Getting better my way: A self-management support tool for people living with mood and anxiety disorders

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JH wrote the main parts of this article, in collaboration with PL and SR. PL and SC conducted the statistical analysis in addition to co-creating the measurement instruments. AB played offered several workshops to assist health care providers in using the tool as part of the study. CG played a central role in supporting the implementation of the tool. BL, MM, MDP, CH, PR, GC and MTL contributed to the design of the study, interpretation of results, and manuscript preparation.

Conflict of interest
JH, SR, SC, AB, GC, BL have contributed to designing the *Getting better my way* support self-management tool mentioned in the manuscript.

The research team also receive honoraria for presentations or discussions regarding the tool and its implementation in various settings. The hard copies of the tool are sold for their production cost. All honoraria are reinvested in the further development of the tool, on a not for profit basis.

A Creative Commons license was obtained for the *Getting better my way* tool, which allows for free noncommercial use of the tool, as long as there is correct attribution and no modifications made without prior consent from the research team.

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Getting better my way: Feasibility study of a self-management support tool for people with mood or anxiety disorders

Abstract

Objective. Self-management support is recognized as an important component of the management of mood and anxiety disorders. The goal of this feasibility study was to evaluate the acceptability, implementation and perceived usefulness of a new comprehensive self-management tool ("*Getting better my way*") in four care settings in Quebec, Canada. **Methods**. Care providers offered the tool to people with difficulties related to mood or anxiety disorders during a seven-month period. A sample of 71 participants filled out an online survey and 27 accepted to participate in a follow-up interview. Focus groups were conducted with 82 care providers. **Results**. Satisfaction ratings were high for the tool overall, the likelihood of recommending it to friends, its attractiveness and interest, and its completion time. Perceived usefulness was high overall and was not related to most demographic and clinical variables. No adverse effects were reported. **Conclusion and Implications for Practice**. The study highlights that *Getting better my way* is a comprehensive recovery-oriented tool, considered useful, acceptable and feasible to use in a variety of settings offering services for mood and anxiety disorders.

Keywords: self-management, depressive disorder, anxiety disorder, bipolar disorder, mental health care

Impact

This article adds to the current literature by describing the implementation and evaluation of *Getting better my way,* which represents one of the first transdiagnostic SMS tools based on experiential knowledge and empirical findings. As suggested by clinical guidelines, the results have shown that this tool has the potential to enhance the engagement of people in their care and recovery as well as facilitate the communication between service users and care providers. This study represents the first step towards a broader implementation of this self-management support tool in settings providing care for people with mood and anxiety disorders.

Introduction

Mood and anxiety disorders are highly prevalent in the population and are leading causes of disease burden worldwide (Baxter et al., 2014; Ferrari et al., 2013). These disorders are mainly managed in primary care and to a lesser extent in more specialized care settings (Sundquist, et al., 2017; Wittchen, et al., 2002). However, there remain many challenges in the prevention and management of mood and anxiety disorders and care for these disorders is not always of high quality or centered on service users' needs (Duhoux, Fournier, & Menear, 2011; Stein et al., 2011; Lecrubier, 2007). New prevention and management models, such as the Chronic Care Model, have been increasingly applied in the mental health field (Coleman, Mattke, Perrault, & Wagner, 2009). Self-management support (SMS) is an important component of the Chronic Care Model (Wagner, 1998) that has only recently received attention in the area of mental health. SMS is not a treatment in itself, but an adjunct to treatment that aims to give people *more power over the illness, as well as an active role in maintaining good mental health and preventing new episodes*. (Houle, Gascon Depatie, Bélanger Dumontier & Cardinal, 2013, p.272). There is growing evidence of the added value of SMS in mental health (Houle, Gascon Depatie, Bélanger Dumontier & Cardinal, 2013, p.272; Gliddon, Barnes, Murray & Michalak, 2017; Janney, Bauer & Kilbourne, 2014; Panagioti et al., 2014) and clinical guidelines now recommend SMS (Lam et al., 2016; National Institute for Health and Care, 2011).

Individuals with mental disorders are willing and able to actively participate in their recovery, and self-management strategies play a key role in that journey (Villaggi et al., 2015; Deegan, 2005; Murray et al., 2011; Sterling et al., 2010). Recovery is conceptualized here as having five distinct but related dimensions: (a) clinical—reduction and control of symptoms; (b)

existential—sense of hope, empowerment, and personal growth; (c) functional—contributing through meaningful roles; (d) physical—focusing on physical health; and (e) social—positive relationships and sense of community (Whitley & Drake, 2010). There are currently few SMS tools for mood and anxiety disorders that reflect all of these dimensions and that have been developed in partnership with service users. Tools such as the Depression Self-Care Toolkit (McCusker et al., 2016), e-couch (Crips and Griffiths, 2016) and Moodgym (Twomey et al., 2014) have been developed in recent years but present limitations, including a focus on specific disorders, an emphasis on clinical, and content that reflects mostly scientific and professional knowledge but not the experiential knowledge of people with lived experience (Faulkner, 2017). This is also apparent in self-management support interventions for serious mental disorders, such as schizophrenia. These programs generally focus on limited aspects of self-management, mainly psychoeducation, medical adherence, relapse prevention, and cognitive-behavioral treatments (Mueser et al., 2002). Self-management programs for serious mental disorders are also generally based on scientific knowledge and led by professionals (McGuire et al., 2014; Mueser et al., 2002).

One notable exception is the Wellness Recovery Action Plan (WRAP) program that has been developed based on consumer experience and is co-delivered by peers and professionals (Cook et al., 2012; Fukui et al., 2011). Many studies have shown the program's efficacy in diminishing psychiatric symptoms and increasing hope (Cook et al., 2012; Fukui et al., 2011). However, WRAP is a highly structured and intensive 8-week program, which could be difficult to implement in certain care settings. There is a need for brief, user-friendly tools that can be

more easily implemented in busy and resource-limited clinical settings such as in primary care or outpatient psychiatric settings.

Our research team recently conducted a qualitative study with 50 people in recovery from mood or anxiety disorders to explore the self-management strategies considered to have been useful in their recovery (Villaggi et al., 2015). This study identified 60 distinct strategies that were classified according to the five dimensions of recovery mentioned above. These empirical findings served as the basis to develop a new transdiagnostic self-management support tool called "*Getting better my way"*. The efficacy of transdiagnostic interventions for anxiety and mood disorders have been shown (Newby et al., 2015). However, to our knowledge, *Getting better my way* is one of the first transdiagnostic SMS tool based on experiential knowledge. Due to the tool's novelty, a feasibility study conducted in real-world care settings was needed to ensure its acceptability and to explore its implementation and perceived usefulness.

The main objectives of this feasibility study (Bowen et al., 2009) were to evaluate the acceptability (to what extent the new tool is considered as suitable and satisfying), implementation, and perceived usefulness of the *Getting better my way* SMS tool from the perspective of both service users and care providers. We chose to conduct a feasibility study in real-world settings to answer the question "Can it work?" as a first step towards more controlled efficacy research (Bowen et al., 2009). Secondary objectives were to explore whether the demographic and clinical characteristics of the sample were related to the perceived usefulness of the tool.

Methods

Design

A feasibility study (Bowen, 2009) relying on a sequential explanatory mixed methods design was used (Creswell & Plano Clark, 2017). Service users completed an online questionnaire in the first month after having received the tool and participated in a qualitative phone interview one month later. In the online questionnaire, quantitative data was collected to describe the sociodemographic and clinical characteristics of the sample and assess the acceptability and perceived usefulness of the tool. The online questionnaire also included open-ended questions to collect qualitative data about users' appreciation of the tool and its potential adverse effects. The service users who accepted to participate in the interviews answered questions about how they used the tool, the type of follow-up they received from their care provider, or ideas to improve the tool and its implementation. Care providers participated in focus groups exploring their experience with the tool and its perceived usefulness three months after the beginning of the implementation, and again four months later. The study was approved by the concerned research ethic boards and informed consent was obtained for all participants.

Participants, procedure and measures

Getting better my way was implemented during a seven-month period, from June 1st to December 31st 2016, in four care settings in the province of Quebec, Canada. Table 1 describes the characteristics of the settings and of the 82 care providers who participated in the study. These settings reflect the variety of mental health care settings in which the majority of people with mood or anxiety disorders in Quebec receive their care.

After having attended a two-hour training session on the basic principles of *Getting better my way*, care providers were instructed to give the tool to service users who reported symptoms related to mood or anxiety disorders (not necessarily with a formal diagnosis) if they thought that it could be useful for them. No specific inclusion or exclusion criteria were provided, allowing us to assess how the tool would naturally be distributed. Furthermore, even if they were encouraged to, professionals were not required to provide a follow-up with the person about the tool during subsequent appointments because we wanted to study the integration of the tool in their usual practice. However, in one site, managers of the mental health team decided to offer the tool to every service user with mood or anxiety disorders during a group session and strongly encouraged their social workers to use the tool during follow-up appointments.

The care providers were invited by email and telephone to attend the focus groups in their specific care settings. During the focus groups, care providers were asked if the tool was suitable for services users, if there were people to which they were less inclined to give the tool and why, if they observed positive and adverse effects among users of the tool. We also asked them how they used the tool in their regular practice.

All service users who received the tool were asked by the care providers if they accepted to be contacted by the research team to participate in the study. People who agreed provided their email address and received an email explaining the study and inviting them to complete an online questionnaire. The Patient Health Questionnaire-9 (PHQ-9; Kroenke et al., 2001; Kroenke et al., 2002) assesses depressive symptoms, the Generalized Anxiety Disorder-7 (GAD-7; Spitzer et al., 2006) assesses anxiety symptoms, and the Patient Activation Measure Mental Health

(PAM-MH) (PAM-MH; Hibbard et al., 2004; Green et al., 2010) measures activation. These three measures are brief, valid and were chosen to describe the clinical characteristics of the sample and examine their association with the tool's perceived usefulness. The PAM-MH was translated to French by using a back-translation method (Beaton et al., 2000; Guillemin et al., 1993). Questions about which professional had given them the tool, if follow-up was provided, their appreciation of the tool and its perceived usefulness were also included in the questionnaire. One month after having completed the questionnaire, participants were contact by email and by phone to invite them to participate in the phone interview. Four follow-up attempts were made to increase the participation rate. A research assistant conducted the interviews by phone, asking with questions like "Globally, how did you find the support offered by the care provider with regards to the tool?" or "In the questionnaire, you answered that you used the tool [answer on frequency]. Why?".

The SMS tool *Getting better my way*

The tool was developed using a mutual knowledge sharing process (Strom and Fagermoen, 2014). A group composed of three researchers (including two with lived experience of mood or anxiety disorders), six practitioners and three people in recovery from a mental health disorder (total n = 12) met on a regular basis over the course of a year to share their respective knowledge and used shared decision making to co-construct the tool. The tool is a booklet 16 pages in length, available in French and in English. A dynamic PDF version is also available in which users can complete the tool directly on their computer.

Getting better my way "*was designed to be used by any person living with challenges related to anxiety, depression or bipolar disorder*" (Houle et al., 2016, p. 1). A four-stage pathway is proposed, inspired by the solution focused brief therapy (DeShazer et al., 2007). In the first stage, the person is invited to note what he/she is already doing to promote their recovery. By acknowledging that he/she is already on the path to recovery, the person increases his/her sense of competency and motivation.

The second stage consists of noting activities that the person used to engage in to get better, but stopped doing. During this stage, the tool invites the person to consider their use of 53 strategies identified in our previous qualitative research (Villaggi et al., 2015). For each strategy, the person chooses one of four options: a) I am already doing this; b) I did this before, but not anymore; c) I would like to explore this further; d) This does not interest me for now (see figure 1 for an example).

The strategies are presented in five sections according to the dimensional model of recovery (Whitley & Drake, 2010):

1) *I deal with my difficulties* (clinical): 13 strategies such as "I learn to recognize the signs of a relapse";
2) *I function well on a day-to-day basis* (functional): 9 strategies such as "I make my schedule keeping in mind what I am capable of";
3) *I take care of my physical condition* (physical): 8 strategies including "I play sports or engage in physical activity";

4) *I maintain positive relationships with others* (social): 7 strategies including "I take care of one or more people (e.g. my spouse/partner, children or friends)";
5) *I develop my potential* (existential): 16 strategies including "I learn to live with my strengths and limitations".

In the third stage, the tool provides the person with a table in which he/she can select a self-management strategy to try over the next few days and weeks. The person is then invited to describe how the strategy will be implemented and to identify resources that would be helpful.

Finally, in the fourth stage, the person is invited to write down the strategies to be reviewed, to reflect on what worked, what did not, and to decide to continue or abandon the strategy. A list of resources is provided and a personalized action plan can be created based on the strategies chosen by the person (see figure 2).

There are no instructions on how often to use the tool in order to get the most benefit from it or how long the person has to complete each stage. We believe that, as experts of their own recovery, people will use the tool at their own rhythm and in their own personalized way. During the two-hour training session, the care providers were presented the five guiding principles for counseling people on how to use the tool: 1) Begin with what already works; 2) Guide, don't direct; 3) Cultivate hope and empowerment; 4) Adopt a realistic and gradual approach; 5) Be aware of the dynamic nature of recovery.

Analyses

Descriptive statistics were performed with the quantitative data collected through the online questionnaire. Associations between demographic and clinical characteristics and perceived usefulness were explored with Pearson's chi-squared. Interview with service users as well as care providers group discussions were transcribed and coded using thematic analysis (Braun and Clarke, 2006). A general inductive approach was used to condense the raw data, identify pattern of response and establish links between the data and the research objectives (Thomas, 2006). Data collected through the questionnaires was used to enrich the qualitative data collection. For example, care providers in the group discussions were presented with the preliminary themes and were invited to comment and refine them.

Results

Sociodemographic and clinical characteristics of the sample

During the seven months of implementation, 377 service users provided their contact information but 31 of them were unreachable. Among the 346 reachable service users, 71 (21% participation rate) completed the online questionnaire 3.1 weeks on average (SD= 1.2; min = 1; max = 5) after receiving the tool. The demographic and clinical characteristics of these participants are detailed in Table 2. The phone interviews were conducted with 27 service users who had responded to the questionnaire (38% participation rate), 2.5 months on average (Mean = 79 days; SD = 26) after receiving the tool. No statistical differences were found in terms of demographics, activation and anxiety symptoms between respondents who participated in the interview compared to those who did not. However a Fisher's exact test showed that interview participants were less likely than other participants to have moderate or severe depressive

symptoms, p = 0.05. Participants who participated in the interviews were also more likely to have received support from their provider when they received the tool, p = 0.01.

Implementation of *Getting better my way*

The tool was mostly distributed by psychiatrists (40%), workers (25%) and family physicians (20%). Psychologists, nurses and educators were marginally represented (see Table 3). *Getting better my way* was mainly given with some explanations, but only half of the respondents reported that their care provider took the time to look at its different sections with them. For the majority of people (76%), the tool was discussed only once with the care provider. However, only 12% of the respondents found that the support offered by care providers was insufficient. A majority (58%) of respondents reported having used the tool once or twice since they received it, while 19% used it two to three times a week.

Acceptability and satisfaction

The perceived quality of the tool was evaluated as good or excellent by 86% of the respondents and 88% would recommend the tool to a friend. More than 80% of the respondents strongly agreed or agreed that the tool's visual presentation is attractive and interesting, and that its layout is user-friendly. Nearly two thirds (63%) of the sample reported that the tool takes a reasonable amount of time to complete.

Group discussions with care providers revealed a high acceptability and satisfaction with the tool in primary care settings. Family physicians, psychiatrists, nurses and psychologists reported that the tool was "easy to understand and to present", "integrates well into usual

practice", and is "complete". However, care providers (mostly social workers) from the mental health team were strongly encouraged by their managers to use the tool in the phone follow-up of all the service users. It seems that in that setting, the "one size fits all" approach was negatively perceived and contributed to less perceived acceptability and satisfaction with the tool.

A majority of care providers believed that the tool should not be used with all service users because they perceived that some were less likely to benefit from it, such as people with severe symptoms, attention deficits, and low literacy or activation levels. Care providers insisted on the fact that the tool should not be intended to replace a therapeutic relationship or treatment. Finally, no adverse effects were reported.

Perceived usefulness

Almost 80% (79.7%) of the service users who answered the question on perceived usefulness (10% missing data) reported that the tool was helpful for them. There is no significant statistical relationship between any demographic and clinical characteristics and the perceived usefulness of the tool (see Table 4). Furthermore, people who received a follow-up with the tool were not proportionally more inclined to consider that the tool was helpful for them compared to service users who didn't. However, there was a trend (Fisher's exact test, $p=0.06$) suggesting that a larger proportion of participants perceived the tool was helpful within the group of service users who received it from a physician, compared to the group who received it from a social worker (89% compared to 65%). An independent t-test was conducted to examine if people who perceived the tool to be more useful were more activated compared to others, and the results were not significant, $t(62)=.41$, $p=.69$.

Qualitative data concerning the usefulness of the tool collected through phone interviews highlights five main themes with regards to perceived usefulness. These results have been presented and refined during the last series of discussion groups with care providers, who observed similar themes.

1. Realization of the active role one plays in the recovery process.

Many service users and care providers reported that the tool highlighted the active role that a person plays in his/her own recovery. In line with patient-centered principles, *Getting better my way* seems to enhance people's sense of control over their recovery.

> "I feel people are less waiting on me [to do things]. We talk once on the phone, and the time after it's not like we had pressed on stop and then on play again only when I call back. Something is happening. I really feel that people are proactive, that there is a continuity between the sessions." - Care provider in mental health care setting
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> "It seems like before, I was not well equipped to know what are the good questions to ask myself or the good things to do… With this [the tool], it gives me avenues, this is what I have to think about to get better." – Service user, female, 51

2. Increased self-awareness.

Service users and care providers also perceived that the tool helped them reflect and better evaluate their current situation. For certain people, it also became an aid to communicate more effectively with their care providers.

"The tool helped me gain awareness of my situation and gave me the vocabulary to express my feelings and explain my situation. To gain awareness of my person, to redefine my priorities and to take action." - Service user, male, 29

"It's well explained and makes me think of things that I would not have thought about. It allowed me to take stock of my situation and to find ways of facing my difficulties." – Service user, female, 43

"I have noticed that they discovered by themselves what they were already doing because of the list. They checked some items. They already had tricks to manage the anxiety… It was helpful." – Care provider in a mental health care setting

3. Hope through encouragement and reassurance.

Since *Getting better my way* is focused on people's strengths, it contributed to create hope for service users, which is a central part of recovery. It also enabled them to review their recovery journey and take pride in what they had accomplished.

"It benefited me a great deal, because I found that it touched sensitive issues that concern me. I found that it was very positive. It encouraged me a lot. It very much helped to get started." – Service user, male, 62

"The strategies to get better are simple. It is sure that a person can reach at least one objective, which leads to a sense of value and hope." – Service user, female, 30

"I have one of my clients who realized that he was putting a lot forward. It's visual… It created a super positive observation for him, he told himself 'I have been working on myself for a long time, it's fun that it shows!'" – Care provider in a mental health setting

4. Taking action through self-management strategies.

Many service users and care providers said that the tool created momentum to initiate certain strategies that they had chosen through the tool.

> "It put me in action. For example, I already enrolled in a yoga class, but I had not necessarily thought about doing that [before using the tool]." – Service user, female, 22
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> "It also gave me the courage to do something. It's to not be shy to talk about it with people around me. To certain people that I have appreciated for a long time." – Service user, male, 63
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> "I have a client who decided to restart doing bracelets. When she does that, she does not think about her problems, she is in the present moment, it defuses certain moments of anxiety." – Care provider in a mental health setting

5. Undesirable effects

The few service users who didn't find the tool helpful mentioned two main reasons: 1) they had concentration difficulties; 2) they would have preferred a closer relationship with a care provider. However, when specifically asked about adverse effects, service users and care providers reported none.

"I tried with the care provider, one step at a time… but it is my comprehension and my concentration, the fact of trying to understand what was written was too hard for me." – Service user, female, 52

Discussion

This study describes the results of a feasibility study for implementing an original transdiagnostic SMS tool that has been developed through a knowledge sharing process between people in recovery from a mood or anxiety disorder, care providers and researchers. This tool is based on a dimensional model of recovery and on empirical findings. It highlights experiential knowledge of people with lived experience of mental health disorders and suggests a variety of self-management strategies that a person can explore in order to play an active role in his/her personal recovery.

With regards to feasibility of the implementation in a "real world" context, this tends to show that professionals working in the varying mental health care settings were willing and able to include the tool in their practice. It also underlines that the tool can be implemented with limited resources. Further investigation should delve in the barriers and facilitators of implementing the tool in certain contexts, for example why were psychologists less likely to give the tool?

The tool has been designed to be used in an autonomous and independent manner without the help of a care provider. Indeed, this study shows that only a quarter of the respondent received the help of their care provider, except for the first encounter where it was generally only briefly described. Despite that, only 11% thought that the support was insufficient. Moreover, people who received further support were not less likely to say that the tool was helpful for them than the people who did not. The results illustrate that care providers can briefly introduce the tool and emphasize the idea that service users are already doing self-management. This short

briefing can feed hope and increase motivation. However, for some participants with more complex needs, more support to use the tool may be necessary. Providers should adjust the level of support provided to the needs and preference of each person, as outlined in recovery-oriented practices (Mental Health Commission of Canada, 2015).

A puzzling finding of our study is that there is a relatively larger group of respondents who found the tool helpful when they received it from a physician rather than from a social worker (89% compared to 65%). Analyses showed no differences in service users' profiles between the two health professionals in terms of activation or symptomatology. Many possible contextual explanations can be discussed. The introduction of the tool was made at the same time as a major organizational change in most social workers' mental health team: the implementation of a brief resource coordination intervention over the phone instead of the previous face-to-face unlimited intervention model. Many social workers reacted negatively to such top-down organizational changes. In that context, many service users received the tool without any pre-existing therapeutic alliance by providers who were in disagreement with the obligation to use it with everyone. In any case, it is important to mention that 65% of service users who received the tool from social workers reported that the tool was useful for them even if the context was not optimal. Other explanations could include different dynamics with regards to therapeutic alliance and power status of the health professional, or more complex recovery needs of service users when involved in a social work intervention. These interpretations should be further investigated.

A large majority of providers mentioned that it is preferable not to give the tool to people with severe symptomatology, which is partly supported by the fact that the primary reason for

not having found the tool useful is concentration problems. Few survey respondents had severe depressive symptoms, and interview participants were even less likely to have severe depressive symptoms, thus preventing us from thoroughly examining the perceived usefulness of the tool among this subgroup. However, two thirds of respondents with severe anxiety symptoms reported that the tool was useful for them. Based on the overall findings, the tool could be proposed to people with mild to moderate depression symptoms, as well as to people struggling with mild to severe anxiety symptoms. For people with severe depression, a closer monitoring by professionals is recommended. Although it may not seem appropriate to give the tool to people with severe symptomatology, it is important not to underestimate each individual's capacities. A strength-based approach could be useful to personalize care for each person.

Overall this feasibility study provided promising findings concerning the acceptability, implementation and perceived usefulness of the *Getting better my way* tool. In feasibility terms, it has shown that it can be done in a "real world" context (Bowen et al., 2009). This study should also be considered within a broader implementation strategy for a more widespread adoption of the tool. Indeed, Powell and his colleagues (2011) compiled strategies for increasing the adoption of new mental health interventions such as staging implementation scale up by starting with smaller pilot projects, building buy-in by including various stakeholders through discussions about the intervention, or developing partnerships with community or academic stakeholders. These strategies were all addressed in the current study and will be further developed with actions such as creating an online community of practice.

Several limitations should be considered. First, this study took place in four real-world care settings with local variations in their practices. We did not control the way care providers presented the tool to service users and to whom they proposed it or not. Moreover, in one setting, the managers decided to implement the tool at the same time as an important organizational change. This created frustration among providers and brought confusion in our data. However, this unexpected situation allowed us to gain knowledge about the importance of giving decisional latitude to providers and avoiding top-down "one size fits all" approaches.

Our 21% participation rate is small. This is not uncommon in primary care research which is a setting where recruitment and sample representativeness may be particularly difficult (Lord, Willis, Carder, West, & Foy, 2016). Our low participation rate can also be explained by the fact that research participation was optional, that the tool was offered even if the service users did not wish to take part in the study, and that there was no financial compensation or incentive for participation. It is probable that people who accepted to participate in the study were more positive about the tool than the people who did not. Desirability bias could also have influenced the results. This could have inflated our satisfaction rate and perceived usefulness of the tool. We also acknowledge that our sample's characteristics limit the generalizability of our findings. Nevertheless, this first study suggests that this low-cost SMS tool seems to have the potential to be beneficial to many people, and no adverse effect have been identified. The next step would be to examine the efficacy and effectiveness though a randomized controlled trial.

Conclusion and Implications for Practice

It is often a challenge to introduce new tools in clinical settings, with an appropriate balance of simplicity and usefulness. *Getting better my way* has shown promise for being such a complementary and feasible intervention. However, further evaluation is needed through randomized controlled trials to show its efficacy and effectiveness as an adjunct to usual treatments. People with a history of mood or anxiety disorders often feel powerless and think that the key to recovery is external to them and can be found through the expertise of care providers (Johanson & Bejerholm, 2017). The results from this first study provide preliminary evidence that the tool has the potential to facilitate the engagement of service users in their care and recovery. Indeed, qualitative data suggests that the tool may be useful to strengthen a sense of shared responsibility between service users and care providers. Overall, the results of this feasibility study indicate that *Getting better my way* is a potentially useful and acceptable tool to implement in mental health and primary care settings, both from service users' and health care providers' perspectives.

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