was important to provide this treatment for those who wanted it or could benefit from it, instead of those who were not receptive or did not accept the time frame. Some therapists found it was challenging to both conduct an assessment and provide adequate treatment within the limit of 10 therapy sessions. They were concerned that the quality of either could be compromised and suggested separating assessment and treatment more clearly from each other. Patients, on the other hand, emphasized the trust that was established between therapist and patient during the assessment and that this laid the foundation for the targeted treatment.

According to the therapists, time-limitation was clearly defined, and any extension had to be discussed and agreed within the therapist team. In contrast to this, most patients said that, although brief therapy was limited, they were confident that they would receive more treatment if they needed it.

But. . . if it becomes clear that I need more sessions, for some reason, I expect that I will receive that [. . .] You can`t stop building when the house is built halfway, can you? (Male patient no. 12)

Clarifying expectations and accountability

Both therapists and patients described the treatment as based on a joint clarification of expectations, committing both parties during therapy and making the patients accountable for their part in the treatment process. The therapists described it as establishing "a contract" with the patients; a concrete mandate for treatment, enabling patients for the treatment process. Patients' commitment was described as crucial for progress during treatment, and progress depended on patients believing that the treatment would work for them. If patients did not "feel ready" for this treatment, they were advised to seek help elsewhere, or wait until they felt ready to work actively on their problems.

It is about making patients accountable through clarifying expectations [. . .] You cannot go to the psychologist to vent and then improve. It requires hard work and spending time sensibly. The goal is to generate change. (Therapist no. 3, group no. 1)

The patients said they felt responsible for doing most of the work in therapy, and that they were expected to play an active role in their treatment. They had to show willingness to work on their problems in between the weekly sessions, and that making progress was their responsibility. Patients and therapists agreed that for therapy to work, patients had to be willing to work hard on their problems. Some described this as the "ball being in their courtyard". They could not be passive recipients of the treatment, as they could not assume the therapist could "fix" them. Instead, patients had to adjust their expectations to what the brief therapy could offer and have the determination and willingness to work hard to change their previous strategies.

In the beginning, I had the same expectations as when going to the doctor, that someone else can fix the problem [. . .] Gradually, I realized that it is not quite like that. But that was my

first expectation–to go to the doctor to be repaired. My previous experience with the health services is that if you have [problems], you go there, and it is fixed. (Male patient no. 2)

The therapists explained that their treatment was mainly inspired by cognitive therapy, and that it was not uniform, or manual based. They reported that patients had to have a specific attitude when receiving short treatment, since the treatment was "no place for rest" but rather required activation. They thought the treatment should be demanding and that change would not be possible if patients were not accountable and highly motivated.

If you are going to jump over an abyss or something similar, it is not smart trying to do this in three small jumps. You must make the big jump. If you try to do this gradually you will have a problem. So. . . this could be a way of selling it to the patients [. . .] the most important is that they themselves must want to make the jump. (Therapist no. 2, group no. 3)

Several patients confirmed the notion that brief therapy required a changed mindset. They took on greater responsibility for doing something about their problems by looking at it from a new perspective. Some patients reported that the treatment had changed the way they dealt with their problems and they believed that their own efforts would help change their everyday lives after the end of treatment. Others said they had changed more than expected, in a very short time. However, several patients experienced this development as a fragile beginning of changing strategies in life, and that they were afraid of relapse. They underlined that personal change would require more time and work after completing therapy.

Of course, the responsibility is mine. . . but I feel that it is in a way based on my capabilities. I become responsible for trying to challenge myself. Every week [. . .] I receive homework that I am expected to do. And then I am responsible for doing them every week.

(Male patient no. 11)

Shared agreement on a defined treatment-project

Both patients and therapists described brief therapy as focusing on a time-limited project, i.e. collaborative treatment that was carefully planned to achieve an aim within a specific period. The patients were not supposed to change their entire lives. Patients described the treatment as a structured, "forward-looking" and intensive training program, and as a "change project" that helped them target and refine their own efforts towards the endpoint of the treatment. They experienced brief therapy as meaningful, because they did not waste any time on something that did not work, like extensive talks about their feelings or their existential pain.

We define a project. . . decide what exactly we are working on. [. . .] To make it focused. And he [the therapist] brings it back whenever it sideslips and drags me back. It makes me aware of exactly where I get lost or what I blame. . . this is the focus now. For better or worse. And I kind of like it. Because it gives me the feeling of having a concrete goal to work towards.

(Female patient no. 5)

The therapists described brief therapy as defined by a beginning and a predetermined end, with a clear treatment plan aiming to achieve concrete goals. According to them, a clearly defined project helped making the treatment more structured. They considered it a concrete and targeted treatment, where patients' ailments might be normalized. They linked this to the

patients' expectations, and the project described what the patient was supposed to work on and what the results should be.

> *Since we have limited time, we have to define a project clearly [. . .] the patients need to know why they are here, what they are working with, and what expectations they can have [. . .] what effect it should have [. . .] It makes you more focused. We are conscious of the number of sessions available, and we must make a plan together with the patients.* (Therapist no. 3, group no. 2)

According to the therapists, they aimed for patients to take ownership of their therapeutic project, based on realistic expectations of what they could achieve within a short period. Therapists and patients had specific roles during the treatment process and developed a shared understanding of how to work as a team to achieve the patients' goals. Patients said that they felt confident in the therapists' role and competence, contributing to their sense of hope for improvement.

Providing tools instead of searching for causes

Both patients and therapists described that the brief therapy process did not entail investigating the causes of patients' problems. Instead, several techniques and "tools" were introduced and discussed. The therapists explained that many patients had searched for the causes of their problems in the past, to find answers as to why they were depressed or anxious. According to therapists, patients' perspectives of their problems were crucial; and taking a more active role and using appropriate techniques would be more helpful than searching for causes. Tools and exercises could for example include "awareness training", allowing patients to see that even when life did not seem so good, they could change the way they viewed their problems. Patients' active use of tools in between treatment sessions was considered essential for learning.

> *Often, I use the physiotherapist comparison. . . that we can demonstrate good exercises, but this doesn't help if you don't practice the exercises between our sessions. Practice is the only thing that gives results. There is no use going see a physiotherapist for one hour a week to improve. You must practice in between.* (Therapist no 2, group no. 3)

Many patients referred to their therapists as teachers, coaches, personal trainers or mentors. They did not feel like traditional patients in treatment, but rather as active students learning how to use tools. Some said that the brief therapy unit was like a fitness center, where you had to work hard and do the exercises regularly to get results. The patients said they had learned techniques for dealing with negative thoughts and stress, and they had found that simple tools had contributed to a greater change in mastering life than they had expected.

> *I am more conscious about things. And I have received tools. I do not have the whole toolbox yet, but. . . maybe, earlier I received the whole toolbox but without tools in it. Now I have a spanner and a hammer. . . and I might need a saw or something like that. And I might eventually start to think that I might not need a power tool. That I can use the screwdriver I received during treatment.* (Female patient no. 3)

Learning to cope—not being cured

According to both therapists and patients, the search for causes entailed a wish to find a definitive cure for the mental health problems. The therapists described brief therapy as having a different aim, namely, to learn ways to "master life as it is". Instead of searching for causes and a cure, they wanted patients to change their focus towards modifying previous strategies. Several patients described previous experiences with mental health treatment and said they were pleased that brief therapy used a different approach. Some pointed out that the search for causes of their ailments could take a long time and they found brief therapy more helpful in finding concrete solutions to strengthen their coping skills.

> *During some [more extensive] previous treatments I quit. I couldn't stand all the deep dives into all that pain.* (Female patient no. 5)
>
> *This makes more sense. I don`t feel that I waste time going there, because I bring something home. Instead of just talking about how I am feeling. I can do that with my friends.*
>
> (Female patient no. 3)

The therapists emphasized that brief therapy did not entail supportive talking about everything the patient wanted or needed to discuss. Instead, they focused on what could lead to a more constructive understanding of the patients' ailments and that patients could be able to cope with their problems without necessarily becoming symptom-free. The main aim was to enable patients to continue their recovery process on their own; to be "their own therapist".

> *People need to understand that it is not me helping you. We discuss what they need to change, how they should relate differently to things. And then they need to implement it themselves. We try to build them up, also their confidence. . . They have the possibility to make changes in their lives. Most patients come with a feeling that their freedom and willpower are reduced by symptoms. When they change that. . . they are the ones getting out of it. Then you can become your own therapist.* (Therapist no. 3, group no. 1)

Therapists said that they aimed for a "change-process" that would continue after the treatment was completed. They wanted patients to understand that they could choose to change the life course and wanted to enable them to continue the process themselves. The therapists wanted patients to understand that challenges did not need to be part of their identity in the future, and that it was possible to manage life better. According to the therapists, patients were not expected to become symptom free during treatment. The goal was to change the patients' understanding of the challenges and provide them with tools enabling them to continue the change on their own. One of the patients illustrated how his perspective towards mental health problems had changed:

> *Here, I feel like I am the boss. My mental health problems should not manage me, I should manage my life. Through them [my problems] or to live with them. Without anything ruining my everyday life.* (Male patient no. 8)

Discussion

The results showed that time-limits in therapy was experienced as a cornerstone in brief therapy. Time-limits were perceived as an explicit framework for targeted change, which helped

both therapists and patients maintain structure and focus during the treatment-process. A joint clarification of expectations, committed both parties during therapy and made the patients accountable for their part in the treatment process. Brief therapy was described as a collaborative treatment that was carefully planned to achieve individual aims in a defined treatment project. The purpose of the treatment was explained as mastering ailments, not getting rid of them. Both patients and therapists explained that it was more about dealing with ailments using tools and techniques and less about finding the causes of the ailments. The therapists explained that the basic idea was that patients could be better able to cope with life as it is, and then to have a greater opportunity to manage life on their own after the end of treatment.

The time-limited therapy process

In the present study both patients and therapists described the therapy as defined by a time-limited framework that helped them shape a shared treatment plan. While an understanding of the effect of time-limits on the therapeutic process is important, it is difficult to examine due to several interacting variables characterizing treatment practice [17]. While it has been suggested that many therapists consider that time-limit does not affect therapy [11], the present study described the time-limit as a cornerstone in brief therapy, helping keep the focus on the patient's personal goals during treatment. Time constraints have been shown to affect both the outcome of treatment and the therapeutic process [11, 17], exerting pressure on the therapy process which creates an expectancy effect for both patients and therapists, with both positive and negative consequences [11]. In the present study, the time-limit forced the therapists to evaluate each step during treatment, making the treatment focused and predictable. An imposed time-limit also has the potential to threaten the therapeutic alliance [17], described as empathy, warmth and acceptance in therapy [32]. Therapeutic alliance is viewed as indispensable in all forms of therapy [33] and as crucial for successful goal setting and treatment [33], and is a robust predictor of psychotherapy outcomes even in brief therapy such as guided internet interventions [34]. In the present study the patients emphasized that trust between therapist and patient was established early in the treatment process, potentially having a positive influence on the treatment process.

In our study, the therapists underlined that brief therapy strengthened the therapists' termination competence and played a role in creating a more positive attitude to treatment closure for the patients. In contrast, research has shown that therapists feel that their way of working is altered by time-limits [11] and termination of treatment in psychotherapy has been recognized as emotionally difficult for both clients and therapists [35]. Patients' reactions to termination are related to their evaluation of the treatment process in the span between experience of success and regression, and can be expressed as a need for further treatment [36]. According to our study, the time-limitation entailed focusing on closure when treatment started and made the treatment process more predictable and focused. Studies have showed that therapists react differently to termination of treatment, dependent on whether the termination is planned or not [35, 36]. Therapists react with more pride when a termination is planned, and with anger, mourning, frustration and anxiety when unplanned termination occurs [35]. Positive emotions are especially related to the therapists' experience of achievement and pride in the clients' success when termination was planned [35].This is in line with our findings, where therapists said it was easier to end treatment when the time for termination was set in advance. Our findings indicate that the time-limited framework might play a positive role in therapists' sense of control over the therapeutic process.

In the present study, patients expressed that they had to accept the time-limits set by the therapists, and that they had to commit and be ready for change. This is in line with research

showing that time-limits can be associated with therapists taking on a more directive or paternalistic role [11]. In our study, this was expressed through the signal to patients that they would not get any treatment if they signaled unwillingness or inability to participate in the limited-time treatment. This may indicate a signal that patients should believe in time-limited treatment to achieve therapeutic results. On the other side, time-limits and continuity in therapy can be experienced as positive and predictable for patients in a period where they must undergo significant changes in life [37]. Some of the patients in the study emphasized that the time constraint felt challenging, but that it had helped strengthening the focus on changing strategies during treatment and was something they needed. A therapist may be described in different ways, partly as a competent expert and partly as a safe point that provides emotional support during a turbulent change process [37]. In our study, patients expressed confidence in the therapists' competence and trusted they could help them acquire coping-strategies within the fixed time frame. They elaborated that the predictable time frame had helped to improve their ability to cope with ailments more than they had expected before treatment. The findings may indicate that a planned and fixed time-limit in brief therapy helped to strengthen patients' motivation during treatment.

Contrary to this, the results also showed that most of the patients believed they would receive more treatment if necessary, after ending brief therapy. This means that therapists and patients perceived the fixed time frame differently. This should be viewed in the context of the comprehensiveness of the Norwegian welfare system. In this context, it can be assumed that patients expect to receive help if they need further treatment.

Patients' readiness and activation

Even though the patients were entitled to general outpatient treatment at the hospital level (DPC), our results showed that both therapists and patients experienced that patients had to have certain resources to be able to take an active patient role in brief therapy. People seeking psychotherapy come to treatment with different motivation, preparation and capacity for behavior change [38]. Patients' readiness to change behavior greatly affects the process and outcome of treatment, and patients can be at different stages of such readiness before therapy takes place [38]. Given a variability in patient readiness to change, uniform time-limits for treatment would not adequately serve all the patients' needs, even though their diagnoses are similar [7]. Patients' expectations before treatment might predict the outcome, and these should therefore be identified to ensure that the treatment satisfies the patients' needs [39]. In our study, few of the patients knew in advance what the treatment entailed. The therapists assessed patients' readiness before starting treatment, emphasizing that they only offered treatment to patients they believed had the ability to take responsibility for their own treatment process. This finding indicates that assessment of the patients' readiness before treatment can be viewed as mapping the potential to patient activation during brief therapy.

The fact that the patient should play an active role during treatment, has become a central goal in mental health treatment [40]. Various terms have been used to describe aspects of this goal, such as patient participation and shared decision making [40]. Patient participation is claimed to be an important element in high-quality mental health services [41] and research has emphasized the need to increase the focus on patients' possibility of influencing treatment by their preferences and values [41]. Better results can be expected when patients and therapists agree on therapeutic goals and the processes for achieving those goals [19]. Recent research has highlighted the need for continuous learning, patient co-production and more efficient care in mental health care, as well as emphasizing the need for mutual learning between therapist and patient during the treatment process [42]. In the present study we

found this described as a clear and reconciled treatment plan aiming to achieve concrete and individual treatment goals through the patients' active participation. The patients expressed that the treatment was based on a shared understanding of expectations, even though the patients could not influence the general time frame or method of treatment. Results of psychotherapy seem to improve significantly when the patient and therapist are actively involved in a collaborative relationship [19]. In the present study, the experiences of shared understanding may thus have reinforced patients' positive expectation of achieving their individual goals through brief therapy.

Also previous studies on brief therapy among young adults have described patients perceiving their therapists as experts or teachers who could give them a new understanding of themselves and their thought patterns, and help ailments appear more understandable and manageable [37]. The patients may see their therapist as an expert with an objective perspective who could shed light on their difficulties [37] and the therapy can be about facilitating self-acceptance of one's own illness or ailments and for dealing with associated consequences [39]. Brief therapy in the present study was strongly influenced by CBT, where both the therapist and the client are seen as experts in their own specialist areas, and work together to create change [43]. The structure and process associated with cognitive therapy has also been shown to contribute to increased adherence to homework given during treatment, and patients have gradually learned to become their own therapists [43]. This is in line with the present study, where patients actively used "treatment tools" between treatment sessions and where responsibility for doing this was emphasized as crucial for learning and further personal effort. Patients also expressed feeling challenged by the treatment process because they knew the results depended on their own efforts. Both patients and therapists emphasized the patients' responsibility in their own treatment. This finding highlights the importance of patients' ability to activate themselves and may therefore be viewed as an important part of brief therapy. It can be assumed that brief treatment preferably should be offered to patients who are prepared and express that they feel ready for activation.

Mastering life as it is

In our study, both patients and therapists expressed that a main purpose of treatment was that patients should be able to master life as it was. The patients emphasized that the therapy made them understand that the ailments did not need to develop into a chronic or long-term condition, and they had experienced that therapeutic tools could be learned and used to better cope with their ailments. Facilitating personal development during treatment can be linked to a recovery-oriented approach [40]. The recovery perspective in mental health treatment has two core principles, that people with mental illnesses can lead productive lives even while having symptoms, and that many will recover from their illnesses [44]. This approach recognizes that people with mental ailments or illnesses might be able to return to and participate in society [44]. The patients in this study described a positive change in their perspectives, seeing the treatment as the beginning of a longer recovery process they had to continue by themselves. This is in line with the recovery-oriented focus on restoring individuals' functioning beyond symptom reduction [44], such as developing skills and knowledge that they need to take personal responsibility for their health [45]. This is also in line with CBT which focuses on the future, as opposed to the past, and on the participants'strengths and abilities, as opposed to their problems and shortcomings [46]. Personal recovery in mental health has been defined as a personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles [47]. Therefore, the patients' expression of brief therapy as a fragile beginning of a longer improvement process might be viewed in the perspective of personal recovery.

The patients in our study described brief therapy as a "change project" making them look at their problems in a new perspective. Similarly, the therapists expressed focusing on ways patients can live a satisfying, hopeful and contributing life. Hope is described as one of the most important factors concerning recovery, and whether one believes that recovery is feasible [48]. Patients' hope is also an important factor in therapy that therapists can help promote and strengthen [32]. Our findings indicate that the patients' hope for recovery after the treatment process were reinforced by clinicians expressing belief that brief treatment could be tailored to them and their individual needs. This is in line with research claiming that hope can enhance motivation to engage in the recovery process [48]. Expectations to benefit from treatment can be regarded as the activating energy of hope, and the therapist also might increase a patient's sense of expectation [32]. This hopeful expectation can again be nurtured by the therapists [32]. Experience of hope might strengthen the patients' focus on changed thinking and behavior in the recovery processes, including strengthened optimism about the future [47]. These findings indicate that brief therapy aimed to be both therapeutic and prevent future problems. The ending of brief therapy might therefore be viewed as a starting point of a personal recovery-process aiming to master life as it is.

Strengths and limitations

The sample consisted of both patients and therapists and variation in age and gender, constituting a strength of this study. In addition, the therapist sample included most of the therapists working in the treatment unit, having various length of experience with brief therapy. A potential limitation is the apparent homogenous therapist group, due to the management recruitment of professionals to the brief therapy unit. Here, those who were especially interested in brief therapy were encouraged to apply, thus being dedicated to brief therapy. The patient sample included a breadth of patient experiences, both patients who experienced mental health problems for the first time and some with recurring episodes over decades. This enriched the data material. A potential limitation is the possibility of a sample bias through voluntary recruitment. The patients were recruited via the therapists, and all the therapists in the unit was supposed to recruit patients who had some experience of receiving brief therapy. The therapists' presentation of the study might have influenced who agreed to participate. Nevertheless, the study depended on the study participants who had first-hand experience with receiving brief therapy. We therefore found this part of recruitment process adequate.

The qualitative semi-structured interview approach strengthened the exploratory approach. The interviews with patients were conducted when they were currently receiving brief therapy, or shortly after the end of treatment. Interviews at a single point include a risk of bias, since the interviews were conducted before patients knew the outcome of their treatment. A longitudinal approach should be pursued in further research on the possible personal recovery process that may take place after brief treatment ending.

As the analysis was conducted by five authors with different professional backgrounds, the researchers had complementary experiences which strengthened the analytical processes. Discussions in a different research group also strengthened the study through providing alternative considerations.

A limitation might also be that both therapists' and patients' experiences and point of view are not confirmed by other types of data in this study. In addition, the Norwegian socio-cultural context, such as the Norwegian health care system and the comprehensiveness of the welfare system, somewhat limits the transferability to other countries. That patients expected to receive more help from the welfare system if they needed further treatment might rest on the Norwegian welfare system.

Conclusion

This study adds knowledge on patients' and therapists' experiences with time limitations during therapeutic processes. The time-limitation appeared to play a positive role, helping the therapists to structure the therapeutic process and strengthening the patients' motivation. An experience of a shared treatment project and the opportunity for active participation in treatment may have reinforced patients' responsibility and positive expectations to achieve individual goals. This emphasizes the importance of the patient's readiness and activation as important prerequisites for brief therapy. In addition, brief therapy was perceived as the beginning of a longer recovery process patients had to continue by themselves. It can be assumed that the therapists'efforts to nurture the patients' hope for improvement during treatment contributed to increasing the motivation for the further efforts and recovery process after the end of treatment. The end of brief therapy can be viewed as a fragile and uncertain start to the patients' process towards "mastering life as it is". More research is needed to investigate the patients' long-term outcome after such treatment and to shed light on the potential for, and limitations of, mastering everyday-life after ending brief therapy.

Supporting information

S1 Fig. Poster presentation; A TREATMENT STRATEGY FOR MEETING LIFE AS IT IS, the results from the present study, presented as preliminary findings to colleagues at «ECMH–European Conference on Mental Health 2020» Online conference, Finland, October 2020.
(TIF)

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References

1. Wittchen HU, Jacobi F, Rehm J, Gustavsson A, Svensson M, Jonsson B, et al. The size and burden of mental disorders and other disorders of the brain in Europe 2010. Eur Neuropsychopharmacol. 2011; 21(9):655–79. https://doi.org/10.1016/j.euroneuro.2011.07.018 PMID: 21896369
2. Holmes EA, Ghaderi A, Harmer CJ, Ramchandani PG, Cuijpers P, Morrison AP, et al. The Lancet Psychiatry Commission on psychological treatments research in tomorrow's science. Lancet Psychiatry. 2018; 5(3):237–86. https://doi.org/10.1016/S2215-0366(17)30513-8 PMID: 29482764
3. Patel V, Saxena S, Lund C, Thornicroft G, Baingana F, Bolton P, et al. The Lancet Commission on global mental health and sustainable development. Lancet. 2018; 392(10157):1553–98. https://doi.org/10.1016/S0140-6736(18)31612-X PMID: 30314863
4. Gianfredi V, Blandi L, Cacitti S, Minelli M, Signorelli C, Amerio A, et al. Depression and Objectively Measured Physical Activity: A Systematic Review and Meta-Analysis. Int J Environ Res Public Health. 2020; 17(10). https://doi.org/10.3390/ijerph17103738 PMID: 32466242
5. Howard KI, Kopta SM, Krause MS, Orlinsky DE. The dose-effect relationship in psychotherapy. Am Psychol. 1986; 41(2):159–64. PMID: 3516036
6. Kopta SM. The dose-effect relationship in psychotherapy: a defining achievement for Dr. Kenneth Howard. J Clin Psychol. 2003; 59(7):727–33. https://doi.org/10.1002/jclp.10167 PMID: 12808579
7. Baldwin SA, Berkeljon A, Atkins DC, Olsen JA, Nielsen SL. Rates of change in naturalistic psychotherapy: contrasting dose-effect and good-enough level models of change. J Consult Clin Psychol. 2009; 77 (2):203–11. https://doi.org/10.1037/a0015235 PMID: 19309180
8. Barkham M, Connell J, Stiles WB, Miles JN, Margison F, Evans C, et al. Dose-effect relations and responsive regulation of treatment duration: the good enough level. J Consult Clin Psychol. 2006; 74 (1):160–7. https://doi.org/10.1037/0022-006X.74.1.160 PMID: 16551153
9. Ewen V, Mushquash AR, Bailey K, Haggarty JM, Dama S, Mushquash CJ. Same-Day Counseling: Study Protocol for the Evaluation of a New Mental Health Service. JMIR Res Protoc. 2016; 5(1):e22. https://doi.org/10.2196/resprot.5206 PMID: 26842891
10. Stulz N, Lutz W, Kopta SM, Minami T, Saunders SM. Dose-effect relationship in routine outpatient psychotherapy: does treatment duration matter? J Couns Psychol. 2013; 60(4):593–600. https://doi.org/10.1037/a0033589 PMID: 23815633
11. De Geest RM, Meganck R. How Do Time Limits Affect Our Psychotherapies? A Literature Review. Psychol Belg. 2019; 59(1):206–26. https://doi.org/10.5334/pb.475 PMID: 31328017
12. Abbass AA, Kisely SR, Town JM, Leichsenring F, Driessen E, De Maat S, et al. Short-term psychodynamic psychotherapies for common mental disorders. Cochrane Database Syst Rev. 2014(7): Cd004687. https://doi.org/10.1002/14651858.CD004687.pub4 PMID: 24984083
13. Zhang A, Franklin C, Currin-McCulloch J, Park S, Kim J. The effectiveness of strength-based, solution-focused brief therapy in medical settings: a systematic review and meta-analysis of randomized controlled trials. J Behav Med. 2018; 41(2):139–51. https://doi.org/10.1007/s10865-017-9888-1 PMID: 28975531
14. Roth A, Fonagy P. What works for whom?: a critical review of psychotherapy research: Guilford Press; 2006.
15. Hersen M, Biaggio M. Effective brief therapies: A clinician's guide: Elsevier; 2000. https://doi.org/10.1016/s0272-7358(99)00055-0 PMID: 10660827
16. Cohen J, Marecek J, Gillham J. Is three a crowd? Clients, clinicians, and managed care. Am J Orthopsychiatry. 2006; 76(2):251–9. https://doi.org/10.1037/0002-9432.76.2.251 PMID: 16719644
17. Wright T, Simpson-Young V, Lennings C. Therapeutic process in the context of third party determined time limits. Clin Psychol. 2012; 16(2):82–92.
18. Cushman P, Gilford P. Will managed care change our way of being? Am Psychol. 2000; 55(9):985. PMID: 11036697
19. Tryon GS, Winograd G. Goal consensus and collaboration. 2011.
20. Hibbard JH, Stockard J, Mahoney ER, Tusler M. Development of the Patient Activation Measure (PAM): conceptualizing and measuring activation in patients and consumers. Health Serv Res. 2004; 39(4p1):1005–26. https://doi.org/10.1111/j.1475-6773.2004.00269.x PMID: 15230939

21. Hickey G, Kipping C. Exploring the concept of user involvement in mental health through a participation continuum. J Clin Nurs. 1998; 7(1):83–8. https://doi.org/10.1046/j.1365-2702.1998.00122.x PMID: 9510712

22. Askheim OP, Christensen K, Fluge S, Guldvik I. User participation in the Norwegian welfare context: an analysis of policy discourses. J Soc Policy. 2017; 46(3):583.

23. Tritter J, Koivusalo M, Ollila E, Dorfman P. Globalisation, markets and healthcare policy: redrawing the patient as consumer: Routledge; 2009.

24. Malterud K. Systematic text condensation: a strategy for qualitative analysis. Scand J Public Health. 2012; 40(8):795–805. https://doi.org/10.1177/1403494812465030 PMID: 23221918

25. Wells A. Emotional Disorders and Metacognition: Innovative Cognitive Therapy. University of Manchester: Wiley; 2002.

26. Hayes SC, Luoma JB, Bond FW, Masuda A, Lillis J. Acceptance and commitment therapy: model, processes and outcomes. Behav Res Ther. 2006; 44(1):1–25. https://doi.org/10.1016/j.brat.2005.06.006 PMID: 16300724

27. Segal ZV, Williams M, Teasdale JD. Mindfulness-based cognitive therapy for depression: a new approach to preventing relapse. New York (NY): Guilford Press; 2002.

28. Patton MQ. Qualitative evaluation and research methods: SAGE Publications, inc; 1990.

29. Malterud K, Siersma VD, Guassora AD. Sample Size in Qualitative Interview Studies: Guided by Information Power. Qual Health Res. 2016; 26(13):1753–60. https://doi.org/10.1177/1049732315617444 PMID: 26613970

30. Peters K, Halcomb E. Interviews in qualitative research. Nurse Res. 2015; 22(4):6–7. https://doi.org/10.7748/nr.22.4.6.s2 PMID: 25783145

31. Tjora A. Qualitative research as stepwise-deductive induction: Routledge; 2018.

32. Reiter MD. Hope and expectancy in solution-focused brief therapy. J Fam Psychother. 2010; 21 (2):132–48.

33. Meissner W. Therapeutic alliance: Theme and variations. Psychoanal Psychol. 2007; 24(2):231.

34. Gómez Penedo JM, Babl AM, Grosse Holtforth M, Hohagen F, Krieger T, Lutz W, et al. The Association of Therapeutic Alliance With Long-Term Outcome in a Guided Internet Intervention for Depression: Secondary Analysis From a Randomized Control Trial. J Med Internet Res. 2020; 22(3):e15824. https://doi.org/10.2196/15824 PMID: 32207689

35. Baum N. Therapists' responses to treatment termination: An inquiry into the variables that contribute to therapists' experiences. Clin Soc Work J. 2007; 35(2):97–106.

36. Anne EF, Bill P, Cherie DR. Reactions to Termination of Individual Treatment. Social work (New York). 1992; 37(2):171–8.

37. Landström C, Levander L, Philips B. Dynamic interpersonal therapy as experienced by young adults. Psychoanalytic Psychotherapy. 2019; 33(2):99–116.

38. Krebs P, Norcross JC, Nicholson JM, Prochaska JO. Stages of change and psychotherapy outcomes: A review and meta-analysis. J Clin Psychol. 2018; 74(11):1964–79. https://doi.org/10.1002/jclp.22683 PMID: 30335193

39. Hamnes B, Hauge MI, Kjeken I, Hagen KB. 'I have come here to learn how to cope with my illness, not to be cured': A Qualitative Study of Patient Expectations Prior to a One-Week Self-Management Programme. Musculoskeletal Care. 2011; 9(4):200–10. https://doi.org/10.1002/msc.212 PMID: 21774066

40. Jørgensen K, Rendtorff JD. Patient participation in mental health care—perspectives of healthcare professionals: an integrative review. Scand J Caring Sci. 2018; 32(2):490–501. https://doi.org/10.1111/scs.12531 PMID: 28940229

41. Rise MB, Westerlund H, Bjørgen D, Steinsbekk A. Safely cared for or empowered in mental health care? Yes, please. Int J Soc Psychiatry. 2014; 60(2):134–8. https://doi.org/10.1177/0020764012471278 PMID: 23321388

42. Gremyr A, Malm U, Lundin L, Andersson A-C. A learning health system for people with severe mental illness: a promise for continuous learning, patient coproduction and more effective care. Digital Psychiatry. 2019; 2(1):8–13.

43. Beck JS, Beck AT. Cognitive therapy: Basics and beyond: Guilford press New York; 1995.

44. Davidson L. The recovery movement: Implications for mental health care and enabling people to participate fully in life. Health Aff (Millwood). 2016; 35(6):1091–7. https://doi.org/10.1377/hlthaff.2016.0153 PMID: 27269027

45. Lloyd C, Waghorn G, Williams PL. Conceptualising recovery in mental health rehabilitation. Br J Occup Ther. 2008; 71(8):321–8.

46. Smith S, Macduff C. A thematic analysis of the experience of UK mental health nurses who have trained in Solution Focused Brief Therapy. J Psychiatr Ment Health Nurs. 2017; 24(2–3):105–13. https://doi.org/10.1111/jpm.12365 PMID: 28124407

47. Leamy M, Bird V, Le Boutillier C, Williams J, Slade M. Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. Br J Psychiatry. 2011; 199(6):445–52. https://doi.org/10.1192/bjp.bp.110.083733 PMID: 22130746

48. Park J, Chen RK. Positive psychology and hope as means to recovery from mental illness. Journal of Applied Rehabilitation Counseling. 2016; 47(2):34–42.

Paper III

This paper is awaiting publication and is not included in NTNU Open

TITLE PAGE

Title:

Who benefits from brief therapy treatment in a district psychiatric centre? A qualitative study investigating patients' stories and general practitioners' experiences

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Appendix

Appendix 1: Information letter, agreement to participate for professionals - study I

Appendix 2: Information letter, agreement to participate for patients - study II

Appendix 3: Information letter, agreement to participate for therapists - study II

Appendix 4: Information letter, agreement to participate for GPs - study III

Appendix 5: Assessment of the Regional Committee for Medical and Health Research Ethics (REK) in Central Norway (2018)

Appendix 6: Assessment of the Regional Committee for Medical and Health Research Ethics (REK) in Central Norway (2019)

Appendix 7: Assessment of the Regional Committee for Medical and Health Research Ethics (REK) in Central Norway (2021)

Appendix 8: DPC's official information brochure on the brief therapy service (flyer, 2018)

Appendix 9: Poster presentation, preliminary findings 2020, study II

Appendix 10: Guide for interviews with professionals, study I

Appendix 11: Guide for interviews with patients and therapists, study II, *retrieved from Markussen et al. (2021, p. 5).*

Appendix 12: Guide for interviews with patients and GPs, study III.

Appendix 13: Advanced literature searches

Appendix 1: Information letter, agreement to participate for professionals - study I

FORESPØRSEL OM DELTAKELSE I FORSKNINGSPROSJEKTET:

Brief therapy ved Nidaros DPS

Nidaros DPS startet i 2016 et nytt tilbud til personer med angst- og depresjonsproblemer. Her tilbys kortvarig terapi, såkalt «brief therapy» med inntil 10 terapisamtaler. Behandlingstilnærmingen fokuserer på meta-kognitiv terapi og kognitiv atferdsterapi, tilnærminger som legger stor vekt på hvordan brukeren håndterer og mestrer sine psykiske problemer. I 2016 gjennomførte omkring 450 personer dette terapitilbudet. Denne studien skal se nærmere på hvordan tilbudet om brief therapy og arbeidet ved Korttidspoliklinikken eventuelt har påvirket arbeidet i Nidaros DPS som helhet.

HVA INNEBÆRER PROSJEKTET?

Alle som deltar blir bedt om å være med på ett eller to intervju. Intervjuene vil være en samtale mellom deg og en forsker. I intervjuene vil du bli spurt om dine erfaringer med arbeidsprosessene og pasientflyten ved Nidaros DPS de siste årene, særlig knyttet til etableringen og driften av tilbudet «brief therapy». Intervjuene vil vare rundt en time og vil foregå på din eller forskerens arbeidsplass – eller et annet sted om du ønsker det. Alle intervjuene vil bli tatt opp på lydfil.

MULIGE FORDELER OG ULEMPER

Det er ingen ulemper knyttet til å delta i dette forskningsprosjektet.

FRIVILLIG DELTAKELSE OG MULIGHET FOR Å TREKKE DITT SAMTYKKE

Det er frivillig å delta i studien. Du kan når som helst, og uten å oppgi noen grunn, trekke ditt samtykke til å delta i studien. Dersom du senere ønsker å trekke deg eller har spørsmål til studien, kan du kontakte Hilde V. Markussen eller prosjektleder Marit By Rise på telefon 993 15 365.

HVA SKJER MED INFORMASJONEN OM DEG?

Informasjonen som registreres om deg skal kun brukes i denne studien. Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. Det er kun autorisert personell knyttet til prosjektet som har adgang til navnelisten og som kan finne tilbake til deg. Informasjon du har gitt i forbindelse med intervju vil ikke bli gitt til ledere eller andre ansatte ved Nidaros DPS. Lydopptakene vil bli slettet når prosjektet er ferdig, og utskriftene vil bli anonymisert. Selv om andre ansatte vil kunne kjenne igjen episoder eller tema du beskriver i intervju, vil det ikke være mulig for utenforstående å identifisere deg i resultatene av studien når disse publiseres.

GODKJENNING

Prosjektet er godkjent av Regional komite for medisinsk og helsefaglig forskningsetikk, 2018/49/REK midt.

SAMTYKKE TIL DELTAKELSE I PROSJEKTET

JEG ER VILLIG TIL Å DELTA I PROSJEKTET

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Sted og dato *Deltakers signatur*

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Deltakers navn med trykte bokstaver

Appendix 2: Information letter, agreement to participate for patients - study II

«Brief therapy ved Nidaros DPS»
Kontaktperson: Hilde V. Markussen, Institutt for psykisk helse, NTNU
Postboks 8905, 7491 Trondheim. Tel. 996 40 060, e-post: hilde.v. markussen@ntnu.no

NTNU
Fakultet for medisin
og helsevitenskap
Institutt for psykisk helse

FORESPØRSEL OM DELTAKELSE I FORSKNINGSPROSJEKTET:

Brief therapy ved Nidaros DPS

Du får denne invitasjonen fordi du har fått tilbud om behandling - «brief therapy» - ved Nidaros DPS. «Brief therapy» er et nokså nytt tilbud ved Nidaros DPS til personer med angst- og depresjonsplager. Her tilbys kortvarig terapi, såkalt «brief therapy» med inntil 10 terapisamtaler. Det mangler fortsatt kunnskap om hvordan de som deltar i «brief therapy» opplever behandlingstilbudet, særlig når det gjelder opplevelse av kommunikasjon og medvirkning i behandlingsprosessen. Vi ønsker også å finne ut hva slags utbytte de som deltar i «brief therapy» eventuelt opplever.

HVA INNEBÆRER PROSJEKTET?

Alle som deltar blir bedt om å være med på ett eller to intervju i løpet av en periode på ett år. Intervjuene vil være en samtale mellom deg og en forsker som har taushetsplikt. I intervjuene vil du bli spurt om dine forventninger til og erfaringer fra behandlingen. Samtalene vil fokusere på din opplevelse av kommunikasjon, samarbeid og medvirkning i behandlingsprosessen, og hva slags utbytte du opplever å ha hatt fra behandlingen. Vi vil gjerne høre hva du tenker om dette. Intervjuet vil vare rundt en time og kan foregå på Nidaros DPS, forskerens arbeidsplass på NTNU eller et annet sted som passer for deg. Alle intervjuene vil bli tatt opp på lydfil.

MULIGE FORDELER OG ULEMPER

Å delta i dette prosjektet medfører ingen endringer i behandlingen du får ved Nidaros DPS eller senere. Det er ingen ulemper knyttet til å delta i dette forskningsprosjektet.
Dersom du har behov for å snakke med noen i forbindelse med å ha deltatt i intervju, kan du ta kontakt med psykologspesialist Elin Ulleberg på telefon 93427084, e-post elin.ulleberg@stolav.no eller psykologspesialist Liv Sigrun Engvik på telefon 416 41 922, e-post liv.sigrun.engvik@stolav.no

FRIVILLIG DELTAKELSE OG MULIGHET FOR Å TREKKE DITT SAMTYKKE

Det er frivillig å delta i prosjektet. Dersom du ønsker å delta, undertegner du samtykkeerklæringen på siste side og leverer denne til personalet ved Nidaros DPS. Du kan også ta kontakt med Hilde V. Markussen for å gjøre en avtale om intervju.

Du kan når som helst - og uten å oppgi noen grunn - trekke ditt samtykke. Dette vil ikke få konsekvenser for din videre behandling. Dersom du trekker deg fra prosjektet, kan du kreve å få slettet innsamlede opplysninger, med mindre opplysningene allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner. Dersom du senere ønsker å trekke deg eller har spørsmål til prosjektet, kan du kontakte Hilde V. Markussen eller prosjektleder Marit By Rise på telefon 993 15 365 eller på e-post: marit.b.rise@ntnu.no

HVA SKJER MED INFORMASJONEN OM DEG?

Informasjonen som registreres om deg skal kun brukes slik som beskrevet i hensikten med studien. Du har rett til innsyn i hvilke opplysninger som er registrert om deg og rett til å få korrigert eventuelle feil i de opplysningene som er registrert.

Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. Det er kun autorisert personell knyttet til prosjektet som har adgang til navnelisten og som kan finne tilbake til deg. Forskerne har taushetsplikt og informasjon fra intervjuene vil ikke bli gitt til ansatte ved Nidaros DPS. Lydopptakene vil bli slettet når prosjektet er ferdig, og utskriftene vil bli anonymisert. Det vil ikke være mulig for utenforstående å identifisere deg i resultatene av studien når disse publiseres.

Prosjektleder har ansvar for den daglige driften av forskningsprosjektet og at opplysninger om deg blir behandlet på en sikker måte. Informasjon om deg vil bli anonymisert eller slettet senest fem år etter prosjektslutt.

GODKJENNING

Prosjektet er godkjent av Regional komite for medisinsk og helsefaglig forskningsetikk, 2018/49/REK midt.

SAMTYKKE TIL DELTAKELSE I PROSJEKTET

JEG ER VILLIG TIL Å DELTA I PROSJEKTET

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Sted og dato *Deltakers signatur*

Deltakers navn med trykte bokstaver

Appendix 3: Information letter, agreement to participate for therapists - study II

NTNU
Fakultet for medisin
og helsevitenskap
Institutt for psykisk helse

FORESPØRSEL OM DELTAKELSE I FORSKNINGSPROSJEKTET:

Brief therapy ved Nidaros DPS

Nidaros DPS startet i 2016 et nytt tilbud til personer med angst- og depresjonsproblemer. Her tilbys kortvarig terapi, såkalt «brief therapy» med inntil 10 terapisamtaler. Behandlingstilnærmingen fokuserer på metakognitiv terapi og kognitiv atferdsterapi, tilnærminger som legger stor vekt på hvordan brukeren håndterer og mestrer sine psykiske problemer. I 2016 gjennomførte omkring 450 personer dette terapitilbudet. Denne intervjustudien skal se nærmere på ansattes erfaringer med tilbudet «brief therapy», med særskilt vekt på kommunikasjon og eventuell medvirkning fra pasientene i behandlingsprosessen.

HVA INNEBÆRER PROSJEKTET?

Alle som deltar blir bedt om å være med på ett eller to intervju. Intervjuene vil være en samtale mellom deg og en forsker. I intervjuene vil du bli spurt om dine erfaringer med å tilby «brief therapy» til denne pasientgruppen. Viktige tema i intervjuene vil være aktivisering og mestring hos pasientene, samt kommunikasjon og medvirkning i behandlingsprosessen. Intervjuene vil vare rundt en time og kan foregå på din eller forskerens arbeidsplass – eller et annet sted om du ønsker det. Alle intervjuene vil bli tatt opp på lydfil.

MULIGE FORDELER OG ULEMPER

Det er ingen ulemper knyttet til å delta i dette forskningsprosjektet.

FRIVILLIG DELTAKELSE OG MULIGHET FOR Å TREKKE DITT SAMTYKKE

Det er frivillig å delta i studien. Du kan når som helst, og uten å oppgi noen grunn, trekke ditt samtykke til å delta i studien. Dersom du senere ønsker å trekke deg eller har spørsmål til studien, kan du kontakte phd kandidat Hilde V. Markussen på telefon 99640060 eller prosjektleder Marit By Rise på telefon 993 15 365.

HVA SKJER MED INFORMASJONEN OM DEG?

Informasjonen som registreres om deg skal kun brukes i denne studien. Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. Det er kun autorisert personell knyttet til prosjektet som har adgang til navnelisten og som kan finne tilbake til deg. Informasjon du har gitt i forbindelse med intervju vil ikke bli gitt til ledere eller andre ansatte ved Nidaros DPS. Lydopptakene vil bli

slettet når prosjektet er ferdig, og utskriftene vil bli anonymisert. Selv om andre ansatte vil kunne kjenne igjen episoder eller tema du beskriver i intervju, vil det ikke være mulig for utenforstående å identifisere deg i resultatene av studien når disse publiseres.

GODKJENNING

Prosjektet er godkjent av Regional komite for medisinsk og helsefaglig forskningsetikk, 2018/49/REK midt.

SAMTYKKE TIL DELTAKELSE I PROSJEKTET

JEG ER VILLIG TIL Å DELTA I PROSJEKTET

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Sted og dato *Deltakers signatur*

Deltakers navn med trykte bokstaver

Appendix 4: Information letter, agreement to participate for GPs - study III

NTNU
Fakultet for medisin
og helsevitenskap
Institutt for psykisk helse

Forespørsel om deltakelse i forskningsprosjekt

Brief therapy ved Nidaros DPS

Nidaros DPS startet i 2016 et nytt tilbud til personer med angst- og depresjonsproblemer. Her tilbys kortvarig terapi, såkalt «brief therapy» med inntil 10 terapisamtaler. Behandlingstilnærmingen fokuserer på metakognitiv terapi og kognitiv atferdsterapi, tilnærminger som legger stor vekt på hvordan brukeren håndterer og mestrer sine psykiske problemer. I 2016 gjennomførte omkring 450 personer dette terapitilbudet. Denne intervjustudien skal se nærmere på fastlegers perspektiv på dette tilbudet.

Dette er en forespørsel om å delta i dette forskningsprosjektet. Du har blitt spurt fordi du arbeider ved henvisende fastlegekontor i Trondheim, og dermed kjenner til tilbudet ved korttidspoliklinikken på Nidaros DPS.

Hva innebærer PROSJEKTET?

Alle som deltar blir bedt om å være med på ett individuelt intervju. I intervjuet vil du bli spurt om dine erfaringer med å henvise pasienter til «brief therapy», hvilke utbytter du opplever at pasientene eventuelt har, og hvordan dette tilbudet inngår i helsetjenestene til denne pasientgruppen. Intervjuet vil vare rundt en time og kan foregå på din eller forskerens arbeidsplass – eller et annet sted om du ønsker det. Alle intervjuene vil bli tatt opp på lydfil.

Mulige fordeler og ulemper

Det er ingen ulemper knyttet til å delta i dette forskningsprosjektet.

Frivillig deltakelse og mulighet for å trekke samtykket

Det er frivillig å delta i studien. Du kan når som helst, og uten å oppgi noen grunn, trekke ditt samtykke til å delta i studien. Dersom du senere ønsker å trekke deg eller har spørsmål til studien, kan du kontakte stipendiat Hilde V. Markussen på telefon 996 400 60 eller prosjektleder Marit By Rise på telefon 993 15 365.

Hva skjer med informasjonen om deg?

Informasjonen som registreres om deg skal kun brukes i denne studien. Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. Det er kun autorisert personell knyttet til prosjektet som har adgang til navnelisten og som kan finne tilbake til

deg. Lydopptakene vil bli slettet når prosjektet er ferdig, og utskriftene vil bli anonymisert. Det vil ikke være mulig for utenforstående å identifisere deg i resultatene av studien når disse publiseres.

Godkjenning

Regional komité for medisinsk og helsefaglig forskningsetikk har vurdert prosjektet og har gitt godkjenning, 2018/49/REK midt. Etter ny personopplysningslov har behandlingsansvarlig NTNU, fakultet for medisin og helsevitenskap, Institutt for psykisk helse og prosjektleder et selvstendig ansvar for å sikre at behandlingen av dine opplysninger har et lovlig grunnlag. Dette prosjektet har rettslig grunnlag i EUs personvernforordning artikkel 6 nr. 1a og artikkel 9 nr. 2a og ditt samtykke. Du har rett til å klage på behandlingen av dine opplysninger til Datatilsynet.

kONTAKTOPPLYSNINGER

Dersom du har spørsmål til prosjektet kan du ta kontakt med:
Stipendiat Hilde V. Markussen. Tel 996 400 60. E-post: hilde.v.markussen@ntnu.no
Prosjektleder Marit By Rise. Tel 993 15 365. E-post: marit.b.rise@ntnu.no

Jeg samtykker til å delta i prosjektet og til at mine personopplysninger brukes slik det er beskrevet

Sted og dato	Deltakers signatur
	Deltakers navn med trykte bokstaver
	Deltakers navn med trykte bokstaver

Appendix 5: Assessment of the Regional Committee for Medical and Health Research Ethics (REK) in Central Norway (2018)

From: post@helseforskning.etikkom.no <post@helseforskning.etikkom.no>
Sent: Friday, May 18, 2018 2:05 PM
To: Marit By Rise <marit.b.rise@ntnu.no>
Cc: MH Liste rek-iph <rek-iph@mh.ntnu.no>
Subject: Svar fra REK midt 2018/49: Godkjenning av delstudie 1 og 2

Vår ref. nr.:2018/49

Til Marit By Rise.

Vi viser til mottatte informasjonsskriv og beskrivelse av rekrutteringsprosedyren samt intervju, datert 03.05.2018. Informasjonsskrivet er revidert i tråd med komiteens merknader. Komiteen godkjenner også rekrutteringsprosedyren og intervjugjennomføringen i prosjektet.

Godkjenningen gjelder kun delstudie 1 og delstudie 2. Dokumentene er vurdert av komiteens sekretariat.

Vilkår for godkjenning

1. Godkjenningen er gitt under forutsetning av at prosjektet gjennomføres slik det er beskrevet i søknaden og protokollen. Prosjektet må også gjennomføres i henhold til REKs vilkår i saken og de bestemmelser som følger av helseforskningsloven (hfl.) med forskrifter.
2. Komiteen forutsetter at ingen personidentifiserbare opplysninger kan framkomme ved publisering eller annen offentliggjøring.
3. Forskningsprosjektets data skal oppbevares forsvarlig, se personopplysningsforskriften kapittel 2, og Helsedirektoratets veileder for «Personvern og informasjonssikkerhet i forskningsprosjekter innenfor helse- og omsorgssektoren». Av kontrollhensyn skal prosjektdata oppbevares i fem år etter sluttmelding er sendt REK. Data skal derfor oppbevares til denne datoen, for deretter å slettes eller anonymiseres, jf. hfl. § 38.
4. Prosjektleder skal sende sluttmelding til REK midt når forskningsprosjektet avsluttes. I sluttmeldingen skal resultatene presenteres på en objektiv og etterrettelig måte, som sikrer at både positive og negative funn fremgår, jf. hfl. § 12.

Merk at offisielt vedtaksbrev for studien kun kan sendes ut når vi har fått tilbakemelding for delstudie 3. Tilbakemeldingen må da sendes inn gjennom skjema.

Med vennlig hilsen
Ramunas Kazakauskas

rådgiver

post@helseforskning.etikkom.no

T: 73597510

Regional komité for medisinsk og helsefaglig forskningsetikk REK midt-Norge (REK midt)
http://helseforskning.etikkom.no

Appendix 6: Assessment of the Regional Committee for Medical and Health Research Ethics (REK) in Central Norway (2019)

Region:	**Saksbehandler:**	**Telefon:**	**Vår dato:**	**Vår referanse:**
REK midt	Ramunas Kazakauskas	73597510	01.03.2019	2018/49/REK midt
			Deres dato:	**Deres referanse:**
			01.01.2019	

Vår referanse må oppgis ved alle henvendelser

2018/49 "Brief therapy" i et distriktspsykiatrisk senter – erfaringer og innflytelse på bruk av Helsetjenester

Forskningsansvarlig: Norges teknisk-naturvitenskapelige universitet
Prosjektleder: Marit By Rise

Vi viser til søknad om forhåndsgodkjenning av ovennevnte forskningsprosjekt. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK midt) i møtet 12.02.2019. Vurderingen er gjort med hjemmel i helseforskningsloven § 10.

Komiteens opprinnelige prosjektsammendrag
Prosjektet består av tre delstudier som har til hensikt å undersøke langtidsutbytte av "Brief therapy", hvordan et avgrenset tilbud om terapi påvirker medvirkning, kommunikasjon og samarbeid under behandlingen, hvordan opprettelsen og driften av "Brief therapy" påvirker arbeidsprosessene og pasientflyten ved senteret. For å besvare forskningsspørsmålene er det planlagt å gjennomføre kvalitative intervju med helsepersonell, ledere og pasienter, samt bruke data fra registeret HELFO, PAS (pasientadministrativt system) og DPSets (Nidaros) egne tall. Inntil 1500 pasienter vil inngå i den delen av studien som omfatter helseregisterdata (36 måneder etter endt terapi), og inntil 25 pasienter og 40 ansatte i de kvalitative delstudiene. Prosjektleder søker om fritak fra kravet om å innhente samtykke for innsamling av registerdata fra PAS og HELFO.

Saksgang
Prosjektet ble første gang vurdert i REK midts møte 07.02.2018. Vedtak ble da utsatt. Komiteen ba om flere endringer i delstudie 3. Tilbakemelding fra prosjektleder ble mottatt 01.01.2019. Prosjektgruppen la frem en ny plan for delstudie 3 som nå fokuserer på bruk av helsetjenester for flere pasienter som mottar psykoterapien "Brief therapy". Prosjektleder opplyste REK midt per e-post om at det er ønskelig å inkludere ca. 3400 pasienter som har fått "Brief therapy" i perioden 2016-2018 og pasienter med tilsvarende diagnoser henvist i 2014-2015, men som ikke har fått denne behandlingen. I tillegg er det nå ønskelig å se på om bruk av helsetjenester har blitt påvirket av innføring av "Brief therapy" for alle pasienter med andre diagnoser, henvist til Nidaros DPS og en annen lignende poliklinikk mellom 2014 og 2018. Data fra ca. 18000 pasienter vil utgjøre datagrunnlaget for denne delen av studien. Prosjektgruppen søker om fritak fra kravet om å innhente samtykke fra alle pasientene i delstudie 3.
Prosjektleder søker i tillegg om en ny delstudie 4 som dreier seg om å gjennomføre intervju med pasienter ett år etter "Brief therapy". Deltakerne som skal inkluderes i delstudie 4 er pasienter som allerede har samtykket til deltakelse, samt fastleger som skal forespørres om deltakelse.

Vurdering: Godkjenning på vilkår

Komiteen har vurdert tilbakemeldingen,søknad, forskningsprotokoll, målsetting og plan for gjennomføring. Under forutsetning av at vilkårene nedenfor tas til følge vurderer REK at prosjektet er forsvarlig, og at hensynet til deltakernes velferd og integritet er ivaretatt.

Dispensasjon fra taushetsplikt
Komiteen viser til helseforskningsloven § 35 og gir herved dispensasjon fra taushetsplikt, slik at opplysninger kan gis fra helsepersonell og registre uten hinder av taushetsplikt, til bruk i delstudie 3 av det beskrevne prosjektet. Komiteen godkjenner også at prosjektleder behandler personopplysninger uten samtykke fra den enkelte deltaker. Prosjektleder kan delegere nødvendig tilgang til de andre personene som er nevnt i søknadens liste over medarbeidere. Komiteen begrunner vedtaket med at det er vanskelig å innhente samtykke på grunn av studiens omfang. Videre finner komiteen at forskningsprosjektet er av vesentlig interesse for samfunnet og hensynet til deltakernes velferd og integritet er ivaretatt.

Fritak fra generell opplysningsplikt
Hovedregelen er at dersom REK gir fritak fra samtykkekravet så skal deltakerne gis informasjon om forskningsprosjektet og anledning til å reservere seg mot deltakelse. Komiteen vurderte likevel at det ikke skulle stilles vilkår om informasjon i dette tilfellet av samme grunn som ovenfor.

Registerkoblinger
Komiteen godkjenner at indirekte personidentifiserbare helseopplysninger hentes fra HELFO, PAS samt DPS og sammenstilles til bruk i prosjektet. Søker må følge registereiers/registereiernes prosedyre for datasammenstilling.

Informasjonsskriv til fastleger i delstudie 4
Komiteen ber om at REKs nyeste versjon av mal for informasjonsskriv benyttes, blant annet for at informasjonen som gis til deltakerne er forenlig med ny personopplysningslov. Malen er tilgjengelig på våre nettsider (Frister og skjemaer -> Maler for informasjon og samtykke).

Forskningsansvarlig institusjon
Nidaros DPS må registreres som forskningsansvarlig institusjon. Komiteen ber om å få oversendt navn og stilling til den som skal stå som kontaktperson (det skal som regel være øverste leder ved institusjonen). Vi ber også prosjektleder om å sende oss navn og stilling for forskningsansvarlig kontaktperson for den andre poliklinikken som etterhvert skal innlemmes i prosjektet.

Vilkår for godkjenning

1. Dispensasjonen fra taushetsplikt gjelder kun for de opplysningene som er relevante for studien.
2. Registerkoblingene i prosjektet kan ikke deles med andre forskergrupper for andre forskningsformål enn det som er beskrevet i dette vedtaksbrevet eller i søknaden.
3. Revidert informasjonsskriv for delstudie 4 og informasjon om forskningsansvarlig institusjon skal sendes komiteen til vurdering. Vennligst benytt e-postadressen post@helseforskning.etikkom.no og "REK midt2018/49" i emnefeltet. Prosjektet kan ikke igangsettes før REK midt bekrefter at informasjonsskrivet er endret i henhold til komiteens merknader.
4. Komiteen forutsetter at behandlingen av personopplysninger i forskningen skjer i samsvar med institusjonens retningslinjer for å gi behandlingsgrunnlag i tråd med personopplysningslovens bestemmelser.
5. Komiteen forutsetter også at prosjektet følger institusjonens bestemmelser for ivaretakelse av informasjonssikkerhet for innsamling, oppbevaring, deling og utlevering av personopplysninger.
6. Komiteen forutsetter at ingen personidentifiserbare opplysninger kan framkomme ved publisering eller annen offentliggjøring.

7. Av dokumentasjonshensyn skal opplysningene oppbevares i 5 år etter prosjektslutt. Opplysningene skal oppbevares avidentifisert, dvs. atskilt i en nøkkel- og en datafil. Opplysningene skal deretter slettes eller anonymiseres.
8. Prosjektleder skal sende sluttmelding på eget skjema, jf. helseforskningsloven § 12, senest et halvt år etter prosjektslutt.
9. Dersom det skal gjøres endringer i prosjektet i forhold til de opplysninger som er gitt i søknaden,må prosjektleder sende endringsmelding til REK, jf. helseforskningsloven § 11.

Vedtak
Regional komite for medisinsk og helsefaglig forskningsetikk Midt-Norge har gjort en helhetlig forskningsetisk vurdering av alle prosjektets sider. Med hjemmel i helseforskningsloven § 10 godkjennes prosjektet på de vilkår som er gitt.

Komiteens beslutning var enstemmig.

Klageadgang
Du kan klage på komiteens vedtak, jf. forvaltningsloven § 28 flg. Klagen sendes til REK midt. Klagefristen er tre uker fra du mottar dette brevet. Dersom vedtaket opprettholdes av REK midt, sendes klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag for endelig vurdering.

Med vennlig hilsen
Vibeke Videm
Professor dr.med. / Overlege
Leder, REK Midt

Ramunas Kazakauskas
rådgiver

Kopi til:*postmottak@ntnu.no*

Appendix 7: Assessment of the Regional Committee for Medical and Health Research Ethics (REK) in Central Norway (2021)

(e-mail)

Marit By Rise

16227 "Brief therapy" i et distriktspsykiatrisk senter – erfaringer og innflytelse på bruk av helsetjenester

Forskningsansvarlig: Norges teknisk-naturvitenskapelige universitet

Søker: Marit By Rise

REKs svar på generell henvendelse

Hei

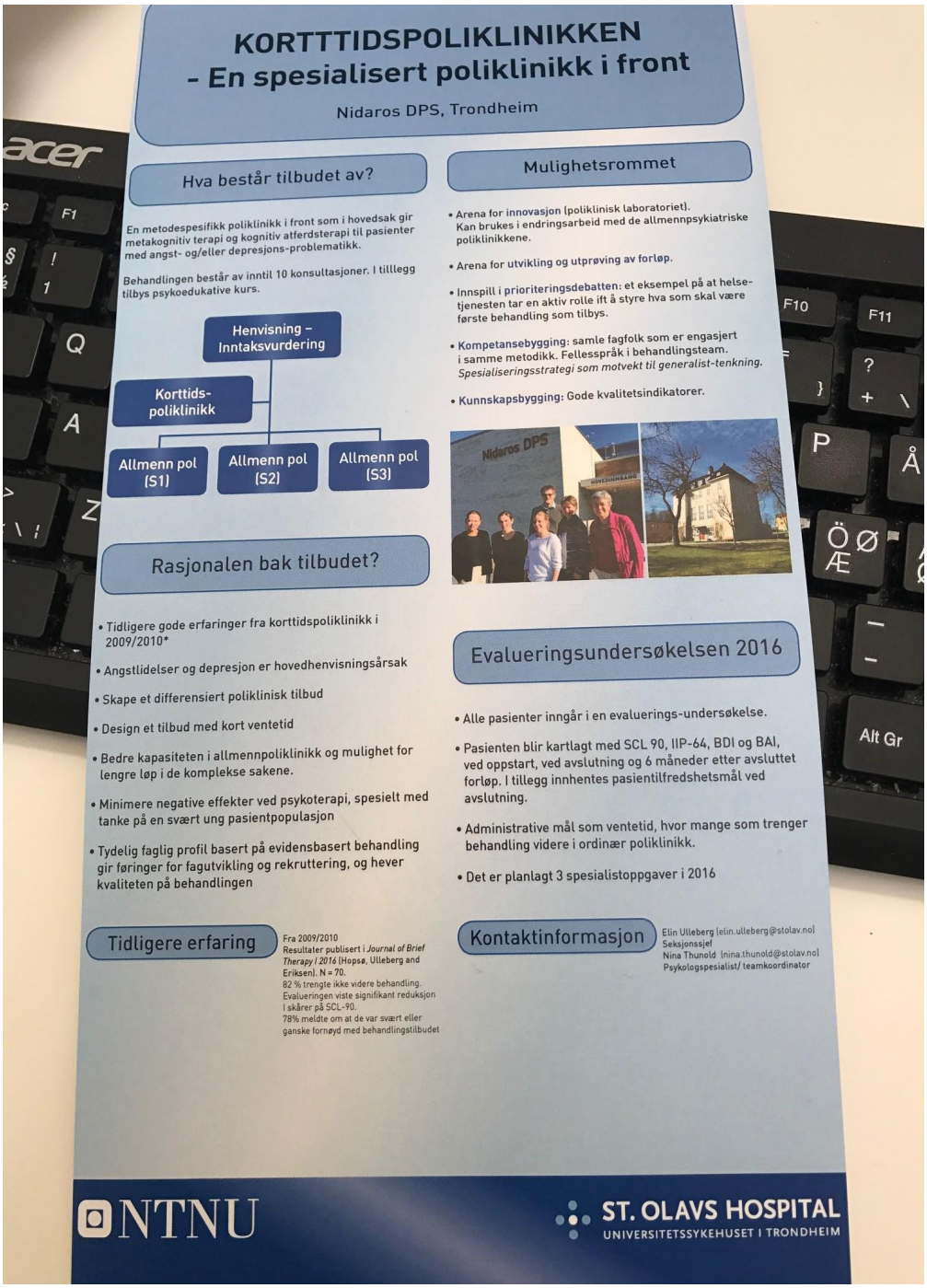
Du sendte oss den 29.12.2020 et nytt informasjonsskriv som skal brukes i forbindelse med rekruttering i studien ""Brief therapy" i et distriktspsykiatrisk senter – erfaringer og innflytelse på bruk av helsetjenester".

Vi har vurdert informasjonsskrivet og godkjenner det. Vi har registrert St. Olavs Hospital, Nidaros DPS som forskningsansvarlig institusjon. Vi ønsker lykke til med prosjektgjennomføringen.

Vennlig hilsen
Regionale komiteer for medisinsk og helsefaglig forskningsetikk

Denne e-posten er sendt automatisk fra REK og kan ikke besvares

Appendix 8: DPC's official information brochure on the brief therapy service (flyer, 2018)



KORTTTIDSPOLIKLINIKKEN
- En spesialisert poliklinikk i front

Nidaros DPS, Trondheim

Hva består tilbudet av?

En metodespesifikk poliklinikk i front som i hovedsak gir metakognitiv terapi og kognitiv atferdsterapi til pasienter med angst- og/eller depresjons-problematikk.

Behandlingen består av inntil 10 konsultasjoner. I tilllegg tilbys psykoedukative kurs.

Henvisning – Inntaksvurdering

Korttids-poliklinikk

Allmenn pol (S1)

Allmenn pol (S2)

Allmenn pol (S3)

Mulighetsrommet

- Arena for innovasjon (poliklinisk laboratoriet). Kan brukes i endringsarbeid med de allmennpsykiatriske poliklinikkene.
- Arena for utvikling og utprøving av forløp.
- Innspill i prioriteringsdebatten: et eksempel på at helse-tjenesten tar en aktiv rolle ift å styre hva som skal være første behandling som tilbys.
- Kompetansebygging: samle fagfolk som er engasjert i samme metodikk. Fellesspråk i behandlingsteam. *Spesialiseringsstrategi som motvekt til generalist-tenkning.*
- Kunnskapsbygging: Gode kvalitetsindikatorer.

Rasjonalen bak tilbudet?

- Tidligere gode erfaringer fra korttidspoliklinikk i 2009/2010*
- Angstlidelser og depresjon er hovedhenvisningsårsak
- Skape et differensiert poliklinisk tilbud
- Design et tilbud med kort ventetid
- Bedre kapasiteten i allmennpoliklinikk og mulighet for lengre løp i de komplekse sakene.
- Minimere negative effekter ved psykoterapi, spesielt med tanke på en svært ung pasientpopulasjon
- Tydelig faglig profil basert på evidensbasert behandling gir føringer for fagutvikling og rekruttering, og hever kvaliteten på behandlingen

Evalueringsundersøkelsen 2016

- Alle pasienter inngår i en evaluerings-undersøkelse.
- Pasienten blir kartlagt med SCL 90, IIP-64, BDI og BAI, ved oppstart, ved avslutning og 6 måneder etter avsluttet forløp. I tillegg innhentes pasientilfredshetsmål ved avslutning.
- Administrative mål som ventetid, hvor mange som trenger behandling videre i ordinær poliklinikk.
- Det er planlagt 3 spesialistoppgaver i 2016

Tidligere erfaring

Fra 2009/2010
Resultater publisert i *Journal of Brief Therapy* i 2016 (Hopse, Ulleberg and Eriksen). N = 70.
82 % trengte ikke videre behandling.
Evalueringen viste signifikant reduksjon i skårer på SCL-90.
78% meldte om at de var svært eller ganske fornøyd med behandlingstilbudet

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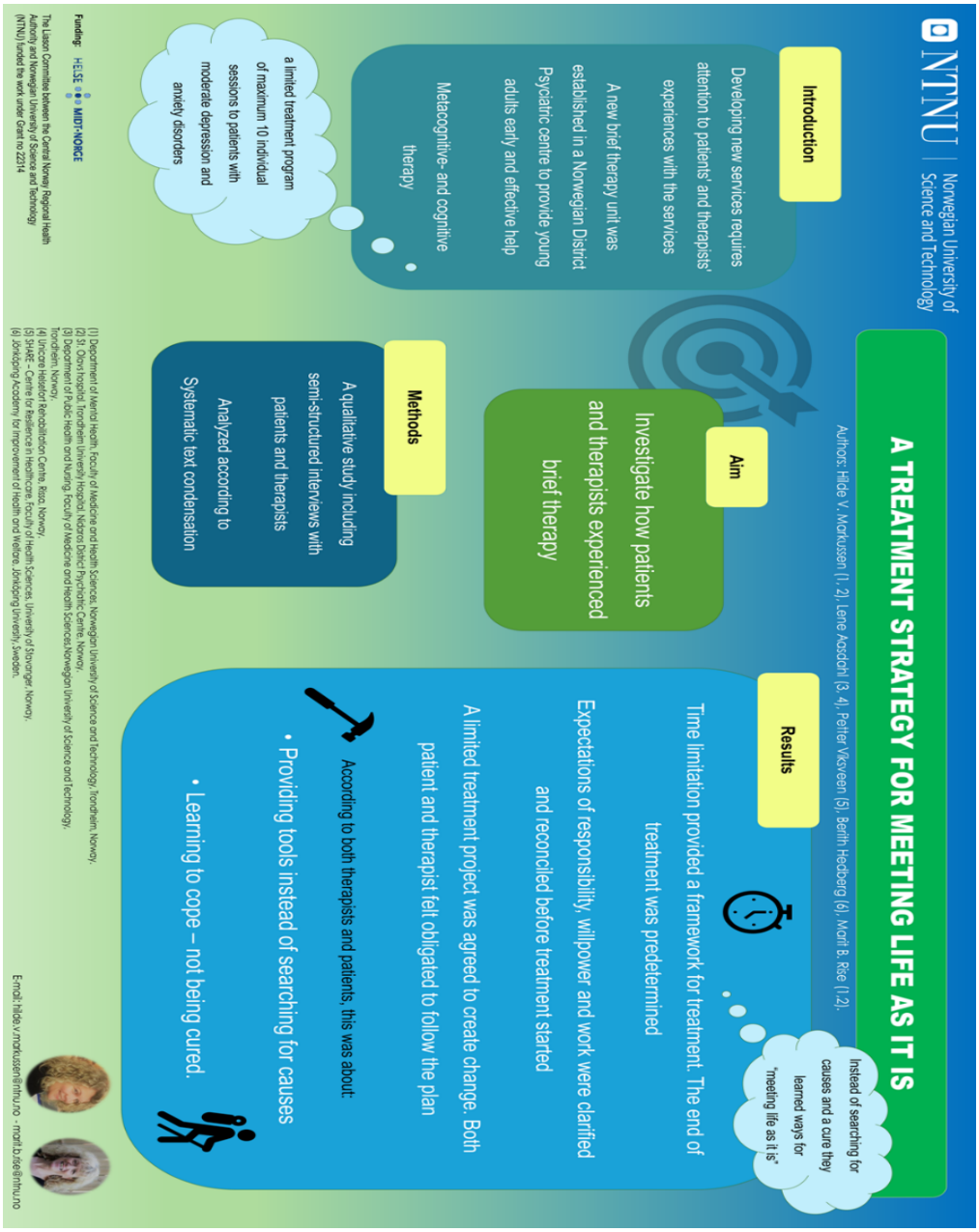
ST. OLAVS HOSPITAL
UNIVERSITETSSYKEHUSET I TRONDHEIM

Appendix 9: Poster presentation, preliminary findings 2020, study II

Poster presentation; A TREATMENT STRATEGY FOR MEETING LIFE AS IT IS, the results from study II, presented as preliminary findings to colleagues at "ECMH-European Conference on Mental Health 2020" Online conference, Finland, October 2020.



Appendix 10: Guide for interviews with professionals, study I

(*translated from Norwegian*)

Professionals' perceptions of the establishment of a specialized brief therapy unit in a district psychiatric centre - a qualitative study.

1. In your view, has the establishment of the brief therapy unit affected the DPC as an organization?
   - What are the potential benefits?
   - What are the potential challenges?
2. In your view, has the establishment of the brief therapy unit affected the outpatient services at the DPC?
   - What are the potential benefits?
   - What are the potential challenges?
3. Has the establishment of the new unit and service affected the work in the DPC?
4. One of the arguments for time-limited therapy is that it provides patients with earlier and more effective treatment.
   - What is your experience with / view on this?
5. The offer of "brief therapy" is limited to up to 10 treatment hours.
   - What is your experience with / view on this?
   - In your experience, is it an advantage? If so, in what way?
   - Is it a challenge? If so, in what way?
6. If the DPC should have done this again:
   - Should they have done anything differently? If so, what and how?
7. Is there anything that you think is important we have not talked about?

Appendix 11: Guide for interviews with patients and therapists, study II, *retrieved from Markussen et al. (2021, p. 5).*

(*translated from Norwegian*)

Interview guide for patients	**Interview guide for therapists**
What did you know about brief therapy before receiving the offer?	What are your experiences with providing brief therapy for this patient group?
What were your expectations of the treatment in the clinic?	What are the advantages and challenges of limiting brief therapy to 10 sessions?
What do you think about the communication with the therapist(s)?	What does this limitation mean for whether patients to take responsibility in their treatment?
To what extent has there been room for adapting the treatment over time?	What does this limitation mean for how and to what extent are patients actively involved in their treatment?
How did you experience your role in the treatment process?	To what extent can patients be involved in decision-making processes or influence the treatment they receive?
In what ways did you experience you were given responsibility in your treatment?	How does brief therapy compare to regular psychotherapy regarding patients' role, responsibility, and possibilities to influence the treatment?
If so, what was the benefit of the treatment?	Based on your experience, what benefits do patients have from brief therapy?
What were the most important experiences with this time-limited treatment offer?	

Appendix 12: Guide for interviews with patients and GPs, study III.

(*translated from Norwegian*)

Interview guide patients "brief therapy" Nidaros DPC - study III	**Interview guide GPs "brief therapy" Nidaros DPC – study III**
1. At the very beginning, I would like to hear about how things have been going with you since we last spoke? Can you tell your story from the period from the end of treatment until today? 2. Has anything changed for you due to the brief therapy treatment? • If so – how would you rate/describe this? 3. How would you describe the outcome after brief therapy at DPC? • Was it as you expected during or just after the end of treatment? 4. Now that some time has passed, what do you think about the BT treatment offer you received at Nidaros DPC? • What do you mean was important (e.g., motivating or challenging)? 5. How many treatment hours at the short-term outpatient clinic did you receive in total? • Do you have any thoughts about this? • Were you offered other treatment at DPC immediately after the BT treatment? 6. Did to seek any form of help for ailments in the period after the end of the short-term treatment? • Possibly what kind of problems? • What kind of healthcare services?	We would like to hear about your experiences of referring patients to "brief therapy," what benefits you feel the patients may have, and how this offer is included in the healthcare services for this patient group. 1. How have you found the "brief therapy" referral process to work? • How many patients have you referred who received this offer at DPC? • Do you have any thoughts about the actual referral process before patients are offered brief therapy? 2. How would you describe the patients' outcome after the short-term treatment at DPC? • Do you have any thoughts about the reason for this? 3. How important do you think brief therapy has been for the patients and their situation after treatment ended? 4. If there is a good result for the patient: how do you assess the duration of the treatment result? • Do you experience that the patients have had more/less need for healthcare services after the end of treatment at DPC? 3. How would you rate/describe this offer as part of the healthcare services to the target group for the offer? (including young adults with anxiety and depression disorders)? • Has the short-term provision contributed to strengthening/weakening the

7. How would you describe your state of health today? • Do you feel you can take care of your health? • Can you tell if the BT treatment has affected your experience of this? 8. How do you see the future? • Do you think differently about the future than in the past? • do you have different expectations of yourself than before? Is there anything else you would like to add or want to tell?	treatment provision for younger patients with anxiety and depression? 4. What are your most essential experiences after referring patients to this short-term treatment? 5. How do you consider this brief therapy as a current treatment offer for other patient groups? 6. Do you have any thoughts about a specific number of treatment hours set in advance? Is there anything else you would like to add? Is there anything you would like to add?

Appendix 13: Advanced literature searches

Our search documentation related to the discussion of results regarding brief therapy is as follows:

- "brief psychotherapy"[Title/Abstract] OR "brief therapy"[Title/Abstract] in PubMed
- "short term psychotherapy"[Title/Abstract] OR "brief psychotherapy"[Title/Abstract] OR "brief therapy" in PubMed
- ((psyc* OR cognitive)) AND (((outpatient) AND short-term) AND therapy) in PubMed

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