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Experiential knowledge in mental health services

-experiences of individuals with mental health problems and service providers in primary and specialist healthcare

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Emmy Nilsson

LUND UNIVERSITY

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Doctoral dissertation for the degree of Doctor of Philosophy (PhD) at the Faculty of Medicine, Department of Health Sciences at Lund University to be publicly defended on 27th of March, at 13.00 in Belfragesalen, BMC D15, Klinikgatan 32, Lund

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Abstract:

Background: The prevalence of mental health problems is increasing, placing growing pressure on mental health services to provide care that is meaningful, accessible, and supportive for those who require it. However, current practices often do not fully meet individuals' needs for person-centred, recovery-oriented, and integrated care and support. As these care and support models are being introduced, it is essential to first explore the experiential knowledge of current practices, those who use services and those who provide them. Such experiential knowledge is vital for informing future initiatives and ensuring that service development is grounded in scientific evidence, relevance, and experience-based knowledge.

Aims: To explore the experiential knowledge of individuals who require care and support for their mental health problems, as well as of the mental health service providers who deliver such care and support within Swedish primary and specialist mental health services.

Methods: A thematic synthesis was conducted to address the overall aim and was based on the results of four qualitative methodologies, each applied to meet the specific aim of its respective study. Study I employed descriptive phenomenology and Study II a constructivist grounded theory these were situated within the context of primary services. Study III applied a reflexive thematic analysis and Study IV employed a content analysis, both conducted within the context of specialist services.

Results. The thematic synthesis emerged in one overarching theme: *'The need to strengthen the culture and structures of services to address human vulnerability'* grounded in three themes, *Vulnerability as not being seen or having influence, Current organisational structures can constrain the conditions for delivering meaningful care and support and Strengthening a culture of safety and belonging through practical collaboration.* The results for each study-specific aim are presented in the respective study.

Conclusion The experiential knowledge of primary and specialist services reveals and highlights that an understanding of human vulnerability, as experienced by both individuals in need of care and support for their mental health problems, and by the mental health service providers themselves, is central to the provision of meaningful mental health care and support. Thus, strengthening the structures and culture of services requires not only organisational reform, but also relational and moral awareness among all actors involved.

Key words: Experiential knowledge, Person-centred, Recovery, Integrated services, Caring, Mental health services, Capability approach

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‘Just because you don’t know where you’re going,
doesn’t mean that you’re lost’
Connor Chalfant

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Abstract

Background The prevalence of mental health problems is increasing, placing growing pressure on mental health services to provide care that is meaningful, accessible, and supportive for those who require it. However, current practices often do not fully meet individuals' needs for person-centred, recovery-oriented, and integrated care and support. As these care and support models are being introduced, it is essential to first explore the experiential knowledge of current practices, those who use services and those who provide them. Such experiential knowledge is vital for informing future initiatives and ensuring that service development is grounded in scientific evidence, relevance, and experience-based knowledge.

Aims To explore the experiential knowledge of individuals who require care and support for their mental health problems, as well as of the mental health service providers who deliver such care and support within Swedish primary and specialist mental health services.

Methods A thematic synthesis was conducted to address the overall aim and was based on the results of four qualitative methodologies, each applied to meet the specific aim of its respective study. Study I employed descriptive phenomenology and Study II a constructivist grounded theory these were situated within the context of primary services. Study III applied a reflexive thematic analysis and Study IV employed a content analysis, both conducted within the context of specialist services.

Results The thematic synthesis emerged in one overarching theme: *'The need to strengthen the culture and structures of services to address human vulnerability'*, which is grounded in three themes, *Vulnerability as not being seen or having influence, Current organisational structures can constrain the conditions for delivering meaningful care and support and Strengthening a culture of safety and belonging through practical collaboration.* The results for each study-specific aim are presented in the respective study.

Conclusion The experiential knowledge of primary and specialist services reveals and highlights that an understanding of human vulnerability, as experienced by both individuals in need of care and support for their mental health problems, and by the mental health service providers themselves, is central to the provision of meaningful mental health care and support. Thus, strengthening the culture and structures of services requires not only organisational reform, but also relational and moral awareness among all actors involved.

Abstrakt

Bakgrund Förekomsten av psykisk ohälsa ökar, vilket innebär ett växande tryck på vården att erbjuda insatser för psykisk hälsa som är meningsfulla, tillgängliga och stödjande för dem som behöver dem. Trots detta svarar nuvarande arbetssätt ofta inte mot individers behov av personcentrerad, återhämtningsinriktad och integrerad vård och stöd. I takt med att dessa vård- och stödmodeller införs är det därför viktigt att först utforska nuvarande vård och stöd, den erfarenhetsbaserade kunskapen, hos både dem som är i behov av vård och stöd och dem som tillhandahåller dem. En sådan erfarenhetsbaserad kunskap är avgörande för att vägleda framtida initiativ och säkerställa att verksamhetsutveckling grundas i vetenskaplig evidens, relevans och erfarenhetsbaserad kunskap.

Syfte Att undersöka den erfarenhetsbaserade kunskapen hos personer som behöver vård och stöd för sin psykiska ohälsa, samt hos de vårdgivare inom primärvård och specialistpsykiatri som erbjuder detta stöd inom svensk psykiatrisk vård.

Metod En tematisk syntes genomfördes för att besvara det övergripande syftet och baserades på resultaten från fyra kvalitativa metodologier, där varje metod användes för att uppfylla det specifika syftet i respektive studie. Studie I använde beskrivande fenomenologi och Studie II en konstruktivistisk grundad teori, båda inom ramen för primärvårdens tjänster. Studie III tillämpade en reflexiv tematisk analys och Studie IV en innehållsanalys inom kontexten av specialistpsykiatrin.

Resultat Den tematiska syntesen resulterade i ett övergripande tema: ”*Behovet av att stärka vårdens kultur och strukturer för att bättre bemöta mänsklig sårbarhet*”, vilket grundas i tre teman: *Sårbarhet att inte bli sedd eller ha inflytande, Nuvarande organisatoriska strukturer kan begränsa förutsättningarna för att leverera meningsfull vård och stöd, Att stärka en kultur av trygghet och tillhörighet genom praktiskt samarbete.* Resultaten för varje delstudie, presenteras i respektive studie.

Slutsats Den erfarenhetsbaserade kunskapen inom primär- och specialistpsykiatrin understryker betydelsen av att förstå mänsklig sårbarhet, så som den erfars både av personer i behov av vård och av de vårdgivare som erbjuder den. Detta är centralt för att kunna tillhandahålla meningsfull psykiatrisk vård och stöd. Att stärka verksamheternas strukturer och kultur kräver därför inte bara organisatoriska förändringar, utan även relationell och moralisk medvetenhet hos alla involverade.

Populärvetenskaplig sammanfattning

Bakgrund

När någon drabbas av psykisk ohälsa påverkas hela vardagen, både för personen själv och för den närmaste familjen. Vård och stöd kan vara avgörande för att återhämta sig och återgå till ett fungerande liv. Primärvården är den första instans en person vänder sig till när hen upplever milda tecken och symtom på psykisk ohälsa. För personer med tecken och symtom på allvarligare psykisk ohälsa utgör öppenvården inom specialistpsykiatrin (om en etablerad kontakt finns) eller en psykiatrisk akutmottagning oftast den första instansen i vården. I Sverige organiseras primärvården på regional nivå, medan specialistpsykiatrin drivs på både regional och kommunal nivå. Dessutom organiseras både primärvården och delar av specialistpsykiatriska av såväl offentliga som privata aktörer. Detta innebär att personer med behov av vård och stöd för sin psykiska ohälsa ofta möter flera olika professioner, vårdgivare och organisationer.

Sedan psykiatrireformen har alltmer vård och stöd organiserats inom primärvården och den specialistpsykiatriska öppenvården för att öka tillgängligheten, möjliggöra tidiga insatser och stärka integreringen av personer med psykisk ohälsa i samhället. I reformen *God och nära vård* betonar att vården ska se hela människan och utgå från individens förmågor, det vill säga vara personcentrerad. Personcentrering har visat sig ge ett bättre omhändertagande av patienter med humörsvängningar samt förbättrad följsamhet till förskriven medicinering för personer med komplex psykisk ohälsa. Att arbeta personcentrerat har även visat sig minska vårdpersonalens upplevelse av arbetsbelastning och samvetsstress.

Trots detta möter nuvarande arbetssätt ofta inte individers behov av personcentrerad, återhämtningsinriktad och integrerad vård och stöd. När sådana modeller införs blir det därför viktigt att först förstå hur dagens vård och stöd fungerar i praktiken, utifrån erfarenheterna hos både dem som använder och dem som ger insatserna. Dagens primär- och specialistpsykiatri är i hög grad fokuserad på diagnoser, medicinsk behandling och symtomlindring, och tillgängligheten upplevs som en utmaning av både vårdgivare och personer i behov av vård och stöd. Därför är det viktigt att utforska den erfarenhetsbaserade kunskapen, för att förstå vilka behov och förutsättningar framtida vård- och stödmodeller behöver möta.

Personer som söker vård och stöd för sin psykiska hälsa, möter ofta en distriktssköterska och/eller sjuksköterska i den initiala kontakten, som därmed har en central roll i mötet med personer som upplever psykisk ohälsa. Inom primärvården möter distriktssköterskan dessutom människor genom hela livet, ”från vaggan till graven”, och kan arbeta olika miljöer, såsom inom barnhälsovård, elevhälsans medicinska insats i skola, vårdcentral samt den kommunala vården och omsorgen.

Forskning visar dock att distriktssköterskor ofta upplever bristande kunskap och osäkerhet i mötet med personer som söker vård och stöd för sin psykiska hälsa. Därför är det viktigt att förstå personers levda erfarenheter av att möta primärvården för sin psykiska hälsa, eftersom en sådan förståelse kan vara värdefull för att utveckla mer individanpassad vård och stöd vid psykisk ohälsa inom primärvården. För att stärka omhändertagandet av personer som söker primärvård för psykisk ohälsa är det också betydelsefullt att förstå distriktssköterskans process och erfarenheter i dessa möten, så att distriktssköterskans kompetens kan används inom hälsofrämjande och förebyggande omvårdnad på individ-, grupp- och organisationsnivå.

Parallellt med utveckling av att bättre omhändertagande inom primärvården, så står specialistpsykiatrin inför stora utmaningar. Specialistpsykiatrin har länge haft begränsade ekonomiska resurser, samtidigt som delar av deras verksamhet har förflyttats till primärvård och specialistpsykiatriska öppenvården, vilket har påverkar möjligheten att ge vård och stöd som är individuellt formade utifrån personens behov.

I specialistpsykiatrin är ett återhämtningsinriktat arbetssätt centralt och vägleder hur vård och stöd struktureras. Begreppet återhämtning består av två delar, där den kliniska återhämtningen syftar till mätvärden och objektiva tecken och symptom är centrala, medan den personliga delen av återhämtning beskriver en persons väg för att återfå ett sammanhang, hopp om framtiden, en identitet, mening och egenmakt i sitt liv. Införandet av den personliga återhämtningsinriktade arbetssättet är inte enkelt, vårdpersonalens traditionella synsätt, attityder och bristande kunskap om personer med psykisk ohälsa utgör hinder för dess framfart. För att möta specialistpsykiatrins rådande utmaningar har den integrerade vård och stödmodellen Flexible Assertive Community Treatment (FACT) börjat införas.

FACT är en återhämtningsinriktad anpassad vård och stöd modell som kombinerar flera evidensbaserade arbetssätt, exempelvis Individuellt Stöd i Arbete (Individual Placement Support, IPS) samt införandet av stöd från personer med egen erfarenhet (Peer support). Forskning visar att personer med komplex psykisk ohälsa som får vård och stöd inom ramen för FACT ofta återfår funktion och livskvalitet i högre grad än de som får traditionell vård. Dessutom möjliggör modellen ett strukturerat men samtidigt flexibelt arbetssätt får vårdpersonalen, vilket underlättar att möta personen vid ”rätt tidpunkt”. Eftersom modellen är integrerad behöver FACT anpassas efter lokala förutsättningar inför dess implementering. Därför är det viktigt att involvera både de personer som kommer att få vård och stöd och de personer som kommer att arbeta inom vård och stödmodellen FACT. Genom deras kunskap kan implementeringen anpassas utifrån lokala förutsättningar samtidigt som den bidrar till en ökad förståelse av hur nuvarande vård och stöd upplevs och vilka behov framtida vård- och stödmodeller kan behöva tillgodose.

Sammantaget är den erfarenhetsbaserade kunskapen från både personer i behov av vård och stöd och från personal inom psykiatrin, central för att utveckla en mer personcentrerad och återhämtningsinriktad, integrerad vård och stöd. Därför syftar denna avhandling till att utforska erfarenheter hos personer med psykisk ohälsa och hos personal inom primärvården och specialistpsykiatrin för att förstå hur vården fungerar idag och vilket stöd som behövs framåt, exempelvis hur en återhämtningsinriktad, integrerad vård- och stödmodell såsom FACT skulle kunna bidra.

Metod

Genom en summerande tematisk analys av resultaten från de fyra delstudierna besvarar avhandlingen det övergripande syftet. Resultatet av den tematisk analysen, består av avhandlingens fyra delarbeten. Varje delstudie svarade mot ett specifikt syfte och hade sin egen metodologi. Genom att använda fyra olika kvalitativa ansatser, deskriptiv fenomenologi, konstruktivistisk grundad teori, reflexiv tematisk analys och innehållsanalys, kan fenomenet förstås från flera perspektiv. Kvalitativa studier är särskilt lämpliga när en fördjupad förståelse av ett fenomen, eftersträvas.

Resultat

Den summerande tematiska analysen resulterade i ett övergripande tema *” Behovet av att stärka vårdens kultur och strukturer för att bättre bemöta mänsklig sårbarhet*” vilka grundades i tre underteman:

- *”Sårbarhet att inte bli sedd eller ha inflytande”*
- *”Nuvarande organisatoriska strukturer kan begränsa förutsättningarna för att leverera meningsfull vård och stöd”*
- *”Att stärka en kultur av trygghet och tillhörighet genom praktiskt samarbete.”*

Varje tema är avgörande; utan alla tre saknas de nödvändiga förutsättningarna för att skapa möjlighet till mellanmänskliga relationer.

Respektive delstudie I - IV

Den första delstudien beskriver en persons levda erfarenhet av att möta primärvården för sin psykiska hälsa, vilken resulterade i en stark önskan om att bli bemötta med värme och omsorg. Deras levda erfarenhet var att de ofta kom ifrån en plats av ensamhet och sårbarhet. När de väl var i kontakt med primärvården var deras erfarenhet att vårdpersonal hanterade deras psykiska hälsa som ett problem. Detta förstärkte deras erfarenhet av att tappa kontrollen över vardagen. Samtidigt som det fanns primärvårdsenheter som arbetade strukturerat och där det fanns utrymmer för ett omhänderta dem. När personer mötte en sådan vård beskrev de att de kände trygghet och fick hopp om återhämtning.

Den andra delstudien resulterade i distriktsköterskan som en relationsbyggare för att initiera dialogen om psykisk hälsa, och distriktssköterskans process vilket var komplex konstruktion och var beroende på distriktssköterskans kunskap, attityd och syn på psykisk hälsa samt organisationens kapacitet för psykisk hälsa. Ju mer arbetserfarenhet distriktssköterskan hade, desto lättare var det för distriktssköterskan att diskutera psykisk hälsa, särskilt om hon eller han har personligt engagemang och intresse för frågan.

Den tredje delstudien belyste personers med komplex problematik erfarenheter av dagens psykiatriska vård och stöd, dessutom deras tankar kring framtida vård och stöd. Detta resulterade i; deltagarnas erfarenhet av att förlora värde och trovärdighet som person när de blev en brukare av stödinsatser, vilket speglade deras erfarenheter av att reduceras till tecken och symtom av sin psykiska ohälsa. Dessutom var nuvarande vård och stöd en labyrint som var svår för dem att navigera i. De önskade större deltagande i framtida vård och stöd utformning och genomförande, och att involvera dem skulle vara stärkande.

I den fjärde delstudien beskriver personalen den överväldigande utmaningen att möta brukarnas behov i en fragmenterad vård- och stödstruktur. De uttrycker ett starkt behov av en sammanhållen och helhetsorienterad, kontextuell och samverkande vård. Deras vision är att implementeringen av FACT ska skapa förutsättningar för en hållbar, transparent och förebyggande specialist psykiatri.

Slutsatser

Den erfarenhetsbaserade kunskapen från både primärvård och specialistpsykiatrin visar och tydliggör att en förståelse av mänsklig sårbarhet, så som den erfars både av personer i behov av vård och stöd för sin psykiska ohälsa, och av vård- och stödpersonal själva. Vid implementering av integrerade vård- och stödmodeller finns det ett behov att ge utrymme för att kunna möta mänsklig sårbarhet, vilket är centralt för att kunna erbjuda meningsfull vård och stöd för psykisk hälsa inom både primärvård och specialistpsykiatri.

Denna avhandling bidrar till ökad förståelse för hur det är att vara person i behov av vård och stöd inom primärvård och/eller specialistpsykiatri, liksom att arbeta som vård- och stödpersonal i dessa verksamheter. Dagens utmaningar visar på ett behov av att stärka båda nivåerna i omställningen mot evidensbaserad praxis genom personcentrerade och återhämtningsinriktade, integrerade vård- och stödmodeller. Avhandlingen vilar på en etisk grund av omsorg och medmänsklighet, vilket utgör en moralisk bas för att främja rättvisa och jämlikhet för personer med psykisk ohälsa. Resultaten är avsedda att användas av kliniker, vårdgivare och beslutsfattare vid policyutveckling och omstrukturering av vården, och uppmuntrar till samarbete över organisatoriska och beslutsmässiga gränser för att stärka gemensam förståelse och skapa förutsättningar för förändring. Det kvarstår samtidigt ett betydande behov av att fördjupa och utveckla den erfarenhetsbaserade kunskapen om vård och stöd vid psykisk ohälsa för att motverka sociala orättvisor och främja social rättvisa.

List of papers

Paper I Nilsson, E., Behm, L., Johanson, S., & Bejerholm, U. (2025). A desire to be embraced - the lived experience of encountering primary health care for a person with mental health problems. A descriptive phenomenological study. *Scandinavian Journal of Primary Health Care*, 1–15. https://doi.org/10.1080/02813432.2025.2587543

Paper II Nilsson, E., Johanson, S., Behm, L., & Bejerholm, U. (2023). Public health nurses experience of mental health encounters in the context of primary health care: a *constructivist* grounded theory study. *BMC Nursing, 22*, 181 (2023). https://doi.org/10.1186/s12912-023-01340-7

Paper III Nilsson, E., Tjörnstrand, C., Lindqvist, D., Wetterling, J., Lexén, A., & Bejerholm, U. (2026). Turning to Service Users for the Understanding of Current and Future Mental Health Services in the Development Process of Research and Practice: A Qualitative Study. *Health expectations : an international journal of public participation in health care and health policy*, *29*(1), e70574. https://doi.org/10.1111/hex.70574

Paper IV Nilsson, E., Behm, L., Lindqvist, D., Johanson Stureson, S., Lexén, A., & Bejerholm, U. Mental health service providers' experiential knowledge of current care and Flexible Assertive Community Treatment – A qualitative study. Submitted

Glossary

This glossary presents key terms and definitions as they are used in this thesis. Its purpose is to provide clarity and to support a shared understanding of the terminology employed throughout.

Clinical recovery	Clinical recovery is viewed as a preliminary focus on symptom reduction and functional improvement (World Health Organisation (WHO), 2025).
Experiential knowledge	Experiential knowledge refers to the distinctive understanding and insight gained through lived experience, that is, experience-based knowledge (Castro et al., 2019).
Holistic	Holistic is described as a whole-person approach to health (Frisch & Rabinowitsch, 2019).
Individual	An individual, is by their unique capabilities, distinguished from others (Ricouer, 1992).
Integrated mental health services	Integrated mental health services are constituted by delivering care and support (across jurisdictions), from a holistic approach (WHO, 2016).
Mental health literacy	Mental health literacy is viewed as a persons' knowledge, views, attitude and beliefs about mental health (Jorm et al., 1997).
Mental health problems	Mental health problems are individuals' own perceptions or experiences of ill health.
Mental health service provider	Mental health service provider refers to professionals such as registered nurses, public health nurses, physicians, psychologists, occupational therapists and social workers, as well as other professionals and managers working within mental health services.
Mental health worker	Mental health workers refer to professionals with unregulated training and thus varied competence, whose roles differ considerably between services (Blay & Roche, 2020; Roche et al., 2021).
Patient	Patient is a person who suffers from ill health, often physically located within the walls of a healthcare environment (Hedman, 2020).

Person	A person is capable, Homo Capax, answers to who is. This forms the philosophical foundation of person-centredness (Kristensson Uggla, 2022; Ricouer, 1992).
Personal recovery	Personal recovery refers to an individual process of building and contributing life i.e. meaningful life, even with limitations caused by ill health (WHO, 2025). Grounded in a person's Connectedness, Hope and optimism for the future, Identity, Meaning in life and Empowerment (Leamy et al., 2011).
Person-centred care	Person-centred care, involves initiating a partnership through the patient's or service user's narrative, safeguarding this partnership through shared decision-making, and documenting it in a standardised (person) or individualised (individual) care plan (Ekman, 2022; Ekman et al., 2011).
Professionals	Professionals are individuals contributing within their professional role.
Service user	Service user is a person with mental health problems who requires both care and support across services and the broader welfare system (National Board of Health and Welfare (NBHW), 2024a).

Abbreviations

ACT	Assertive Community Treatment
CCM	Collaboration Care Model
CHIME	Connectedness, Hope and optimism for the future, Identity, Meaning in life, and Empowerment
FACT	Flexible Assertive Community Treatment
ICM	Intensive Case Management
IPS	Individual Placement Support
MHL	Mental Health Literacy
MHS	Mental Health Services
MHP	Mental Health Problems
NBHW	National Board of Health and Welfare
NSPH	(Swedish Partnership for Mental Health), Nationell Samverkan för Psykisk Hälsa
PHAS	Public Health Agency of Sweden
PHC	Primary Health Care
PHN	Public Health Nurse
RN	Registered Nurse
SALAR	Swedish Agency of Local Authorities and Regions
SAHCA	Swedish Agency for Health and Care Analysis
SOU	(Swedish Government of Official Reports), Statens Offentliga Utredningar
YLD	Years Lived with Disability
WHO	World Health Organisation

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Preface

Today's primary and specialist mental health services provide a person-centred and recovery-oriented, integrated care and support. However, professionals often struggle to fully comprehend the underlying principles of person-centredness and to genuinely deliver a recovery-oriented care. These challenges may hinder individuals with mental health problems from achieving optimal health outcomes. This reflects my own experience during my first years as a newly graduated Public health nurse. I recognised an urgent need to deepen my understanding of how the current mental health services were experienced, both from the perspective of professionals and most, importantly, of individuals experiencing signs and symptoms of mental health problems, in need of care and support and their views on how primary health care could be improved were of particular interest.

The starting point of this thesis was thus an involvement with Public health nurses and patients within Primary health care (PHC) which constitutes the first line of mental health services in Sweden. This involvement resulted in my licentiate thesis *"Experiences of mental health encounters among Public Health Nurses and patients: In the context of Primary Health Care"* (Nilsson, 2023) based on *In Dialogue for Mental Health project (I dialog för psykisk hälsa).* As part of my continuing towards a doctoral dissertation, I had the privilege of participating in the co-production and feasibility stage of the *Ups and Downs in Mental Health - Flexible Assertive Community Trial trial (ISRCTN11268588)*. In both projects, I worked in an interprofessional research environment united by a shared focus on mental health, activity and participation. In alignment with this, the thesis provides insights into the experiential knowledge in mental health services, drawing on the perspectives of individuals who has experience- based knowledge of primary and/or specialist services for their mental health problems, as well as professionals and other mental health service providers.

Learning from and integrating the experiences of all participants into scientific knowledge has been invaluable for my professional development. It has shaped my clinical orientation as a Public health nurse, currently working in a primary and secondary school setting, and has culminated in this doctoral dissertation. My point of departure has over the course of my academic journey expanded from an initial focus on professional ethics, centred on promoting health, preventing illness, restoring health, and alleviating suffering, whether physical or mental, which lies at the heart of clinical practice, to incorporating the philosophical ethics of Paul

Ricoeur (Ricoeur, 1992) and interpreted by Kristensson Uggla (2011). Ricoeurs' concept *Homo Capax* explores the fundamental question of who a person is. Ultimately, it is the professional who must first reflect upon this question, drawing on their own professional expertise and in partnership, use the person's story as the point of departure. This thesis marks the conclusion of one chapter and the beginning of another, and with it, I carry forward the insights, questions, and commitments that will continue to shape my work as both a Public health nurse and a researcher.

Introduction

Self-reported Mental Health Problems (MHP) have increased over time in Northern Europe (Hagquist et al., 2019; Potrebny et al., 2017; Public Health Agency of Sweden (PHAS), 2024) and most individuals experiencing mental illness in Sweden are treated within primary Mental Health Services (MHS) (Milos-Nymberg et al., 2023; Sundquist et al., 2017). Moral helping behaviours, such as caring, are shaped by prevailing cultural values and perceptions of who bears responsibility for supporting individuals with MHP (Pope et al., 2018). However, caring is understood within the caring sciences not merely as a helping act, but as a relational and ethical practice grounded in empathy, presence, and an understanding of the other's lived experience (Lindwall & Lohne, 2021; Martinsen, 2000). Individuals seeking care often emphasise the importance of building relationships and participating in their care (Nerurkar et al., 2024; Newman et al., 2015; Parker et al., 2020). At the same time, mental health service providers report a lack of knowledge, time, and resources to fully engage in meaningful encounters with these individuals (Adams et al., 2021; Björkman et al., 2018; Janlöv et al., 2018). Today's transformation towards person-centred and recovery-oriented MHS, grounded in what individuals themselves regard as a meaningful life (Håkansson Eklund et al., 2019; Leamy et al., 2011; WHO, 2025), is therefore not being realised. This gap highlights the need for a deeper understanding of the experience-based knowledge of both individuals in need of these services as well as service providers within contemporary MHS.

Despite growing recognition of person-centredness and personal recovery, primary and specialist MHS continue to prioritise medication and medical treatment, largely shaped by tradition and established norms (Bejerholm & Roe, 2018; Nerurkar et al., 2024; Parker et al., 2020; Patel et al., 2018; Saunders et al., 2019). Person-centredness have proven to reduce signs and symptoms of aggregation among individuals and improved concordance with prescribed medications for psychosis (Ballard et al., 2018; Rosettier et al., 2020). At the same time, it reduces the moral distress experienced by mental health service providers and improves their working conditions (Gustavsson et al., 2025).

The delivery of services embedding person-centredness, together with recovery-oriented practices, is regarded as the provision of high quality care (Powell & Rowen, 2022). Care and support are thus delivered within a quantitative framework that draws on population-based research to estimate the risks and benefits of interventions (Greenhalgh & Dijkstra, 2024; van Os et al., 2019). While such

evidence guides service providers in their decision-making and in delivering appropriate care and support to individuals, there remains limited knowledge about how these approaches shape a person's experience of being a "patient" and a "service user" (Greenhalgh & Dijkstra, 2024; Swedish Agency for Health Care and Analysis (SACHA), 2025a). A complementary qualitative perspective is thus needed to enhance high quality service delivery in alignment with the Evidence-Based Practice (EBP) model (National Board of Health and Welfare (NBHW), 2025; Melnyk et al., 2010).

A person in need of services provided in primary and specialist MHS for their MHP is referred to in this thesis as an individual with MHP with a focus on their unique knowledge and attributes. This choice is made because *person* may imply a plural form when referring to many people, which can unintentionally resemble a collectivist perspective, whereas *individual* can be consistently applied to denote multiple individuals without altering its meaning. While, the term patient is acknowledged as a suffering human being i.e., physically located within a healthcare environment traditionally focused on somatic treatment and curative services (Hedman, 2020). A *service user* refers to a person with MHP who requires both care and support across primary and specialist MHS and the broader welfare system (NBHW, 2024a, World Health Organisation (WHO), 2016). While mental health service providers refer to mental health workers (Blay & Roche, 2020; Roche et al., 2021), professionals and managers within these settings. Each person in this thesis, whether referred to as an individual, participant, patient, or service user, mental health worker, professional, mental health provider, is recognised as a person with capabilities, a unique contributor with personal stories of MHS (Kristensson Uggla, 2011; 2022, Ricouer, 1992). Thus, due to described linguistic constraints above, this thesis uses the term *individual* to refer to a person.

A central concept in this thesis is experiential knowledge, which refers to the unique insight that emerges from experience-based, lived experience and complements traditional professional and scientific forms of knowledge (Castro et al., 2019). Experiential knowledge offers valuable insights that can improve service delivery (Castro et al., 2019; Ocloo & Matthews, 2016), inform the development of clinical practice guidelines (Bryant et al., 2022), and bridge the gap between theoretical framework and the realities of clinical practice (Abelsson et al., 2024). In clinical practice, professionals must navigate the balance between human rights and ethical principles in every encounter (Ventura et al., 2021). One way of strengthening encounters and the relationships between individuals in need of care and the professionals involved is through recovery-oriented and integrated models of care and support (Borgh et al., 2024). However, research evidence alone is not sufficient to change in clinical practice; it must be considered in relation to contextual factors and professional judgement (Melnyk et al., 2010).

Therefore, supporting the transition towards person-centred and recovery-oriented care and support requires active involvement with those who have experiential

knowledge of primary and specialist MHS (Ekman, 2022; Skivington et al., 2021). By exploring the experiential knowledge of both those requiring care for their MHP and those providing is essential for understanding current service provision. Such understanding is crucial for shaping future person-centred and recovery-oriented, integrated models of care and support such as the implementation of the Flexible Assertive Community Treatment (FACT) (van Veldhusien & Bahler, 2015), as well as for informing contemporary clinical practice within Swedish MHS.

This thesis contributes to the existing body of knowledge within the experience-based tradition of the health sciences, approached through a caring science perspective. Caring science, understood as a human science (Martinsen, 2000), embodies a deliberate and intentional stance, an attitude, decision, and guiding principle that informs professional behaviours and actions (Damiano, 2024; Martinsen, 2000). The insights presented in this thesis may be of value to a range of mental health stakeholders, including policymakers, politicians, researchers, patient and service user organisations, and healthcare managers, when reflecting on current care provision and envisioning the future of both primary and specialist MHS. Furthermore, this knowledge may also support a person with perceived MHP, patients and service users in making sense of their own experiences of seeking and receiving care and support within these services.

Theoretical framework

This thesis adopts the capability approach proposed by Nussbaum (2013) from a societal perspective, asserting that society holds the responsibility and moral obligation to support and provide individuals with opportunities to live a full life. To further understand this perspective, the ethical foundation of personhood defined by Ricoeur (1992), later discussed and elaborated by Kristensson Uggla (2011; 2022) was chosen. Ricoeur emphasized that a person is capable and strives for "a good life with and for others, in just institutions" (Ricoeur, 1992, p 172). Furthermore, as the context of this thesis concerns the care and support of individuals with experiencing signs and symptoms of MHP, a caring perspective developed by Martinsen (2000) was adopted to establish the ethical and moral stance for mental health service providers, enabling them to support individuals with MHP fulfil this societal promise of a meaningful life. These perspectives taken together provide an alternative framework for conceptualising quality of life, highlighting the opportunities available to individuals at the societal level within the context of care and support based on their unique capabilities (Bloodworth, 2006; Nussbaum, 2013). These perspectives will be presented in this order.

The provision of individually tailored care and support - a matter of social justice

Nussbaum (2013) describes society's responsibility to provide opportunities based on individual capabilities framing capabilities in relation of social justice - *The Capabilities approach* in line with Ricoeur (1992) and interpreted by Kristensson Uggla (2011; 2022). Emphasis is placed on the uniqueness of a person, *individual capabilities* (Kristensson-Uggla, 2011, 2022; Nussbaum, 2013; Ricoeur, 1992), which do not necessarily align with opportunities for each person in a group of people (collectivism) (Nussbaum, 2013). Diverging views regarding who holds responsibility for supporting individuals with MHP may lead to gaps in the provision of appropriate care and support (Pope et al., 2018). Decisions surrounding care provision at the societal level are shaped by current legislation, policies, and prevailing public attitudes toward healthcare. The Capability Approach addresses structural injustice and inequality, particularly where discrimination and marginalisation persist (Nussbaum, 2013). By creating real opportunities for

individuals, this approach offers a framework that can guide health policy and support the embedding of person-centred, recovery-oriented, and integrated services. Therefore, by exploring the experiential knowledge of individuals who require care and support for their MHP, as well as that of the care providers within primary and specialist MHS who deliver such care and support, a deeper understanding of the societal opportunities available to individuals experiencing MHP can be strengthened. It may also contribute to the transition towards person-centred and recovery-oriented care and support, as well as to the future development of integrated MHS, with the intention of enhancing social justice.

The Capability Approach

Life – Having the opportunity to live a full life, not cut short or diminished to the point where it no longer feels worth living.

Bodily Health – Access to good physical health and healthcare.

Bodily Integrity – Freedom of movement, protection from violence, and autonomy over one's own body.

Senses, Imagination and Thought – The ability to use one's senses, to imagine, think, and reason in a way that reflects human dignity, supported by a well-rounded education.

Emotions – The capacity to develop and express emotions, particularly through meaningful relationships and attachments.

Practical Reason – The ability to reflect on one's life, form personal values, and make considered life choices.

Affiliation – The ability to live with others in mutual respect and dignity, free from humiliation and discrimination, supported by social and legal protections.

Other Species – The ability to live in harmony with nature and other living beings.

Play – Having the freedom to enjoy leisure, play, and recreational activities.

Control over One's Environment – The ability to participate in political decisions and to have control over one's material surroundings, including the right to own property.

Nussbaum, 2013

Viewing the role of being a patient or a service user through individual capabilities

The patient is a role accepted and imposed within healthcare, often positioning the individual as a passive recipient of care (Hedman, 2020). Based on the role defined as a patient, the user movement encouraged individuals to move beyond being passive service recipients of opinions and instead become active negotiators of change (Pilgrim & Waldron, 1998). This shift was influenced by developments in service provision, deinstitutionalisation, the legitimacy of biomedical theory and practice, and the rise of consumerism in healthcare. Service user involvement has evolved since this shift started, and five key attributes have been identified: person-centredness, informed decision-making, advocacy, obtaining service user views and feedback, and working in partnership (Millar et al., 2016). One of the most profound challenges of suffering arises when an individual in need of MHS is viewed as not capable. Person-centredness emphasises the ontological distinction between being regarded as a patient or service user and being recognised as a person. It seeks to deepen the understanding of human capabilities by recognising human as a capable being, that is, *Homo Capax*, with an understanding of who by the answer- the self (Ricoeur, 1992).

- ❖ *who speaks*—expressing themselves and making themselves understood by others
- ❖ *who acts*—shaping the world through their actions
- ❖ *who reflects*—considering and evaluating their own actions, morally responsible

Furthermore, Ricoeur's notion of *Homo Capax*, as outlined in the philosophical framework *The Little Ethics* (Kristensson Uggla, 2011; 2022; Ricoeur, 1992), is closely linked to interpersonal relations. A person's narrative is understood in this theory of the Narrative *act* as socially constructed and shaped by the surrounding environment. Ricoeur further emphasises that when a person speaks or acts, it may seem that others understand them, without recognizing that the speaker or agent carries a history and indeed embodies their own history (Ricouer, 1992). He contrasts the unchanging identity (*idem*) with the changing identity (*ipse*), both of which unfold within the constraints of actual circumstances and evolve over time – surrounding community.

This understanding shapes how people are treated in caring settings, how decisions are made, and how empathy is expressed. A strong connection exists between a person's story and their actions. To truly understand experiential knowledge, it is essential to grasp the depth and complexity of their narrative and how it informs

their actions. This deeper understanding emerges through exploring the meaning and interpretation of actions as they unfold in a narrative form. Opening dialogue about their experiences also reveal vulnerabilities, which in turn calls for responsibility (Yeo et al., 2022). For health professionals, a person's story should inform a richer understanding of their reality and support meaningfulness in the delivery of a person-centred care (Håkansson Eklund et al., 2019). Thus, being person-centred is considered an ethical act (Allerby et al., 2022; Ekman, 2022; Ekman et al., 2011; Kristensson Uggla, 2022, Ricoeur, 1992), grounded in Ricoeur's philosophical principles. Recognition and respectful care are not always extended to all patient groups (Ekman, 2022), as described by individuals with MHP (Richards et al., 2019).

Current services are often structured around a collectivist approach, described by Greenhalgh and Dijkstra (2024) as a 'one-size-fits-all' model. This suggests that today's services frequently lack the capacity to deliver care and support tailored to individual capabilities (Sundler et al., 2020; Sundler et al., 2022). On the other hand, Kristensson Uggla (2022), drawing on Ricoeur's philosophical framework *The Little ethics*, highlights personalism as a view of personhood in which one sees oneself in another emphasising shared human similarities. There is thus no inherent contradiction within person-centred care between collectivism, often associated with medicine, biomedical aspects, and disease and personalism, linked to caring and the perceived experience of ill health. Rather, these dimensions are equally important dimensions that enable health-promotive and caring interventions to be realised through the empowerment of human capabilities (Wallström & Ekman, 2018). There is thus an urgent need to explore the experiential knowledge of individuals with MHP within both primary and specialist MHS, to better understand how services might be adapted to meet their needs. Within the context of this thesis, whether one is experiencing signs and symptoms of MHP, or working as a mental health service provider, or conducting research in a service setting, these roles shape human experiences and influence the interpretation of them (Kristensson Uggla, 2011; 2022).

Caring science - to explore human health experiences

Caring is regarded in this thesis as a human science and an interprofessional endeavour (Kirkevold, 1997), in line with Norwegian scholar Kari Martinsen's understanding of caring (Martinsen, 2000). She focuses on the interpersonal relationship between the individual experiencing illness and the mental health service provider, where ethics, morality, and culture converge, and human beings are understood as fundamentally interdependent (Martinsen, 2000). Caring involves making professional assessments based on an understanding of the individual's situation and the roots of their suffering, followed by actions focused on alleviating

it (Kirkevold, 1997; Martinsen, 2000). The moral and relational dimensions of caring can therefore not be separated from its practical application.

Furthermore, Martinsen rejects the notion of a positivistic view of knowledge i.e., primarily based on observable facts and logical reasoning (Martinsen, 2000). She argues instead that phenomena exist because they are experienced, and that, as human beings, we must know or believe in them in order to function within a given society. This perspective aligns with phenomenological epistemology, in which the researcher seeks to set aside their own preconceptions and understandings when exploring a phenomenon (Moon & Blackman, 2014). At the same time, Martinsen acknowledges that patterns of knowledge and meaning are transmitted across generations (Martinsen, 2000), with a historical perspective always present. This reflects a constructivist epistemology, in which experiences are inseparable from their context and are shaped by it (Moon & Blackman, 2014).

Caring emphasises the notion of experiential knowledge, when striving to understand the patient/service user (Kirkevold, 1997). Professionals in healthcare are guided by a moral and ethical stance to engage with the perspective of the suffering individual (Kirkevold, 1997; Martinsen, 2000). This philosophy of caring is situated within the scientific fields of natural science (biomedical aspects) and ethics (Kirkevold, 1997). It also resonates with the ongoing shift from patient-centred to person-centred and recovery-oriented services, which seeks to provide care and support based on what the individual considers a meaningful life (Håkansson Eklund et al., 2019; Leamy et al., 2011, WHO, 2025).

Summary

Those in society who require additional support to cross the threshold of being able to choose and act should be given the help they need to do so (Nussbaum, 2013; Martinsen, 2000). Conversely, those with greater opportunities to act and hold agency often possess greater power within human relationships (Martinsen, 2000). Exploring experiential knowledge within MHS thus involves examining the meaning of caring as it is expressed in human health experiences. This includes addressing philosophical and empirical questions in this thesis such as: *What does it mean to be an individual with MHP within primary MHS? How do such individuals experience current care within specialist MHS, and how do they view recovery-oriented and integrated models of care and support?* In other words, to understand the experiential knowledge of both individuals who requires care and support for their MHP, but also mental health service providers working in those services.

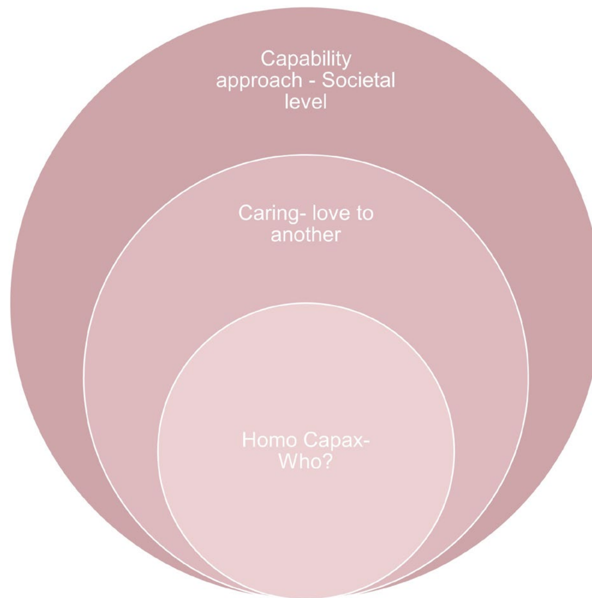

Figure 1. Theoretical foundations in this thesis for health and welfare practice grounded in human capabilities and caring. The theoretical perspectives build on the Capability Approach (Nussbaum, 2013) at a societal level, grounded in the concept of the human as capable, Homo Capax (Ricoeur, 1992; Kristensson Uggla, 2011). These perspectives are further supported by an understanding of Caring as a relational and ethical foundation for all care and support services where the experience-based knowledge of a person is central (Kirkevold, 1997; Martinsen, 2000).

Background

Experiential knowledge: what, why, and who is it for?

The concept of *experiential knowledge* in this thesis (Castro et al., 2019) provides insight into what it is like to encounter primary and specialist MHS, why these encounters unfold as they do, and for whom such knowledge may be of value. Experiential knowledge can be understood as the processed and articulated form of insight that emerges from lived experience, made meaningful within the relational, social, and institutional contexts in which it is developed (Castro et al., 2019; Ekman, 2022; Kristensson- Uggla, 2022; Martinsen, 2000).

Experiential knowledge should be understood as the outcome of, or an encounter between, the individual and the world (Casey, 2023). Casey extends this view by suggesting that the world is multifaceted, meaning that a person's experiences reveal certain aspects of it while leaving others concealed. In this sense, their experiential accounts capture only a partial view of reality (Casey, 2023).

Within healthcare contexts, individuals' experiential knowledge may be placed at the centre of debates on exclusion and inequality. It may also contribute to misunderstandings of person-centredness (Kristensson Uggla, 2022), caring practices (Kirkevold, 1997; Martinsen, 2000), and personal recovery (Leamy et al., 2011; Slade et al., 2012), as well as the EBP-model (Melnyk et al., 2010), all of which emphasise individual experiences, views, preferences and wishes. Such misunderstandings may lead to the perception of the person in need of services as 'almighty' regarding decisions about their planned care and support (Kristensson Uggla, 2022). However, a person's narratives should be viewed through Ricoeur's narrative act, which means that their experience becomes understandable as a narrative and can be regarded as interpreted, meaning-making knowledge about human experience. However, if the essence of subjectivity of experience-based knowledge is not acknowledged within MHS, meaningful forms of human knowledge risk being excluded from the outset (Casey, 2023).

Borkman (1976) distinguishes between two forms of experiential knowledge, in this thesis, that of individuals with MHP and that of mental health service providers. Experiential knowledge of individuals with MHP is rooted in holistic, subjective reflection (wisdom) and immediate specific action and practical knowledge, whereas service providers experiential knowledge is grounded on theory, systematic

frameworks, and the long-term accumulation of academic expertise. Furthermore, in this thesis their stories or narratives are used to generate scientific knowledge in the form of experiential knowledge. This form of scientific knowledge can contribute to the development of a shared language and foster a sense of belonging (Grundman et al., 2021).

EBP integrates the best available evidence from high-quality empirical research with professional expertise, as well as data and preferences and values from the individual with perceived ill health (NBHW, 2025; Melnyk et al., 2014; Saunders et al., 2019). The principles represent essential sources of knowledge for all professionals across disciplines and MHS (Melnyk et al., 2014; Saunders et al., 2019). By valuing all three knowledge elements equally, professionals can develop a more comprehensive understanding (O'Shea et al., 2019). There is currently a lack of EBP initiatives addressing critical healthcare challenges such as mental health (Connor et al., 2023). van Os and colleagues (2019) argue that the EBP-model has contributed to biomedical dominance within MHS, as it emphasises technical skills and specialised knowledge. However, complex MHP emphasises participation and existential domains, there is therefore, a need to align services more closely with individuals' wishes and needs (Dwivedi et al., 2025; Oliver et al., 2026). Generating experiential knowledge of individuals with MHP is, therefore, crucial when informing current services.

Experiential knowledge is conceptualised differently in research depending on the context and culture, e.g., *user involvement, patient engagement, patient participation, and patient and public involvement* (Castro et al., 2019; Halloy et al., 2023; Jørgensen & Rendtorff, 2018; Miah et al., 2019; Westerink et al., 2023). Experiential knowledge is currently recognised as one key foundation of high quality care (Ballard et al., 2018; Bombard et al., 2018; WHO, 2025), contributing to valuable insights into how phenomena are interpretated (Castro et al., 2019). However, there are still barriers that limit its full potential to enrich and empower health policies, processes and practices (NBHW, 2020; Saunders et al., 2019; Westerink et al., 2023).

By recognising and integrating experiential knowledge, services can better understand the experiences of their recipients, thereby improving the design, delivery, and responsiveness of care and support (van Os et al., 2019; WHO, 2025). The present thesis thus aims to contribute scientific insights into experiential knowledge in mental health. By exploring mental health service providers and individuals with MHP, their needs, wishes, and preferences, the intention is that these scientific insights will create the conditions for service providers to deliver EBP within both primary and specialist MHS.

Mental health and mental health problems- evolving concepts

People face challenges that affect their mental health and well-being across countries and societies, and, in some cases, these lead to a diagnosis of mental illness (Olafsdottir, 2019; WHO, 2022), comorbidity (Saha et al., 2021), and suicide (Holmstrand et al., 2015; Saha et al., 2021). According to Manwell et al. (2015), the core concepts of mental health are predominantly centred on the individual, particularly on a person's capacity and ability to make choices when interacting with society. This aligns with the WHO's (2003) definition of mental health. However, the definition of good mental health encompasses different core domains such as Mental Health Literacy (MHL), attitudes towards complex MHP, self-perceptions and values, cognitive abilities, academic and occupational performance, behaviours, self- management strategies, social abilities, family and significant relationships, physical health, sexual health, meaning of life and quality of life (Fusar-Poli et al., 2020). Furthermore, beliefs about mental health are culturally determined and culture-specific, which adds to its complexity and multifaceted nature as a phenomenon (Ahuvia et al., 2024; Manwell et al., 2015). Such recognition acknowledges that individuals may hold multiple beliefs simultaneously and are more likely to prefer and engage with MHS that align with those beliefs (Ahuvia et al., 2024). It may also constitute a contributing factor in shaping perceptions of responsibility for meeting needs and maintaining health, particularly for individuals with MHP (Pope et al., 2018)

The World Health Organisations' definition of mental health.

"Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community"

(WHO, 2003).

The definition of MHP similarly encompasses a broad spectrum, ranging from everyday challenges to complex MHP (WHO, 2022). Individuals with complex MHP are typically characterised by the severity and duration of symptoms of MHP, the level of service involvement, and the presence of at least one primary mental health illness (Harvey et al., 2023). Mental health symptoms, such as anxiety and sleep disturbances, are often perceived as physical complaints, prompting individuals to seek care in "traditional" physical healthcare settings (Spurrier et al.,

2022). Physical health illness such as coronary heart disease and diabetes mellitus are also commonly observed among patients with MHP (Fogarty et al., 2021). Notably, signs and symptoms of physical health problems are more frequently the cause of hospitalisation in individuals with depression than the psychiatric illness itself (Frank et al., 2023). This underscores the importance of structuring care and support around a holistic approach (Frisch & Rabinowitsch, 2019; Ohrnberger et al., 2017), particularly given that comorbidities such as mood and anxiety disorders are among the most prevalent (Fogarty et al., 2021; Saha et al., 2021).

Prevalence and patterns of mental health problems

Globally, 11.5% of individuals aged 5 to 24 have experienced at least one mental illness (Kieling et al., 2024), and by the age of 75, more than half the population will have encountered common mental health illnesses such as anxiety, depression, or substance-related illness (McGrath et al., 2023). Complex MHP rank among the top ten causes of the global burden of disease and account for an estimated 20.3% of Years Lived with Disability (YLD), with one quarter of the cases occurring before the age of 25 (Global Burden of Disease, 2022; Kieling et al., 2024). Reducing the global burden of MHP is thus an increasing public health concern and priority (Kieling et al., 2024; Piao et al., 2022; Rehm & Shield, 2019; Wainberg et al., 2017). Concerns have also been raised about the impact of the Covid-19 pandemic. Public health policies, such as social distancing and school lockdowns were predicted to increase the prevalence of MHP and the risk of complex MHP among young people worldwide, thereby overloading already strained MHS (Clemens et al., 2020; Piao et al., 2022). However, to the best of our knowledge, current studies provide mixed results and should be interpreted with caution (Sun et al., 2023). Self-reported MHP have increased in Sweden, mainly among adolescents and young adults (Hagquist et al., 2019; Potrebny et al., 2017; PHAS, 2024). Experiencing MHP as a young adult is associated with an increased likelihood of long-term consequences, such as weak attachment to the labour market and dependence on disability and activity compensation (NBHW, 2021a).

One billion people worldwide are affected by complex MHP, which account for around 20% of Disability-Adjusted Life Years (DALYs) (Rehm & Shield, 2019). Current prevalence statistics continue to rely on traditional and established diagnostic classifications, such as *the International Classification of Diseases, 11th edition* (ICD-11) (Gaebel et al., 2020), and the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition, Text Revision* (DSM-5-TR) (First et al., 2023). While these frameworks remain central, they are gradually evolving to incorporate the subjective experiences of individuals (First et al., 2023; Gaebel et al., 2020). It is therefore important to enhance experiential knowledge of individuals with MHP within primary MHS while also examining current care and support for individuals

with complex MHP in specialist MHS. Their experiential knowledge is not only important for ensuring the legitimacy and sustainability of future interventions (Aarons et al., 2011; Skivington et al., 2021), but also for enriching the scientific field of experiential knowledge in mental health (WHO, 2025). Given the varying and often overlapping definitions of mental health and MHP, this thesis focuses on the individuals' own perceptions of their experiences with MHP, as well as their perceived need for care and support within both primary and specialist MHS.

The provision of a person-centred care and recovery-oriented services

The WHO (2008) called for a global shift towards person-centred care within healthcare services in the early 2000s. However, psychologist Carl Rogers in the context of mental health, argued already in 1963 that psychology was becoming capable of engaging with a broader reality, one that included the person and perspective of both the observer and the observed, rather than maintaining a solitary focus on behaviour (Rogers, 1963). Most current mental health policies and guidelines advocate for the delivery of person-centred care within primary and specialist MHS (NBHW, 2024b). However, each organisation needs to incorporate person-centredness in their own way, working closely with professionals and patients/service users within their services (Britten et al., 2020).

This shift aligns with a broader societal consensus on the need for a more holistic healthcare in which individuals are encouraged to use their experiences of care, capabilities, and resources to actively participate in the transition towards person-centred care models (Ekman, 2022). Ekman and colleagues introduced person-centred care into Swedish healthcare in 2011 (Ekman et al., 2011), outlining three core routines for its implementation, which have since become foundational for the development of healthcare services. It has later been labelled the Gothenburg model of person-centred care (Britten et al., 2020). The three core routines involve initiating a partnership through the patient's or service user's narrative, safeguarding this partnership through shared decision-making, and documenting it in an individualised care plan (Ekman, 2022; Josephsson et al., 2022). The core principle underlying these routines is *partnership*, which ensures that care and support are perceived as person-centred (Ekman, 2022; Ekman et al., 2011; Staniszewska et al., 2019), in alignment with the attributes of the service user involvement movement (Millar et al., 2016; Pilgrim & Waldron, 1998).

This development is accompanied in Sweden by attempts to incorporate recovery-oriented approaches into mental health policies (Bejerholm et al., 2022; Delaney, 2012). The concept of personal recovery is embedded within these services as a '*a deeply personal, unique process of changing one's attitudes, values, feelings, goals,*

skills, and/or roles, a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness' (Anthony, 1993). Personal recovery is increasingly being distinguished as separate from clinical recovery (Bejerholm & Roe, 2018; Slade et al., 2012; WHO, 2025). While clinical recovery focuses on symptom reduction and functional improvement, personal recovery refers to an individual's journey towards building a meaningful and fulfilling life despite ongoing MHP (McLure et al., 2023). Core concepts in personal recovery are individual participation in everyday life and the strengthening of self-agency (Ridgway, 2001).

The CHIME framework, Connectedness, Hope and optimism for the future, Identity, Meaning in life, and Empowerment, was developed as a synthesis of a substantial body of qualitative research studies exploring what recovery means for individuals living with severe MHP (Leamy et al., 2011). It represents an evidence-based conceptualisation of personal recovery, capturing key internal processes that service users themselves identify as central to their recovery journey (Leamy et al., 2011; Slade et al., 2012). Recovery-oriented services involve creating a safe and respectful environment where individuals with MHP are recognised as more than their diagnoses (Chatwiriyaphong et al., 2024). Professionals can foster hope by identifying individuals' strengths, supporting identity development, and helping them find meaning in life despite their mental health challenges (Hillborg et al., 2020; Leamy et al., 2011; Liljeholm & Bejerholm, 2020; Liljeholm et al., 2020; Liljeholm et al., 2022; Slade et al., 2012) and the first point of contact in primary MHS play a crucial role in supporting individuals' recovery (Bristow et al., 2011). Professional attitudes and norms play a crucial role in the successful implementation of these services (Harkko et al., 2023; Svensson et al., 2017).

Despite these developments, the economic foundation and organizational structures of Swedish healthcare continue to prioritise more traditional forms of patient-centred care (Swedish Agency of Local Authorities and Regions (SALAR), 2023). A Swedish standard for participation in healthcare - minimum requirements for person-centred care, was published in 2020 to provide solutions to recurrent problems (Swedish Standards Institute, 2020). There thus remains a recognised need to allocate adequate resources to promote and protect the individuals' mental health and well-being (Mahomed, 2020). With the aim of understanding how care is currently delivered within MHS in Sweden, it may be assumed that a shift towards person-centred care is underway across healthcare in general, and that recovery-oriented interventions are particularly being developed within MHS. Both concepts stem from a perspective that complements the traditional biomedical aspects, incorporating a qualitative approach in which experiential knowledge is essential and equally valued, which is also emphasised within the EBP model (Melnyk et al., 2010; van Os et al., 2019). However, both approaches require organisational change to provide the prerequisites for delivery in order to be fully implemented (Chatwiriyaphong et al., 2024; Ekman, 2022).

One way of promoting person-centredness within specialist MHS has been through introducing recovery-oriented, evidence-based practices that are incorporated within structures of the integrated, care and support model, FACT. FACT has subsequently been widely implemented both in Sweden and internationally (Svensson et al., 2017; Trane et al., 2017; van Veldhuizen & Bahler, 2015). Examples of evidence-based recovery-oriented practices are among others, the Individual Placement Support (IPS) (Bejerholm et al., 2015) and the Supported Education with IPS (Hillborg et al., 2024). FACT model is now being implemented in Swedish general psychiatry context within specialist MHS in the project *Ups and Downs in Mental Health*. To explore how the FACT model may need to be adapted, it is essential to understand both the experiential knowledge of mental health service providers and the first-hand accounts of individuals receiving care and support, in alignment with the feasibility stages outlined in the Medical Research Council's framework for complex interventions (Skivington et al., 2021). While it is also crucial in relation to current primary and specialist MHS, it is important to explore the care pathways experienced by individuals as they navigate both levels of care for their MHP. This exploration should encompass their stories of current care, and their views and needs regarding the future implementation of person-centredness with recovery-oriented, integrated models of care and support.

Implementing person - centred and recovery-oriented care: Barriers and facilitators

To support the implementation of a person-centred care and recovery-oriented services, it is necessary to address the dominance of the biomedical aspects. Achieving such a transformation, there is a need for outreach facilitation, leadership training, financial investment, and the promotion of interprofessional team activities (Russell et al., 2018). Current literature identifies limited organisational capacity, lack of resources, and health professionals' attitudes as the most common barriers (Chatwiriyaphong et al., 2024; Lorien et al., 2020; Russell et al., 2018). Another well-documented barrier to implementing a person-centred and recovery-oriented framework is the presence of stereotypical attitudes among mental health service providers (Moore et al., 2017; Stumbo et al., 2018). One such attitude is the assertion that "we're already person-centred", which often reflects a traditional patient-centred approach (Ekman, 2022). Another is the defeatist view towards individuals with complex MHP, which can hinder the adoption of person-centred and recovery-oriented approaches (Stumbo et al., 2018).

Mental health service providers often find themselves caught between theoretical ideals and practical realities (Abelsson et al., 2024) constantly navigating human rights and ethical values in each encounter (Ventura et al., 2021). Yet, successful

implementation of person-centred and recovery-oriented delivery of services is not solely dependent on interactions with professionals (Bejerholm et al., 2022; Davidson et al., 2021; Moore et al., 2017).

Previous research has shown that the organisational context of the services can act either as a facilitator or a barrier to establishing and sustaining relationships between the individual with MHP and health professionals (Bejerholm et al., 2022; Bergmark et al., 2018; Le Boutillier et al., 2015; Lorien et al., 2020; Merner et al., 2023; Moore et al., 2017; Slade et al., 2014; Staniszewska et al., 2019). There still remains a need for experiential knowledge to support professionals in their daily practice (Raj, 2022), even though mental health service providers play a crucial role in safeguarding individuals' rights to their perceived health (Santana et al., 2018; Ventura et al., 2021). Their understanding is often shaped by personal experiences with MHP, with those holding positive attitudes, frequently influenced by their own or significant other experiences, and demonstrating lower levels of stigma. Integrated MHS which both adhere to clinical recovery (biomedical aspects) and personal (CHIME) recovery are more likely to succeed than those advocating for radical changes to existing clinical practices (Lorien et al., 2020). A similar result is seen during the implementation stages of adopting person-centred care (Ekman, 2022).

Within a recovery-oriented, integrated service, the focus shifts from symptom reduction to collaborative engagement, addressing mental health needs that may hinder the pursuit of personal goals (Klodnick et al., 2021). By creating caring environments that foster individual empowerment, to be included, involved and in control of their care the support of recovery-oriented services can be embedded (Leamy et al., 2011; Slade et al., 2012). Even with recovery-oriented integrated services in place, barriers to interprofessional collaboration may persist (Beacham et al., 2012; Roy et al., 2020), together with the challenge of embedding person-centredness that fully includes individuals in need of care and support (Jørgensen et al., 2024). Additionally, variations in knowledge and competence across and within services can lead to power imbalances and inconsistent practices, hindering communication and the development of a shared working culture (Jørgensen et al., 2021; Russell et al., 2018). It is therefore vital to incorporate the experiential knowledge of individuals as well as mental health service providers (Jørgensen et al., 2021; Santana et al., 2018; WHO, 2022) of current services, when striving for a person-centred, recovery-oriented integrated service delivery.

Experiential knowledge of accessing mental health services

Seeking care and support from primary or specialist MHS is rarely a decision taken lightly for individuals with experiential knowledge of signs and symptoms of MHP

(Richards et al., 2019; Vandewalle et al., 2020). Individuals receiving care in Swedish primary MHS for their MHP, have described their experiential knowledge as "*hiding behind a mask*", a coping strategy often employed while seeking care for worry, anxiety, or similar symptoms related to long-term suffering (Arvidsdotter et al., 2016). Research on help-seeking for unexplained symptoms highlights the importance of encountering professionals who can help individuals make sense of their experiences (Lidén et al., 2015). It is crucial that professionals recognise how these symptoms limit their daily functioning. However, several barriers related to unmet needs have been reported by individuals in primary MHS, including a lack of trust in professionals (Lovén Wickman & Schmidt, 2023; Phelan et al., 2023), a lack of continuity of care, insufficient treatment, and inadequate follow-up (Sundler et al., 2020). Young adults with MHP often perceive primary MHS as more competent and experts on physical ill health rather than mental health and therefore seek elsewhere for support (Lovén Wickman & Schmidt, 2023). Young adults in the study by Westberg et al. (2020) describe the healthcare system as fragmented and difficult to navigate in, and call for an easy access primary MHS, free of charge.

Another concern is the lack of shared decision making, where service users describe how professionals jumped to conclusions before they had fully expressed their concerns. This left them feeling disempowered in decisions regarding their own care (Dahlqvist Jönsson et al., 2015), which contributed to perceptions that symptoms were being over-medicalised (Phelan et al., 2023).

Much of the Western world continues to face significant challenges related to unmet needs within MHS (Corscadden et al., 2019; Olsson et al., 2021), such as continuity of care and coordination in and between primary and specialist services (Ludvigsson et al., 2025). Improving organizational capacity is sometimes described as the 'invisible hand' in health promotion practices (Nutbeam et al., 2024). The organizational capacity of public health services is highlighted as an important determinant of service performance, i.e., service delivery (Meyer et al., 2012). Thus, empowering individuals with MHP is not currently regarded as a natural part of the care provided by primary MHS for the general population (Haddad et al., 2005; Moreno & Chhatwal, 2020). Even though there is evidence describing current barriers and facilitators of accessing primary and specialist services for individuals with MHP, there is still a need of experiential knowledge of current care and support delivery (WHO, 2025) and their views of further development in alignment with person-centredness and recovery-oriented practices. It is thus particularly urgent within specialist MHS, where there is a growing call to reduce inpatient care for individuals with MHP and promote person-centred, recovery-oriented, outreach, and community-based models (WHO, 2022).

Current mental health service delivery

Healthcare systems in a global perspective are organised and structured in every varied ways to meet the mental health needs of their populations (WHO, 2022). The responsibilities in Sweden are divided between 290 municipalities and 21 regional health authorities, each with independent political governance (Janlöv, et al., 2023; Ludvigsson et al., 2025; SALAR, 2024a). The municipalities organise social services, while the regional health authorities oversee primary and specialist MHS, necessitating strong collaboration to ensure effective care and support (Silfverhielm & Kamis-Gould, 2000). While Swedish specialist MHS are divided between two main systems: specialist psychiatric care, which itself is split into four types of organisations, including general psychiatry (for individuals aged 18 and over), child and adolescent psychiatry, forensic psychiatry, and substance abuse psychiatry, all provided by the regional health authorities; and general support services, which are delivered through the municipal social welfare system (Silfverhielm & Kamis-Gould, 2000; Silfverhielm & Stefansson, 2006). The Swedish healthcare system is tax-funded, which reduces cost-related avoidance of healthcare (Ludvigsson et al., 2025). Primary and specialist MHS whether concerning physical or MHP, situated in-hospital or outreach services, is financed, organised, and provided by the regional health authorities. However, the proportion of private primary and specialist healthcare providers varies across the regional health authorities (Ludvigsson et al., 2025; SALAR, 2024b; Swedish Association of Health and Social Care Providers, 2022). Half of all appointments to primary healthcare services are to privately operated providers, and one fifth to private psychiatric services (Swedish Association of Health and Social Care Providers, 2022). Although the accessibility to primary services is generally high (Ludvigsson et al., 2025), challenges remain in integrating MHS into primary healthcare contexts (Kim et al., 2023).

Ongoing transition of primary mental health services

The shift from inpatient to outreach-based primary services began in the mid-1970s and Sweden now has the lowest number of inpatient beds per inhabitant in the European Union (Janlöv et al., 2023; Ludvigsson et al., 2025). The transition to outreach MHS in Sweden began with the Mental Health reform in 1995 (Silfverhielm & Stefansson, 2006) and was further advanced by the *Good quality, local healthcare - A primary care* reform (Swedish Government of official reports, SOU 2020:19). Accessibility, continuity of care and active participation as essential pillars of equitable primary healthcare provision was emphasized in this later reform (SAHCA, 2025b).

Care has gradually moved closer to the individual, with less access to in-patient beds and an increased emphasis on outpatient and primary care settings (Janlöv et al., 2023; Ludvigsson et al., 2025; NBHW, 2025; SALAR, 2024b). Individuals who present with newly developed signs or symptoms of MHP, or with previously unrecognised symptoms not requiring emergency care, are typically considered patients within primary MHS (NBHW, 2025a). Healthcare services in general are primarily guided by the lowest effective care level, shortly named 'LEON'-principal, meaning that the individual with MHP should be cared for at the lowest level of care to meet their needs (NBHW, 2024b).

Primary MHS should provide a simple and swift pathway for anyone seeking support and help for their MHP (NBHW, 2024a). Most individuals with complex MHP are cared for in primary or specialist outreach services today (NBHW, 2024b). However, the transition from specialist to outreach and/or primary MHS has and is still faced with persistent challenges such as fragmented clinical information systems, unclear role boundaries, limited capacity among providers and patients, and insufficient organisational and leadership support (Ludvigsson et al., 2025; Kim et al., 2023; NBHW, 2024a). The *Good quality, local healthcare - a primary care* reform (SOU 2020:19) has strengthened the focus on person-centredness, health promotion and preventive care, but there remains limited evidence regarding the impact of these changes on the experiential knowledge of care and support among patients and service users (SAHCA, 2025a, WHO, 2025).

Many countries recognise that integrating mental health professionals into traditional PHC can improve access, patient experiences, and overall system capacity (Kates et al., 2019). It has therefore been emphasized that primary MHS must strengthen collaboration and consultation with specialist services (NBHW, 2024a). Further progress is needed to increase accessibility to care, particularly for treatment and assessment, while persistent challenges remain in triage, assessment, and diagnostics (NBHW, 2024a). This ongoing transition also calls for competence-building initiatives among mental health service providers and the development of a framework for managing MHP within primary care settings (NBHW, 2024a). Informing this development through the experiential knowledge of individuals who encounter primary MHS for their MHP and exploring the role of PHNs as the first point of contact within these services, is therefore crucial.

The role of registered and public health nurses as the first point of contact

Globally, RNs who have a bachelor's degree in nursing represent the largest non-physician workforce in Primary MHS (Freund et al., 2015). MHP are a common reason for individuals to contact primary MHS (NBHW, 2025a), where PHNs

and/or RNs are frequently reported as the first point of contact (Björkman et al., 2018; Hauger et al., 2025; Karlsson et al., 2021; Smith & Bevan, 2020; Sundler et al., 2023). A great majority (89 percent) of individuals with MHP report having RN as their initial point of contact in Swedish primary MHS, and 71 percent report PHNs (NBHW, 2025a). Additionally, physical encounters between RNs or PHNs and individuals in need of primary healthcare, are estimated to account for one third of overall patient encounters in this context (SALAR, 2023). According to PHNs individuals encountering Primary MHS for their MHP, exists in all age groups (Björkman & Salzmann-Erikson, 2018). PHNs and RNs in a municipality setting identify and provide early interventions to individuals with MHP (Heaslip et al., 2023; Smith & Bevan, 2020). Neither PHNs nor RNs are formally defined as psychosocial resources within Swedish primary MHS, despite being among the most frequently reported professionals conducting initial assessments of individuals seeking care and support for their MHP (NBHW, 2025a).

Key facts about public health nurses

Educational background: PHNs hold a bachelor’s degree as well as a one-year master’s in nursing. (Benton & Shaffer, 2016; Dickson et al., 2015; Young & Thompson, 2018, Swedish Society of Nursing, 2025)

Primary role: PHN main responsibility is to promote health and prevent illness from a public health perspective, working with individuals, groups, and organisations i.e., primary, secondary, and tertiary health promotion and preventive working field (Benton & Shaffer, 2016; Dickson et al., 2015; Griffith & Tengnah, 2013; Young & Thompson, 2018)

Historical terminology: PHN are traditionally referred to as 'district nurses', a designation that depends not only on their operation within a defined geographical area but also on cultural and contextual factors (Burke, 2014; Dickson et al., 2015; Young & Thompson, 2018).

Scope of practice: Traditionally, PHNs have worked within defined geographical areas (Burke, 2014; Dickson et al., 2015; Young & Thompson, 2018). In Sweden, however, their role has shifted in line with changes in the organisation of PHC. This thesis therefore recognises PHNs working across various settings, including PHC centres, child health centres, and municipal services such as school health and elderly care (Swedish Society of Nursing, 2025)

Nature of care: A commonly used phrase to describe their work is “caring for families from cradle to grave.” (Dickson et al., 2015)

Patient experience: Encounters with PHNs are often perceived by patients as respectful and person-centred. (Lundberg et al., 2020)

RNs and specifically PHNs with their speciality in the provision of primary, secondary and tertiary health promotion and preventive working field, play a critical role when encountering individuals with MHP (Ventura et al., 2021). The scope of PHN' work is broad within primary MHS as noted in *Key facts about public health nurses*. There is currently limited research within this setting, focusing on their initial assessment and communication and decision-making during this process, but the research is progressing (Grundberg et al., 2016; Moyes et al., 2024; Sundler et al., 2023). Reports frequently highlight the challenges faced by RNs and PHNs, particularly their perceived lack of knowledge in addressing MHP (Björkman et al., 2018; Grundberg et al., 2016; Janlöv et al., 2018; Kaskoun & McCabe, 2022; Lundin-Gurné et al., 2023; Löyttynen et al., 2023; Östangård Olofsson & Lovén Wickman, 2023). Individuals in need of care and support experience of nursing care can significantly shape their overall satisfaction and perception of healthcare delivery (de Rosis et al., 2021).

PHNs emphasise that a good first encounter is essential for building a trusting and lasting relationship with individuals in need of care (Nygren Zotterman et al., 2015). However, PHNs describe mental health encounters and health promotion activities as lacking clear goals and report a lack of confidence, which necessitates collaboration with others (Grundberg et al., 2016; Lundin Gurné et al., 2023; Östangård Olofsson & Lovén Wickman, 2023). Given the steady increase in individuals suffering from and needing care and support for their MHP in society today, (PHAS, 2024) there is a need to strengthen the knowledge about how PHNs can support individuals with MHP (Björkman et al., 2018; Björkman & Salzmann-Erikson, 2018; Janlöv et al., 2018; Löyttynen et al., 2023; Östangård Olofsson & Lovén Wickman, 2023), by their experiential knowledge of encountering individuals with MHP in the primary MHS context.

PHN's knowledge, views, attitudes, and beliefs about mental health i.e., their MHL (Jorm et al., 1997), may influence how they identify, explore, and respond to situations involving individuals with MHP (Ventura et al., 2021). Furthermore, it also affects their communication and interactions with patients during such encounters (Höglander et al., 2023). Low MHL among professionals may increase the service gap and thus reduce opportunities for care and support for individuals with MHP (Lovén Wickman & Schmidt, 2023). The Public Health Agency of Sweden (PHAS, 2022) emphasises the importance of enhancing primary MHS professionals' competence in mental health and evidence-based interventions to improve access for individuals with MHP. It is thus essential to deepen the understanding of how PHNs' knowledge, attitudes, and beliefs about mental health influence their encounters with individuals with MHP within primary MHS.

Professionals' mental health literacy and the interplay of relationships

The strong relationship between the individual and the professional is central to experiences of good care and support across contexts and cultures (Borgh et al., 2024; Rocelli et al., 2024; Roennfeldt et al., 2024; Sheridan Rains et al., 2021; Vandewalle et al., 2020), and variously described as genuine, interpersonal, therapeutic, or caring, and often framed as a partnership or alliance (Hartley et al., 2020; Kane, 2015; Martinsen, 2000; Slade et al., 2014). Moreover, the professionals' relationships with services users' significant others are also of importance (Sjöström et al., 2021). However, evidence on how to develop and sustain such relationships remains limited (Hartley et al., 2020; Sundler et al., 2023).

The quality of encounters in MHS largely depends on professionals' MHL, resulting in varied outcomes (Lovén Wickman & Schmidt, 2023; Vandewalle et al., 2020). MHL is according to Jorm et al. (1997) a person's knowledge, views, attitudes, and beliefs about mental health. Higher levels of MHL among professionals are associated with reduced perceived stigma among individuals with MHP (Lexén & Svensson, 2016; Svensson & Hansson, 2016). However, individuals with complex MHP report non-helpful relationships in care contexts, describing professionals as indifferent to their needs and well-being (Ljungberg et al., 2016). Such experiences are particularly harmful given the vulnerability of individuals seeking care (Biringer et al., 2017; Kuek et al., 2023; Richards et al., 2019) and their persistent fear of encountering stigma (Trevillion et al., 2022; Wainberg et al., 2017).

Stigma remains a major barrier to seeking care and individuals frequently report fear of being stigmatised (Clement et al., 2015; Trevillion et al., 2022; Wainberg et al., 2017), a concern echoed by the Swedish Partnership for Mental Health (NSPH) (NSPH, 2024). Experiencing stigma can lead to a loss of autonomy and discrimination (Richards et al., 2019). Stigma is often internalised as self-stigma, which may result in individuals avoiding or delaying seeking the care and support they need (Dubreucq et al., 2021). Public stigma and negative societal attitudes towards individuals with MHP remain among the most significant psychosocial and environmental barriers today (Hanisch et al., 2016). Severity of perceived MHP also influences the degree of stigma experienced (Sadler et al., 2012; Svensson & Hansson, 2016).

People thus generally share and seek support and knowledge from friends and family to help inform their health decisions (Bhowmick et al., 2025; Pinho et al., 2025). Being supported by significant others is an important element for individuals with MHP (Wickramaratne et al., 2022). Significant others play an important role in person-centred care, supporting service users in encounters with professionals in their assessment and joint decision-making process regarding an individual's future care plan (Staniszewska et al., 2019). Another approach to improving the

understanding and support is the implementation of Peer Supporters within MHS (Mutschler et al., 2022). Peer support workers, in comparison to non-peer professionals, are often considered essential for promoting recovery-oriented practices and often establish stronger relationships with service users contributing to higher satisfaction with care (Bejerholm & Roe, 2018).

Reducing stigma by exposing mental health service providers to experiential knowledge may enhance access to services for individuals with MHP (Mårtensson et al., 2014). One way to achieve this is through the implementation of recovery-oriented, integrated care and support models (Klodnick et al., 2021). Integrated healthcare emphasises collaborative practices and the organisational structures required to sustain them (Frisch & Rabinowitsch, 2019). Recovery-oriented models within specialist MHS can reduce perceived stigma among service users and improve job satisfaction among professionals (van Weeghel et al., 2019; Svensson et al., 2017; Yanos et al., 2020).

The attitudes and beliefs of mental health professionals in Sweden are strongly influenced by workplace culture (Mårtensson et al., 2014). To support a person-centred and recovery-oriented transition, providers play a crucial role during implementation stages of integrated care and support, as well as in promoting EBP (Roy et al., 2020; Svensson et al., 2017; van Duijn et al., 2018; Birken et al., 2018). They also have a key responsibility within organisations to create conditions that enhance capacity for delivering person-centred, recovery-oriented, and integrated MHS (Meyer et al., 2012; Santana et al., 2018). Experiential knowledge from both primary and specialist services is therefore essential for understanding current workplace culture by exploring the encounters in services, when informing future person-centred and recovery-oriented developments (Galvin, 2021; Grim et al., 2022).

Primary healthcare as the first line in mental health services

The overall goal of Swedish primary MHS is to promote health on equal terms, with care delivered holistically and focused on health promotion and prevention (Janlöv et al., 2023; SALAR, 2024b). Holistic care is described as a whole-person approach to health (Frisch & Rabinowitsch, 2019), where healthcare and medicine are integrated, interdisciplinary, and interprofessional. Primary MHS settings are traditionally described as a team-oriented practice, constructed by formal or non-formal teams (Everett et al., 2022). The professional roles within such interprofessional teams differ depending on role boundaries described as structural, interpersonal and individual factors (Freund et al., 2015; MacNaughton et al., 2013). Prevention specialists within primary MHS, such as PHNs and general practitioners,

whose professional remit places health promotion and disease prevention at its core, are well positioned to guide the funding and implementation of comprehensive public mental health strategies (NBHW, 2021b; Swedish Society of Nursing, 2025). However, delivering effective interventions across primary, secondary, and tertiary prevention remains complex, particularly when professionals lack a clearly defined remit in mental health (Lyne et al., 2023).

The most commonly provided mental health interventions in primary MHS include social skills training, lifestyle changes, stress reduction, behavioural activation, and psychoeducation (de Oliveira et al., 2023). Primary MHS globally often employ cognitive-behavioural techniques as a response to the urgent need for effective MHS delivery (de Oliveira et al., 2023) and promote interprofessional, collaborative, team-based approaches (Körner et al., 2016). Promoting collaboration and meeting organisational requirements is emphasized within the Swedish context of primary MHS, where models vary within their first line of support (Ashcroft et al., 2021; NBHW, 2025b). In addition, a lack of focus on structural and organisational capacity has been highlighted, along with the limited availability of tools for professionals to use in clinical practice (Mareya et al., 2024; Raj, 2022).

Integrated care and support models in primary mental health services

Approximately half of PHC centres in Sweden report using structured care models to meet the needs of individuals with MHP in primary MHS, see Table 1 (NBHW, 2025b). A larger proportion of these reports are found in regional health authorities where local initiatives are supported by accompanying materials, training, and/or implementation support. Structured care models were the Integrated Behavioural Health Model (17% of respondents), Step-Up (14%), the Alaska model, the Collaborative Care Model (CCM) (2%), or similar locally developed models of Stepped Care. Some of these models can be found in published literature, such as the implementation of the CCM by Unützer and Park (2012), the Integrated Behavioural Health Model by Shim and Rust (2013), and the Stepped Care Model (Mareya et al., 2024; Scogin et al., 2003). Other models were local initiatives and to our knowledge not scientifically validated.

Table 1. Integrated care and support models in Swedish primary mental health services.

Model of care and support	**Collaborative Care Model (CCM)** (Unützer & Park, 2012)	**Integrated Behavioural Health model** (Shim & Rust, 2013)	**Primary Care Behavioural Health model** (Farnsworth von Cederwald et al., 2023)	**Step Up** (Region Stockholm, 2021)	**Stepped care model** (Mareya et al., 2024; Scogin et al., 2003)
Workforce	consisting of a General physician, a Care manager, usually a specialist in nursing, has been reported to create a more personal approach and provide a social context for the individual (Martel et al., 2021).	A psychologist/psychotherapist/counsellor is introduced and becomes a key member of the team.	A behavioural expert adds to the general workforce within PHC	Constitutes a General physician, a nurse and a psychologist	Adapts to the local context and culture and has evolved to deliver patient-centred care based on individual needs
Methods	Team-based approach using a structured management plan based on evidence-based practice and a person's specific identified needs (Cerimele et al., 2015; Coventry et al., 2014).	Focus is for the behavioural expert to guide other members of the team when encountering patients with behavioural challenges to support and to work directly with behavioural changes.	Team-based approach to improve care for the overall clinic population, to inform behaviours and skills relevant for preventing destructive somatic and psychological health outcomes	E-learning model which aims to improve health professionals' competence in identifying and treating common mental health conditions, such as anxiety, depression, substance abuse, and eating disorders, by a team-based approach.	The model follows a stepped approach, prioritising evidence-based low-intensity treatments before progressing to more intensive ones if needed.

Another structured model that was not listed in the final report, is the Primary Care and Behavioural Health Model (Farnsworth von Cederwald et al., 2023; NBHW, 2025). The Step-Up model reference indicates a local initiative however, a quick literature search identified a care and support model with a similar name; the Australian Step-Up and Step-Down service, also known as Prevention and Recovery Care, which provides short-term subacute care and support to bridge the gap between hospital-based care and municipal services (Harvey et al., 2019). It is difficult to provide a comprehensive description of the models currently offered by Swedish primary MHS to individuals with MHP based on these local initiatives of care models (NBHW, 2025b). However, concerns have been raised regarding the most reported structured care model within Swedish primary MHS, the Integrated Behavioural Health Model (NBHW, 2025b; Supper et al., 2015). The role of behavioural experts or mental health workers in this model is often described as twofold: to provide individual, patient-centred care, and to educate and act as consultants for other professionals within primary MHS (Supper et al., 2015). There is also a reported lack of involvement of service users' experiential knowledge during the implementation and evaluation processes of these models (Baxter et al., 2018; Mareya et al., 2024). Common barriers to integrating MHS into the traditional PHC context have been shown to include attitudes, knowledge and skills, motivation to change, management and leadership, and resources (Ross et al., 2015; Wakida et al., 2017). Three essential components for effective shared care have been emphasized: clearly defining the role of PHC in mental health, supporting and expanding this role through integration with specialist services, and establishing system-level supports to sustain these changes (Kates et al., 2019).

A transition from inpatient care to outreach and community-based services is essential for individuals with complex MHP (Jørgensen et al., 2024). The FACT model consists of EBP and therefore aims to improve the delivery of integrated, recovery-oriented services. To enhance the implementation sustainability and to explore how the current model meets the needs of service users, experiential knowledge must thus be taken into account. Such knowledge is crucial to inform and support this ongoing transformation (WHO, 2025).

Integrated care and support models in specialist mental health services

Integrated healthcare models strive to uphold and promote individuals' human right to mental health (Mahomed, 2020; WHO, 2022), in alignment with the capability approach (Nussbaum, 2013). Current specialist MHS focus on addressing harmful social environments, prioritising needs-based care, equipping professionals with evidence-based tools, adopting rights-based approaches, and integrating lived

experience into service design (Patel et al., 2023). This ongoing shift from hospital-based care to outreach care for people with complex MHP has highlighted the need for collaborative care and support models (see Table 2), such as the Assertive Community Treatment (ACT) (Bond & Drake, 2015; Burns et al., 2001). ACT has emerged as a valuable experiential model, influencing both practice and research. It has been widely implemented and is now a well-documented model of integrated care and support, suitable for individuals with complex MHP (Burns, 2010; Sudbeck et al., 2024). A more traditional model is Intensive Case Management (ICM), which is based on individual case managers (Dieterich et al., 2017). Each ICM consist of a team of professionals with a fewer load of cases (20). The ICM care and support is offered around the clock, and clients are seen in a non-clinical setting. The ICM and the care and support model share the feature of smaller caseloads, but place particular emphasis on caseloads being shared across the team.

FACT was introduced and viewed as an alternative to ACT, due to its flexibility, designed for individuals whose mental health problems fluctuate over time (van Veldhuizen & Bahler, 2015). Inter-professional teamwork in this context becomes essential in order to ensure cohesive and effective support (van Duijn et al., 2018).

Table 2. Integrated care and support models in Swedish specialist mental health services.

Model of care and support	**Assertive Community Treatment (ACT)** (Burns, 2010; Burns et al., 2001; Sudbeck et al., 2024)	**Flexible Assertive Community Treatment (FACT)** (Lexén & Svensson, 2016; van Veldhuizen & Bahler, 2015)	**Intensive Case Management (ICM)** (Aberg-Wistedt et al., 1995; Dieterich et al., 2017)
Workforce	Is a specialised, multidisciplinary team with a shared caseload. The team works closely together, often developing a strong sense of companionship, which supports the delivery of person-centred, collaborative care.	Is a multidisciplinary, recovery-oriented team with full responsibility for treatment delivery. Care is coordinated through daily team meetings, with flexible transitions between individual case management and shared caseloads depending on service user needs.	The team consists of case managers with small caseloads (fewer than 20 clients), allowing for intensive, long-term support. There is less sharing of caseloads compared to other models, and 24-hour support is available.
Methods	The approach includes case management, integrated services, community-based care, and varying levels of recovery-oriented practices	It includes individual care (e.g. case management and home visits) with intensive team care during crises or risk of relapse. A digital FACT board supports dynamic care planning, enabling seamless shifts between care modes. Most services are delivered in the community.	Services are delivered in non-clinical, community-based settings to promote accessibility and continuity.

FACT originated in the Netherlands (van Veldhuizen & Bahler, 2015) and was introduced in Sweden during the 2010s (Workbook FACT Programme Fidelity Scale, 2017). This model of care and support is derived from the Assertive Community Treatment (ACT) model and is characterised by its flexibility in meeting the needs of individuals with complex MHP, such as those living with psychosis, where the need for MHS may fluctuate over time (Van Veldhuizen & Bahler, 2015). FACT is a recovery-oriented, integrated care and support model that incorporates evidence-based services for individuals with complex MHP (Svensson et al., 2017). It was subsequently implemented within Swedish specialist MHS for service users with

psychosis (Lexén & Svensson, 2016; Svensson et al., 2017; Svensson et al., 2018). FACT has been rapidly implemented, owing to a national initiative and sustained support throughout the implementation process, facilitated by collaboration between researchers and the participating MHS (Svensson et al., 2017).

Integrated services such as FACT, place strong emphasis on collaborative practices across primary and specialist MHS, as well as community support structures (Markström et al., 2015; Searby et al., 2025). FACT was shown to deliver a safer and more intensive approach to care compared to traditional specialist MHS when evaluated in a quasi-experimental study (Nielsen et al., 2021). Furthermore, a cohort study from Sweden indicated that FACT improved everyday functioning among service users (Svensson et al., 2018). However, a recent study found that the FACT model led to an increase in emergency department visits compared to the ACT and ICM models of care and support (Rotenberg et al., 2025). FACT also fosters the development of collaborative partnerships, which is supported by both service users (Borgh et al., 2024) and professionals (Bejerholm et al., submitted), and aligns well with person-centredness.

It is crucial to understand service users' experiential knowledge of current care before developing further research on FACT in a new context, namely, individuals with complex MHP within general MHS. This understanding is essential for informing the relevance and direction of future research. Moreover, it is necessary to engage with mental health service providers, in order to explore their views on current care and support models prior to scaling up the implementation of models such as FACT, as it had been to gauge their engagement and attitude prior to a successful implementation (Svensson et al., 2017). To inform the implementation of FACT within Swedish specialist MHS, it is vital to examine the experiential knowledge of both individuals and mental health service providers regarding current care and support, thus guiding the development of integrated, recovery-oriented services.

Understanding services through experiential knowledge

Experiential knowledge is increasingly utilised in research and quality improvement projects to improve patient outcomes, clinical practice, and healthcare policies (Castro et al., 2019; Gabriel et al., 2023; Westerink et al., 2023). Sequential trials, where experiential knowledge informs and shapes future interventions in complex and evolving contexts such as MHS, have proven valuable for continuous learning and adaptation (Gyllensten et al., 2025; Merner et al., 2023). This integration is increasingly recognised as essential and underscores the importance of involving those most affected by a given issue in shaping clinical practice solutions (Baxter et al., 2018; Ocloo & Matthews, 2016).

The influence of experiential knowledge on health policies and processes has been characterised as comprising two co-existing layers of power (O'Shea et al., 2019). The first layer reflects the power of stakeholders, such as policymakers, researchers, and professionals, who invite the patient, service user, or patient associations into their settings, in some cases with a pre-determined agenda. The second layer concerns how the outcomes of these encounters have power to influence stakeholders' everyday work. There will therefore always be an imbalance of power, where stakeholders hold greater power than patients, service users and patient associations (O'Shea et al., 2019). Such imbalances are also present in MHS' clinical encounters, even when individuals possess the required knowledge to be involved in a meaningful way (Joseph-Williams et al., 2014; Josephsson et al., 2022).

By legitimizing individuals' experiential knowledge, traditional hierarchies in MHS can be challenged, particularly concerning the working culture and the distribution of power and professional roles (Grim et al., 2022). Importantly, experiential knowledge is a core component of EBP (Melnyk et al., 2010, NBHW, 2025a). An integrated process for better-informed decision-making is facilitated through a transparent dialogue, in which experiential knowledge, contextual factors, and scientific evidence are weighted equally alongside professional expertise, and is consistent with person-centred and recovery-oriented service (Ekman, 2022; Leamy et al., 2011; NBHW, 2025a, Melnyk et al., 2010; Slade et al., 2014). Such collaborative approaches, derived in partnership and co-created solutions (Ekman, 2022), are reflected in the literature as a shared decision-making model, favoured by both professionals and service users (Puschner et al., 2016). This model is also fundamental to recovery-oriented services and person-centredness (Dahlqvist Jönsson et al., 2015; Ekman, 2022; Ekman et al., 2011).

Recognising and integrating experiential knowledge strengthens research, health policy, and clinical practice, while fostering participation, empowerment, and improved quality of life for people living with MHP (Castro et al., 2019; Kuipers et al., 2019). This thesis therefore aims to explore experiential knowledge within current primary and specialist MHS to inform the future development of person-centred, recovery-oriented, and integrated service delivery

Rationale

The prevalence of signs and symptoms of MHP is increasing, while the current provision of MHS lacks sufficiently person-centred, recovery-oriented, and integrated models of care and support, to adequately meet individuals' needs and capabilities (Rugkåsa et al., 2020). The overall goal for professionals who embrace person-centredness in encounters with individuals in need of care and support is to promote health and well-being by helping them create a meaningful life (Håkansson Eklund et al., 2019; Martinsen, 2000; Nussbaum, 2013) in alignment with recovery-oriented services (Leamy et al., 2011; McLure et al.,2023; Slade et al., 2014). Interpersonal relationships may be more accurately understood as permeating all facets of recovery, including experiences such as hope, identity, and empowerment (Price-Robertson et al., 2017), in alignment with caring scholar (Marinsen ,2000). It has therefore been maintained that the relationship between the individual in need of care and support and the professional plays a fundamental role both in the recovery process and in person-centred care (Ekman, 2022; Ekman et al., 2011; McLure et al., 2023; Staniszewska et al., 2019) and is best facilitated within a caring environment (Martinsen, 2000). These approaches promote the empowering of a person's own unique qualities and the delivery of care and support for achieving a better health (Chatwiriyaphong et al., 2024; Lidén et al., 2015). However, many individuals in need of MHS continue to encounter stigmatising attitudes and a lack of adequate knowledge when seeking care and support for their mental health needs (Clement et al., 2015; Davidson et al., 2021; Rocelli et al., 2024; Sturman et al., 2022; Trevillion et al., 2022; Wainberg et al., 2017).

Achieving this ongoing transformation towards person-centred and recovery-oriented service delivery requires a concerted effort across all levels of care, including addressing mental health service providers' knowledge, attitudes, and beliefs, while also drawing on their experiential insights (Ashcroft et al., 2021; Baxter et al., 2018; Raj, 2022). Experiential knowledge is therefore essential for informing current initiatives aimed at providing person-centred, recovery-oriented, integrated care and support as well as for guiding the implementation of EBP for individuals with MHP (Melnyk et al., 2010; Skivington et al., 2021). Furthermore, professionals who have had direct contact with individuals experiencing MHP tend to perceive them as less stigmatised (Mårtensson et al., 2014). This suggests that stigmatising attitudes among professionals may be reduced through exposure to

research-based insights into the experiential knowledge of those with MHP (Lexén et al., 2021; Mårtensson et al., 2014).

This thesis addresses the pressing need to explore the experiential knowledge of individuals with MHP and mental health service providers within both primary and specialist MHS (WHO, 2025). Investing in care and support models that promote continuous care and foster trusting relationships between those in need of care and professionals is fundamental for any health-promotive and preventive intervention. By exploring the needs, preferences, and experiences of individuals with MHP and mental health service providers, this thesis seeks to inform and support the development of person-centred, recovery-oriented, and integrated service delivery. Grounded in a person-centred philosophical stance, it acknowledges that roles, whether as patient, service user, provider, or researcher, shape the interpretation of results. Consequently, understanding mental health through multiple approaches is essential for guiding practice, policy, and implementation, including the adaptation of models such as FACT within Swedish MHS.

Overall aim

The overall aim of this thesis is to explore the experiential knowledge of individuals who require care and support for their mental health problems, as well as of the mental health service providers who deliver such care and support within Swedish primary and specialist mental health services.

Specific aims of the studies

- **Study I,** to explore the lived experience of encounters with primary health care of a person with mental health problems
- **Study II**, to construct a theory that explains the process public health nurses experience when encountering people with mental health problems, based on their knowledge, attitudes, and beliefs about mental health
- **Study III**, to explore service users' experiences of their current mental health services and their reflections on the Flexible Assertive Community Treatment (FACT) model and its role in future practice
- **Study IV**, to explore mental health service providers' experiences of current general psychiatry in specialist mental health services, and their views on what is needed for the implementation of a recovery-oriented and integrated care and support model, Flexible Assertive Community Treatment

Methods

Research design

This thesis comprises four exploratory studies that seek to understand the experience of individuals who require care and support for their MHP as well as the experience of service providers within both primary and specialist care and support services. An explorative approach is suitable when the phenomenon of interest is new to them or provides an openness towards what they might learn, and therefore, adapts the research design accordingly (Rendle et al., 2019).

Four qualitative approaches were applied to achieve this aim, recognising that clinical practice often entails subjective judgement, measured responses, intuitive decision-making, and the relational aspects of care that underpin the professional, patient/service user interaction (Broom & Broom, 2024). In alignment with the concept of the *Narrative act* by Ricoeur, a person's narrative is socially constructed, shaped by the surrounding environment (Josephsson et al., 2022; Kristensson Uggla, 2011; 2022; Ricouer, 1992). Furthermore, the ontology of this thesis recognises mental health, as a multi-dimensional and multifaceted phenomenon, encompassing not only clinical facts but also subjectivities such as meaning, context, values, ethics, and cultural considerations. See Figure 2 for the outline of the thesis. Addressing this complexity requires diverse methodologies to capture experiential knowledge of MHP as well as the steering and operational aspects of the service delivery (Manwell et al., 2015). Varied methods, as described below, were thus applied to generate data reflecting the richness and depth of human experience within MHS (Broom & Broom, 2024).

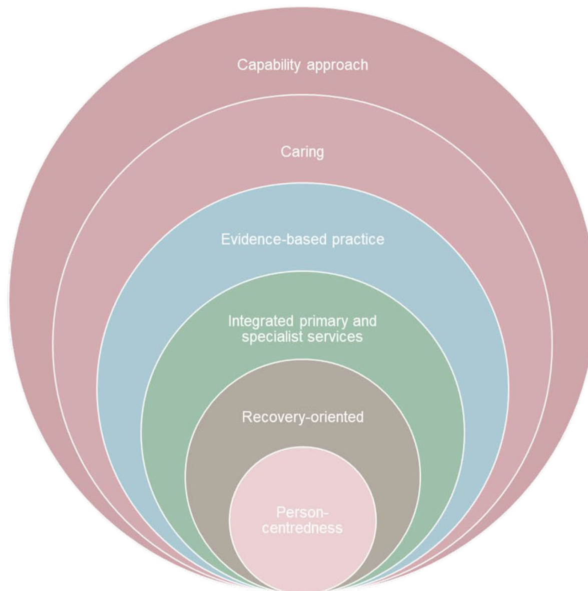

Figure 2. Illustration of the conceptualisation of theoretical perspectives that informs this thesis, in relation to the overall aim and the specific aims of Studies I-IV. The concentric circles illustrate how theoretical, ethical, organisational, and practice-based perspectives are embedded within one another. Together, the figure shows how the thesis is situated within a coherent, multi-level framework that encompasses societal values, ethical principles, organisational structures, and relational practices in mental health care.

Setting and context

The setting for the first part of this thesis, encompassing Studies I and II, was primary MHS, the first line of care for individuals experiencing MHP, and where the focus was on the experiential knowledge of both individuals with MHP and PHNs working in this setting (see Table 3). These studies thus included experiential knowledge of regional PHC centres, child health centres, and municipal healthcare, such as school health services and elderly care, in alignment with the scope of PHN practice (Swedish Society of Nursing, 2019), in addition Study I also included student welfare services, as a part of the first line of MHS for individuals with MHP (see Table 3).

The initial phase of implementing FACT within general psychiatry in specialist MHS in southern Sweden was explored in the latter part of the thesis, comprising Studies III and IV (see Table 3). The context was formed by an organisational initiative launched in 2017 by the regional health authority and local municipalities, supported by implementation strategists, project leaders, professionals, service users/organisations, and researchers. These studies constitute part of the feasibility stage of the Medical Research Council’s framework for developing and evaluating

complex interventions (Skivington et al., 2021). The studies formed part of a co-production approach aimed at developing a shared preunderstanding among stakeholders prior to the planning and implementation of a future randomised controlled trial *(ISRCTN11268588)*. Specifically, it sought to explore experiential knowledge of service users and mental health service providers, i.e., mental health workers, professionals, and head and operational managers, across three regional health authorities and eleven municipalities in Skåne, Sweden.

This thesis outlines the settings and context of primary and specialist MHS based on the researchers' pre-understandings of how individuals with MHP may seek and receive care and support for their mental health signs and symptoms. Student welfare services were included due to the specific design of Study I, however, they were excluded from Study II, as these settings do not constitute the primary field of PHNs (Swedish Society of Nursing, 2019).

Table 3. Overview of the settings in this thesis: Studies I–IV.

<table>
<tr><th colspan="9">Mental health services</th></tr>
<tr><th colspan="6">Primary</th><th colspan="3">Specialist</th></tr>
<tr><th>Responsible authority</th><th>Regional healthcare</th><th colspan="3">Municipal care and social services</th><th>University health services</th><th colspan="2">Regional healthcare</th><th>Municipal care and social services</th></tr>
<tr><td>Assignments /goals</td><td colspan="5">To promote good health on equal terms holistic, with a primary focus on health promotion and health preventive activities (Janlöv et al., 2023; SALAR, 2024b)</td><td colspan="2">To improve mental health and preventing ill health, which includes assessment, diagnosis, treatment, and support for psychiatric disorders and substance use conditions (Silfverhielm, & Stefansson, 2006)</td><td>To promote economic and social security, equality in living conditions, and active participation in community life (SFS 2025:400)</td></tr>
<tr><td rowspan="2">For whom?</td><td colspan="5">Individuals who present with newly developed signs or symptoms of mental helath problems, or with previously unrecognised symptoms not requiring emergency care (National Board of Health and Welfare (NBHW), 2025).</td><td colspan="2">Adults (18+) with severe mental illness</td><td>Adults 18 + with psychiatric disabilities or mental illness who experience significant difficulties in managing their daily lives</td></tr>
<tr><td colspan="8">First line of care under the level of effective care principle (NBHW, 2024b).</td></tr>
<tr><td>Context</td><td>Primary health care centres</td><td>Child health centres (0-5 years of age)</td><td>School health services (6-18 years of age)</td><td>Elderly Care</td><td>Student welfare</td><td>Out-reach services</td><td>General Psychiatry</td><td>Out-reach services</td></tr>
<tr><td rowspan="2">Study settings</td><td colspan="4">Study I*</td><td>N/A</td><td colspan="3" rowspan="2">Studies III and IV***</td></tr>
<tr><td colspan="5">Study II**</td></tr>
</table>

*Study I. Public health nurse field of practice (Swedish Society of Nursing, 2019; 2025), **Study II. To explore the phenomenon of encounters with Primary health care for their mental health problems. , ***Studies III and IV. The context in which Flexible Assertive Community Treatment was to be implemented.

Participants and sampling

Different participant sampling methods were applied in this thesis, each tailored to the specific design of the respective study. Criterion sampling was applied in Study I (Giorgi, 2005) and in Study III, based on predefined inclusion criteria (see Table 4), with the selection grounded in pre-identified factors (Tenny et al., 2025). Moreover, convenience sampling was applied in Study 1 whereby participants were selected based on their availability (Gill, 2020; Tenny et al., 2025), while purposive sampling was applied in Study III , which involves the intentional selection of participants deemed most informative and knowledgeable about the phenomenon under study (Gill, 2020; Tenny et al., 2025). Purposive sampling followed by convenience sampling was utilised in Study IV where the mental health service providers who were accessible, were asked to participate. Purposive sampling was initially applied in Study II, followed by theoretical sampling (Charmaz, 2006). This process involved selecting participants of varying ages from different primary MHS settings, with diverse work experience as PHNs and differing levels of experience in encounters with individuals experiencing MHP, who were progressively included as the analysis evolved (see Table 4).

Table 4. Methodological overview of Studies I, II and III and IV.

Study	**I.** THE DESIRE TO BE EMBRACED - THE LIVED EXPERIENCE OF ENCOUNTERING PRIMARY HEALTH CARE FOR A PATIENT WITH MENTAL HEALTH PROBLEMS. A DESCRIPTIVE PHENOMENOLOGICAL STUDY	**II.** PUBLIC HEALTH NURSES EXPERIENCE OF MENTAL HEALTH ENCOUNTERS IN THE CONTEXT OF PRIMARY HEALTH CARE: A CONSTRUCTIVIST GROUNDED THEORY STUDY	**III.** TURNING TO SERVICE USERS FOR THE UNDERSTANDING OF CURRENT AND FUTURE MENTAL HEALTH SERVICES IN THE DEVELOPMENT PROCESS OF RESEARCH AND PRACTICE: A QUALITATIVE STUDY	**IV.** MENTAL HEALTH SERVICE PROVIDERS' EXPERIENTIAL KNOWLEDGE OF CURRENT CARE AND FLEXIBLE ASSERTIVE COMMUNITY TREATMENT – A QUALITATIVE STUDY
Design	Descriptive Phenomenological Approach (Giorgi, 2005)	Constructivist Grounded Theory (Charmaz, 2006)	Reflexive Thematic Analysis (Braun & Clarke, 2006)	Content-analysis (Graneheim & Lundman, 2004)
Epistemology	Phenomenology, A person's lifeworld takes shape when their awareness centres on a specific experience. This experience, or phenomenon is given meaning through the way participants articulate it in their stories (Giorgi, 2000)	Constructivism, knowledge is co-created through interaction between the researcher and participants. It acknowledges that experiences are shaped by changing contexts and diverse perspectives, and that reality is not fixed but constructed through meaning-making (Charmaz, 2006)	A participatory design and was grounded in a critical realist perspective, interpreting the data through a lens informed by social constructionism, where knowledge is understood as emerging through social processes (Moon & Blackman, 2014)	See Study III
Participants	A total of 11 patients were enrolled in the study.	A total of 13 Public Health Nurses (PHN) including a student in public health nursing	A total of 17 experts were enrolled in the study.	Five focus groups with a total of 30 participants were enrolled in the study
Sampling	A Criterion sampling – convenience sampling	Purposeful sampling - Theoretical sampling	Criterion sampling - Purposeful sampling	Purposeful sampling - convience sampling
Inclusions Criteria	Atleast 16 years old, with experience of encountering Primary Health Care (PHC) for their Mental Health Problmes (MHP) within the last 5 years, able to communicate in Swedish, cognitively lucid i.e., having been provided both written and verbal informed consent to participate, being aware of the aim of the study, and being able to proceed with the interviews	PHNs working in different PHC context with varied experiences of the field, thereafter theoretical sampling.	The potential experts were recruited via notices "Psychiatry for the future" in those services that were planned to take part in the larger project. The Swedish Partnership for Mental Health Skåne and its sister organisation, LIBRA Skåne, further supported recruitment by sharing information with their members.	Mental health service providers within general specilaist MHS, specifically mental health care workers, social workers, registered nurses, operational and head managers, project facilitators, as well as representatives from user involvement groups.
Context and Setting	Swedish context, distributed digitally via social media platforms of user organisations and research networks, and printed for display at PHC centres	In southern Sweden, PHC centres were in small to medium-sized towns, while municipal school health services operated in larger cities	Specialist general Mental Health Services (MHS) in southern Sweden, three regional health sectors and 11 municipalities	See Study III

Data collection	In depth individual interviews via Zoom platform Time: October 2022 to April 2023 Interviews lasted between 37-1h 7 min	In depth -interviews face to face - via Zoom platform (during the covid-19 pandemic). Time: October 2019 to June 2021 Interviews lasted between 34 to 1h 20 min	In depth individual and dyadic face to face interviews, as well as via Zoom platform Time 2019-2020 Interviews lasted between 23 min. and 1h 18 min.	Focus group Interviews face to face Time August 2018 – Maj 2019 Interviews lasted 1h 13 min and 1h 39 min
Data analysis	The analysis began with repeated readings and listening of interviews to grasp patients' experiences with PHC for MHP. Through eidetic reduction, experience-near expressions were identified and organized into meaning units and constituents, forming four core themes. A schematic overview illustrated their interrelations. All authors collaboratively identified invariant meanings and constructed the general structure of the phenomenon, while bracketing their preconceptions	The coding process consisted of theoretical sampling, coding, constant comparison, identification, and data saturation (Charmaz, 2006).	Thematic analysis was conducted inductively through repeated reading, manifest and latent coding, and collaborative discussions among the authors. Patterns of meaning were identified, subthemes and themes developed, and a thematic map constructed. (Braun & Clarke, 2024)	Data were analysed using inductive content analysis to capture the perspectives of mental health srevice providers. The first author conducted familiarisation and manifest coding, followed by collaborative categorisation and refinement. Latent patterns were allowed to emerge, and transcript accuracy was verified.
Ethical Considerations	The research was carried out in accordance with the ethical principles outlined in the Declaration of Helsinki (World Medical Association (WMA), 2025). Ethical approval was obtained by the Swedish Ethical Review Authority Reference number (Dnr 2022-02164-0)	The study regards professionals' experiences and is not covered by the provisions of §3-4 the Swedish Ethical Review Act (SFS 2003:460). The study followed the ethical standards of the Declaration of Helsinki (WMA, 2025)	The research was carried out in accordance with the ethical principles outlined in the Declaration of Helsinki (WMA, 2025). Ethical approval was obtained by the Swedish Ethical Review Authority Reference number. (Dnr 2019-02866),	The study regards professionals' experiences and is not covered by the provisions of §3-4 the Swedish Ethical Review Act (SFS 2003:460), the study was a part of a larger project, which obtained an ethical approval (Dnr 2019-02866). This study adhered to the guidelines set forth in the Helsinki Declaration (WMA. 2025)

The choice of sampling methods varies depending on the phenomenon of interest and the chosen methodology (Gill, 2020). Theoretical sampling differs from criterion and purposive sampling in that the researcher becomes dependent on the ongoing data analysis to guide participant selection (Charmaz, 2006). On the other hand, purposive strategies are particularly appropriate when the aim is to gain in-depth insights from individuals with relevant expertise and experiential knowledge (Gill, 2020; Palinkas et al., 2015; Patton, 2014; Sandelowski, 2004; Tenny et al., 2025).

This thesis adopted the information power approach proposed by Malterud et al. (2016) when estimating the minimum number of participants in a qualitative study. This is because sample size is primarily guided by the conceptual requirements of the study rather than by the representativeness of participants (Hennink & Kaiser, 2022; Malterud et al., 2016; Moser & Korstjens, 2018). The sample sizes of each study thus vary according to the chosen methodology and study aim. Data collection details are presented in Table 5.

Table 5. Informed power of sample size (Studies I- IV) inspired by Malterud et al. (2016).

Five Key Dimensions	Yes*	No*	Study I	Study II	Study III	Study IV
I Aim: Is the study aim considered narrow?	*Fewer*	*Larger*	*Yes*	*Yes*	*Yes*	*Yes*
II Sample Specificity: Does the study require a specific type of participant?	*Fewer*	*Larger*	*Yes*	*Yes*	*Yes*	*Yes*
III Established theory: Is the study theoretically informed?	*Fewer*	*Larger*	*Yes**	*Yes***	*No*	*No*
IV Quality of dialogue: Were the interviews considered good interview dialogues?	*Fewer*	*Larger*	*Yes*	*Yes*	*Yes*	*Yes*
V Analysis strategy: Requires the study in-depth exploration such as narratives or discourse?	*Fewer*	*Larger*	*Yes*	*Yes*	*No*	*No*
Number of participants (n)			11	13	17	30 (à 5 focus groups)

The participants' socio-demographic data were collected in Studies I and II (see Table 6) to gain a greater understanding of the phenomenon, consistent with Gill's (2020) notion of *thick description*. However, such details were deemed not applicable in Studies III and IV, due to the specific context of the *Ups and Downs in Mental Health* project. In alignment with the principles of co-production and the feasibility stage of a complex intervention (Vargas et al., 2022; Skivington et al., 2021), these studies instead aimed to inform the implementation of the FACT intervention and the forthcoming randomised controlled trial *(ISRCTN11268588)*. No personal information was thus recorded during the recruitment process. Details concerning participant recruitment and sampling strategies for each study are presented in the following sections.

Table 6. The vignettes of Flexible Assertive Comminuty Treatment (FACT) 'Indvidual with complex mental health needs' and 'Mental health service providers'

'Indvidual with complex mental health needs'	'Mental health service providers'.
"I've received support from other people the last eight years. It's the flexible ACT team who checks on me. They come home to me to talk and see if I'm alright. And they help me to deal with things so that they get done. It means a lot to have a whole team when you feel bad, people who can help with all types of problems. It's almost like being in the hospital although I'm at home. But the benefit is that you're in your own flat and know all the staff. I managed to get out of my depression quite quickly this time and I now only meet my key worker and the recovery group. All in all, I'm quite pleased about my situation just now"	"The main strength of the Flexible ACT model is that my consumers in need of intense support are regularly monitored, even if I'm not available for some reason. It is written clearly on the digital Flexible ACT board what needs to be done day by day. Now I can leave work on time and head home without feeling anxious, and without having the responsibility for the consumer hanging over me. Now I feel less alone, and I don't need to carry everything alone anymore. Now we share the hard parts in the care for our consumers"

Study I

Advertisements with information about the study and the inclusion criteria were created to reach out to potential participants to participate *In Dialogue for Mental Health project*. A picture was co-produced with young people to attract the participation of young adults due to their increased reporting of signs and symptoms of MHP (Clemens et al., 2020; Piao et al., 2022). This was then digitally distributed on social media platforms of user organizations and research network platforms or printed on posters to be put up on information boards at PHC settings. The advertisement was also linked to a webpage at Lund University where potential participants could register their interest. They were then contacted via an "Expression of interest e-mail" with pre-formulated information about the study aim, and a question whether they still were interested. If this was the case, they could reply with a signed consent form. 11 patients responded and gave their written consent to participate. Two patients did not respond, and one declined participation after receiving initial information due to limited time for participation.

Study II

The participants were gradually included in the study, initially using purposive sampling and later a focused theoretical sampling procedure in alignment with the standards of grounded theory (Charmaz, 2006). Head and operational managers were initially contacted via e-mail to give a written consent to facilitate the study among their working PHNs. 13 participants were interviewed and completed the process.

Study III

Potential participants were recruited and invited to contribute as experts in the context of specialist general MHS. The potential experts were recruited via poster notices "Psychiatry for the future" in the context of the *Ups and Downs project.* The notices were put up in waiting rooms with information on the date, time and place of the interview. The Swedish Partnership for Mental Health (Nationell Samverkan för Psykisk Hälsa (NSPH)), and their sister organisation LIBRA Skåne, further facilitated the process of recruitment by providing information to their members. All potential experts who showed an interest were included in the study which had a total of 17 participants.

Study IV

Mental health service providers with experience of general psychiatry in specialist MHS were recruited for focus group discussions by a moderator (a social worker with a PhD). They were selected through purposive sampling (Palinkas et al., 2015; Patton, 2014), based on criteria including employment within one of three broader managerial sections in MHS in southern Sweden or affiliated municipalities, experience supporting individuals with complex mental health needs, or involvement in service user organisations, interest in implementing FACT, and a willingness to participate (see Table 4). Convenience sampling was also applied to enhance feasibility, as participation depended on service providers' availability and willingness to attend focus groups (Bornstein et al., 2013). This enabled the inclusion of busy professionals while ensuring valuable experiential insights. All service providers who expressed interest and attended were included (n=30). Focus groups 1 and 2 comprised members of the steering committee (n=5) and the operational working group (n=8), including senior managers from regional health authorities and municipal services, user organisation representatives, process leaders, method developers, and professionals such as psychiatrists, psychiatric nurses, and social workers. Focus groups 3 (n=7), 4 (n=5), and 5 (n=5) each represented one operational unit and reflected the composition of a multiprofessional FACT team, including registered and specialist nurses, psychiatrists, process leaders, social workers, addiction and housing specialists, and user representatives. No personal or professional affiliation data were collected, but the moderator and researcher confirmed that all the groups were multidisciplinary and represented both general psychiatry and municipal care and support for specialist services.

Data collection

A range of interview strategies has been applied in Studies I–IV, field notes in Studies II, III and IV, and memos in Study II with the aim of understanding the participants' experiential knowledge of mental health. Field notes provide a descriptive account of the overall setting in this thesis, supplying rich contextual detail to support the study (Phillippi & Lauderdale, 2018). Memos capture the researcher's reflections, comparisons, and emerging connections, while also prompting specific questions and suggesting directions for further inquiry in alignment with the constructivist grounded theory by Charmaz (2006) (Study II). Furthermore, the individual and/or dyadic interviews (Morgan et al., 2016) were in-depth interviews (Studies I–III), while Study IV utilised focus group discussions (Powell & Single, 1996).

Interviewing is one of the most used methodologies when aiming to explore subjective experiences of a phenomenon (Dicicco-Bloom & Crabtree, 2006), and in-depth interviews are particularly suited for providing a rich and nuanced understanding (Powell & Single, 1996). Respect towards the interviewee is particularly vital in qualitative interviews, where the researcher must carefully consider ethical responsibilities, such as minimising the risk of unanticipated harm, safeguarding personal information, clearly communicating the purpose of the study, and reducing the potential for exploitation (Powell & Single, 1996, Swedish Research Council, 2024).

Parts of the data for Studies II, and III were collected during the Covid-19 pandemic, which limited the possibility of conducting face-to-face interviews, i.e. physical meetings with the interviewees, due to physical restrictions. The researchers considered alternative methods when face-to-face interviews were no longer possible. The aim was to ensure the participants' integrity and anonymity in accordance with sound research ethics (Swedish Research Council, 2024) and in alignment with the approved ethical protocols for Studies II and III, while also considering how these alternative approaches affected data collection, interpersonal dynamics, and feasibility and logistics (Davies et al., 2020). Data for Study I were collected after the Covid-19 pandemic, while the society remained in a post-pandemic phase. This resulted in the interview location being transferred to a secure Zoom platform provided by the University of Lund, protected by a password and hosted on servers within the EU. The Zoom platform provides video recording, but this was deleted by the responsible interviewer at the end of each interview and only the audio was recorded. The interviewee had to actively accept being audio and video-recorded, prior to the digital interview. Digital interviewing is now considered a suitable alternative when physical meetings with the interviewee are not feasible or applicable (Boland et al., 2022).

The individual in-depth interviews for Study II were also conducted via the Zoom platform, due to geographical distance i.e., feasibility and logistics. Focus group discussions planned for Study III were changed to individual interviews and dyadic interviews due to interpersonal dynamics. Dyadic interviews incorporate elements of comparison and mutual reflection, which is also a feature of focus group interviews, but they maintain the intimacy of individual interviews, as each participant is paired with another participant and engages solely with the interviewer (Morgan et al., 2016). Focus group interviews are often chosen for their ability to foster group interaction, which can encourage participants to explore and clarify both individual and shared experiences or perceptions on sensitive and/or challenging subjects.

Three different interview guides were developed for the interviews, to either gain insight into a phenomenon (Studies I and II) or to stimulate discussion (Studies III and IV). The concept of an interview guide is referred to in the literature by various terms, as are the interview questions themselves (Kallio et al., 2016). Semi-structured interview guides were constructed by the authors of Studies I and II, while a shared guide, also developed by the two of the authors and the moderator of Studies III and IV, was used. A semi-structured interview guide is considered appropriate when the prerequisites for its use are met, i.e. particularly suitable when the focus is on subjects that are meaningful to participants, allowing for the expression of diverse experiences and views, including those that are complex or emotionally sensitive. It is also deemed suitable when exploring topics that participants may not be accustomed to discussing, such as values, intentions, and ideals related to the subject matter (Kallio et al., 2016).

The data collection took place between 2018 and 2023 (see Figure 3). The data for Studies I- IV were digitally recorded and transcribed verbatim. All data were securely stored in accordance with Lund University's guidelines for managing sensitive data, using the LUSEC platform (www.intramed.lu.se). The data collection procedures for each study will be outlined below.

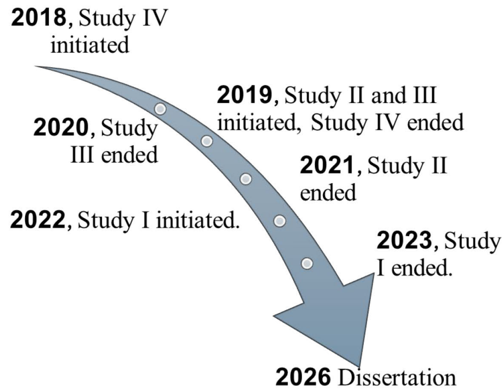

Figure 3. The outline of data collection processes of the four studies included in this thesis

Study I

All researchers applied an open attitude towards the phenomenon where previous knowledge was set aside. The description of the person is understood to be what they are presented as; their consciousness of the phenomenon was taken as its presence. This data was collected after the Covid-19 pandemic; the accumulated experience of the research group in conducting digital, individual, in-depth interviews was therefore considered most appropriate. Socio-demographic characteristics of the participants were collected to support the data analysis. The interview guide was constructed by the first author who read and reread methodology articles on phenomenology (Giorgi, 2000, 2005; Matua, 2015; Robinson & Englander, 2008) before drafting a preliminary interview guide. The guide was designed to reflect a comprehensive review of the current literature on the experience of being a patient with MHP within primary MHS. It was not pilot tested due to ethical considerations, such as respect for the first interviewee. and instead, the first interview was carefully reflected upon by the first author (EN) in collaboration with the second (LB) and third (SJ) authors. This critical discussion highlighted that the relevance of the probing questions was key to capturing the narrative of the person's lived experience (Giorgi, 2005). No additional questions were added to the interview guide. The enrolment period lasted for six months. A consensus discussion of the first interviews was conducted by all authors with a focus on being open to the phenomenon (putting our own knowledge and preunderstanding on hold).

Study II

The first author (EN) contacted operational managers in the PHC services to inform and invite them to participate in the study. The primary MHS that accepted the invitation then contacted PHNs and those who showed a positive interest in participating in the study were then approached by the first and second authors. Face-to-face interviews were initially proposed but due to the Covid-19 this was changed to digital Zoom platform interviews. The interviews all started with a standardized background narrative that was provided to introduce the participants to the field of interest. The narrative incorporated the origin of the research question, its theoretical foundation, and the first author's clinical experience. The interview guide was grounded on the MHL concept (Jorm et al., 1997) with a focus on PHNs primary, secondary, and tertiary health promotion and preventive work (Swedish Society of Nursing, 2019). The preliminary interview guide was pilot tested by the first author (EN) in interviews with two university lecturers specialising in mental health. Data collection in the framework of a constructivist grounded theory approach synergises with the initial stages of analysis involved coding, memo-writing, and the development of preliminary concepts (Charmaz, 2006). This analytical process prompted revisions to the interview guide to better capture the emerging themes and further guided the theoretical sampling.

Study III

Focus group interviews were chosen to enable interaction, consensus and dissensus, which can provide rich insights into the dynamics from several provider contexts, rather than individual interviews (Powell & Single, 1996). However, the format in Study III was adapted to individual in-depth and dyadic interviews (Morgan et al., 2016) in response to the participants' preferences and in recognition of their integrity and autonomy. The first interviews were face-to-face in safe locations, but due to the Covid-19 pandemic, they were later conducted online via Zoom platform. A moderator posed the main questions in the two dyadic interviews, allowing the participants time to reflect and discuss before moving on. A co-moderator observed the interaction and took field notes.

Study IV

Focus group interviews with mental health service providers were retained for Study IV. The participants were provided with the main question prior to the sessions and were encouraged to note down their initial reflections. The moderator invited them to elaborate on this during the discussions before proceeding to the next topic.

Additionally, two vignettes were designed to encourage participant reflection in the interviews for Studies III and IV. One represented the service user perspective

(Study III) and the other the service provider perspective (Study IV) (see Table 6). These were presented after the initial questions from the common interview guide with the aim of prompting discussions about current services.

Data analysis

Four different analytical approaches were applied in this thesis to meet the specific aims of the studies (see Table 4). Giorgi's phenomenological analysis (2005), inspired by Husserl and aligned with Martinsen's (2000) view that phenomena exist because they are experienced by participants, was applied in Study I. Meaning arises when consciousness focuses on a particular experience, shaped through participants' narratives. Martinsen further maintains that individuals must know or believe certain things to function in society, with patterns of meaning and knowledge transmitted across generations (Martinsen, 2000), thereby acknowledging a constructivist stance while advocating phenomenology to understand caring from the lived experience of patients.

A constructivist approach as described by Charmaz (2006) was applied in Studies II, and III, where researchers are part of the meaning-making process although using different qualitative methodology such as constructivist grounded theory (Study II), reflexive thematic analysis (Braun & Clarke, 2006; 2023) (Study III). This perspective acknowledges the evolving context and multiple realities, asserting that phenomena are co-constructed by participants and shaped by researchers' interpretations. An inductive approach was adhered to in Study IV and a manifest content analysis, as described by Graneheim and Lundman (2004; 2017) was utilised. This approach in phenomenology and constructivism stems from distinct epistemological traditions. Both require researchers to be reflexive, aware of their preunderstandings, and conscious of their ontological and epistemological positions throughout the analytical process (see Table 4).

To address the overall aim of the these is a thematic synthesis, inspired by Thomas and Harden (2008) was conducted. While each study had its own specific aim and methodology, synthesising the results thematically made it possible to address the overall aim by identifying common patterns across contexts, perspectives, and methods see Table 7.

Table 7. Results of Studies I–IV: Each Study is presented according to it specfic methodlodgy

Study I	Study II	Study III			Study IV		
Essence	**Core Category**	**Themes**			**Main categories**		
Desire to be embraced by health professionals	Public health nurses as relationships builder- to initiate the dialogue	Losing value and credibility as a person when becoming a service user	Navigating through the mental health maze'	Involving service users in their care and support would be empowering, holds participants	The overwhelming challenge of meeting service users' needs in fragmented care and support	Need for cohesive and holistic, contextual and collaborative care and support	Creating the conditions for sustainable, transparent and preventive mental health care and support
Constituents	**Main categories**	**Subthemes**			**Subcategories**		
To come from a place of loneliness and vulnerability	Being on your own	Being reduced to signs and symptoms of mental health problems	Being exposed to scattered islands of good services	Being valued and included as a full member of the team	Current resource allocation created feelings of frustration rather than delivering quality of care	Encountering service users in their own setting provides a holistic understanding of real-life needs	Short-term projects pose challenges when aiming for sustainable development
To sense mental health was viewed as problematic	Being on top of things- knowing your limits	Finding themselves at the bottom of the hierarchy	Receiving care in an in-and-out service and being placed in the fast lane	Being encountered in everyday life would enhance the understanding of the overall situation	"Playing it safe" increases the burden of risk management	Coordination and cooperation in and between providers can lead to cohesive care	Leaders and managers play a critical role in adapting operational activities to meet future needs
To not be in control	Professional comfort zone		The lack of resources is taking its toll	Being surrounded by a team could help to feel less abandoned and unprotected by services	Lack of human resources affects the delivery of care and support.	Professionals in interprofessional team support each other's workload and collaborate in service delivery	Enabling coordination and collaboration into practical partnerships
To feel safe.					"Individual hair salons" impede care and support from a holistic perspective		Enhancing transparency and emphasising both mental health promotion and prevention to make psychiatry more attractive
					Service users with complex mental health problems slip through the net in current care		

The first step involved free line-by-line coding of the results from the primary studies in Studies I–IV. These 'free codes' were then organised into related areas to construct descriptive themes.

The data analysis for all four studies, is described in more detail below.

Study I

The data analysis started with a thorough understanding of the spoken word, descriptions of the phenomena, by listening to the interviews to hear the tone and the timbre of the voices, to get a sense of concrete descriptions of specific situations within the natural attitude of the phenomenon, i.e., encountering PHC for their MHP. In line with Giorgi (2005), the data was transformed by the authors adopting a disciplinary attitude, which entailed a health science perspective and included a person-centred stance. This approach according to Ekman et al. (2022) is based on the perspective of the person seeking care, a person with capabilities is to be viewed as an active partner in the decisions concerning his/her own care and treatment in collaboration with professionals. The eidetic reduction was then performed, which was essential for the specific expressions used by the patients to describe the phenomenon from a health science perspective from a person-centred stance. The original meaning units, based on the spoken word of the person, were the experience-near terms that created the constituents, which were then used to manage the data. The specific constituents were identified and formed the four themes which explain the lived experience - the essence. The constituents were placed in a schematic diagram to gain an overview of the analysis. The interrelatedness of the constituents was analysed to describe the casual aspect of the specific essence. The analysis involved all authors in the search for the essence (invariant meanings), the structures of meaning that describe the general structure of the lived experiences of patients with MHP encountering PHC. The researchers aimed to understand meanings throughout the construction of the essence, which entailed a conscious act to untangle one's own perception and experienced knowledge of the phenomenon and the sense in which the phenomenon was presented (Giorgi, 2005).

Study II

The data analysis followed principles of theoretical sampling, coding, constant comparison, identification, and data saturation (Charmaz, 2006; Singh & Estefan, 2018). Insights from the early stages of analysis informed revisions to the interview guide and guided further theoretical sampling. Memos written during interviews were used to navigate the data, constructing meaning and identifying actions. These memos were clustered to explore relationships and significance. Theoretical sampling was employed to refine and respond to emerging topics from the initial coding. Codes were analysed to develop concepts, with constant comparisons used

to categorise data related to encounters with individuals experiencing MHP. The interviews were coded line-by-line using NVivo 12.2 for data organisation and storage. Initial coding was conducted by one author, while two supervisors independently coded four randomly selected transcripts to validate the process. Consensus was reached in a joint meeting. The final author analysed emerging concepts and the developing theory. A workshop was held to further explore the material and establish relationships between codes. Meaning was derived by identifying patterns, and the properties and dimensions of tentative categories were defined through relational analysis. The core and main categories were collaboratively constructed to understand how PHNs' attitudes, beliefs, and knowledge shaped their encounters with individuals with MHP.

Study III

The data analysis, which began with each interview, was familiarized by reading the transcripts several times and listening to the audio. A manifest coding was then performed separately by CT, AL and JW, UB and then EN (Braun & Clark, 2006, 2023). Similar codes formed the subthemes and then the themes were identified that corresponded to the research aim. This additional step was taken to ensure that the transcribed interviews were sufficiently accurate. Finally, the subthemes were combined into themes, which resulted in the overarching theme that corresponded to the more reflexive phase of the analysis. The authors CT, AL, JW and UB used an inductive, or bottom up, approach by identifying shared patterns of meaning within the interview transcripts. Prolonged engagement with the data was undertaken by the authors CT, AL, JW and UB. Multiple interactions discussing the data analysis were performed by CL, AL, JW, UB and EN with the aim of gaining theoretical coherence during the manifest - latent coding process. The first author (EN) then developed a draft of the results. These processes were completed multiple times throughout the analysis and the writing of the manuscript, resulting in an iterative and reflexive process for the data analysis, and ensuring the credibility and trustworthiness of the process. All the authors were responsible for identifying the final themes and subthemes. Furthermore, to ensure credibility, the first author EN performed text verification following the transcription by replaying the conversation audio files and validating them against the transcribed scripts.

Study IV

Data analysis began with the familiarisation of the data, followed by manifest coding. This iterative process started with decontextualization, meaning dividing transcripts into meaning units, which were then condensed and coded by the first author (EN). Codes were grouped by similarity and abstracted into subcategories and categories through recontextualization in alignment with Graneheim et al.

(2017). While the analysis remained close to the manifest content, latent patterns were allowed to emerge. The three authors (EN, SJ and LB) applied an inductive approach, collaboratively identifying patterns and refining categories. A final mapping of subcategories and categories was produced, with all the authors contributing to the final structure.

Trustworthiness and Rigour

To enhance the trustworthiness, this thesis adhered to Cohen and Crabtree's (2008) seven strategies. These are; *conducting ethical research, highlighting the significance of the research, maintaining clarity and coherence in the research report, employing appropriate and rigorous methods, demonstrating reflexivity and addressing researcher bias, establishing validity and credibility, and ensuring verification and reliability*.

Conducted ethical research. This thesis highlights the experiential knowledge of both individuals with MHP and mental health service providers, each with their specific ethical considerations as addressed in the section *Ethical Considerations*. No new data were generated, nor were any sensitive data handled during the writing of this thematic synthesis.

Highlighted the significance of the research. By employing a thematic synthesis inspired by Thomas and Harden (2008), the intention was to emphasise their unique contribution of experiential knowledge and thereby strengthen the evidence base grounded on experiential knowledge within the field of mental health.

Maintained clarity and coherence in the research report. The intention with and the approach in this thesis were to present each study in a logically structured manner, with clear arguments and a coherent narrative that guides the reader through the research journey. According to Harris (1987), good writing emerges when the writer and the reader intersect, initiating an interplay between writer, text, and reader. In line with this, the thesis was strengthened by the Kappa seminar, which provided external transdisciplinary perspectives and considerations that contributed to the final version.

Employed appropriate and rigorous methods. The thematic synthesis inspired by Thomas and Harden (2008) was chosen for its clear and distinctive connection between the conclusions and the texts of the primary studies (Studies I and III) and the preliminary results of Study IV. In doing so, it preserves principles that have traditionally been regarded as essential in systematic reviewing.

The methodology for each specific study was carefully chosen, not only due to the educational nature of the research journey but also to ensure that the results aligned with the study's specific aims and the overall aim of this thesis. Consequently, the

methodology was applied with rigour, striving that the research design, data collection, and analysis were robust and appropriate for the intended purpose, therefore different quality standards were applied, each selected to fit the chosen study design and methodology.

Study I was carried out in alignment with the Standards for Reporting Qualitative Research (SRQR) for supporting the quality of the reporting of the qualitative data (O'Brian et al., 2014). Studies II, III and IV were performed in accordance with the COnsolidated Criteria for REporting Qualitative research (COREQ) checklist (Tong et al., 2007). Comprehensive and detailed reporting of each research process was thus ensured. One of these was chosen because of the requirements of the scientific journal, such as SRQR in Study I, while the others were chosen based on the accumulated knowledge within the research group when conducting qualitative research. Additionally, specific quality standards were selected to validate and enhance the credibility of the results depending on the methodological approach adopted in each study. These are outlined in detail below.

- Study I, practical guidance for conducting a descriptive phenomenological nursing study was followed, based on Shorey and Ng's (2022) framework, which outlines seven key aspects: research objectives, design, theoretical framework, sampling, data collection, analysis, and presentation of results.
- Study II, the GUideline for Reporting and Evaluating Grounded Theory research studies (GUREGT) (Berthelsen et al., 2018) was used.
- Study III, the Reflexive Thematic Analysis Reporting Guidelines (RTARG) by Braun and Clarke was followed (2024).

Demonstrated reflexivity and addressed researcher bias. Active reflections were undertaken concerning positionality throughout this thesis, including our ontological and epistemological stance and the ways in which these evolved during the writing process. Our preunderstandings were also recognised and critically examined in relation to their potential influence on both the research process and its outcomes. Further details are presented in the section *Preunderstanding and Reflexivity*.

Established validity and credibility. Strategies related to pre-understanding and reflexivity were applied in this thesis to enhance the credibility of the results, thereby strengthening the validity of the studies. Ontological and epistemological positions varied according to the methodology adopted in each study, offering different perspectives on knowledge within the field of mental health and thereby reinforcing the thematic synthesis (Thomas & Harden, 2008). The exploration of different aspects of encounters in MHS across all studies is understood as socially contextual and shaped by the prior knowledge of those involved. It is therefore essential, when interpreting the results of this thematic synthesis, to consider these

factors in order to ensure the validity and credibility of the results - or to recognise any limitations thereof.

Ensured verification and reliability Measures were taken in this thesis to verify the consistency and dependability of each specific study's data, by for example, providing socio-demographics in Studies I and II, and presenting quotations in the results, thereby reinforcing the reliability of the research.

Preunderstanding and reflexivity

Reflexivity, i.e. reflecting on the relationship with participants and how it may have influenced the results, has been continuously considered throughout this thesis (Dodgson, 2019) as well as an ongoing ethical discussion within the research group. Reflexivity and preunderstandings were addressed in each study by taking deliberate steps to enhance transparency regarding the choices of study design, context, and methods. According to Dodgson (2019), a principal aspect of reflexivity is the researcher's position in relation to the participants. Contact with the participants in Studies I and II was solely for scientific motives, there was no relationship between the interviewee and the interviewer, prior to the encounter. I had no prior relations to the interviewees in Studies III and IV, while some of the co-authors had knowledge of the context and settings, due to these being feasibility studies prior to a randomised controlled trial *(ISRCTN11268588)*. By describing this power in interpersonal relationships, the transparency of this thesis is strengthened, while the authors' prior knowledge and experience of the phenomenon are made explicit.

The authors' experiences are mainly from the research field of nursing, occupational therapy, mental health, and MHS sciences as well as clinical practice. My formal background is a qualification as a PHN since 2014, and work in different settings, primarily within PHC centres and as a school nurse within primary and secondary, Swedish school health services. This includes experience-based knowledge of assessing signs and symptoms, diagnosing, planning, implementing, and evaluating nursing interventions for individuals with perceived ill health across various care settings, with a recent focus on the PHC context. One of the co-supervisors, has a professional background as an Occupational Therapist within PHC centres, experience of qualitative research methods, person-centred mental health interventions, and of being a Lecturer within the field of Occupational Therapy. Another co-supervisor is a PHN with experience of working in PHC centres, municipal healthcare, experience of qualitative research models, person-centred health interventions, and is an Associate Professor and Senior Lecturer in Nursing. The third co-supervisor is an Occupational Therapist, and Associate professor within the field of mental health. The main supervisor is a professor in mental health

and MHS research with a joint position at Lund University and MHS of Region Skåne, with previous experience of co-producing the development, evaluation and implementation of person-centred mental health interventions. Our preunderstandings and knowledge of the field was used differently depending on the analytical framework.

An open attitude was adopted in Study I, setting aside prior knowledge while remaining aware of and engaging with it when necessary, in line with Giorgi (2005). This was conceptualised in Study II as preunderstanding, whereas greater emphasis on our ontological stance as a constructivist, realist critical approach was applied in Study III (Moon & Blackman, 2014) as our different spheres of knowledge merged into a theoretical coherence.

My involvement as a doctoral student and novice researcher in Studies I and II thus differed from that in Studies III and IV. I was actively involved in the design, methodology, and data collection in the former, while these elements had already been determined and carried out by others in the latter. This consequently also influenced the reflexive stance and the relationship with the participants. The focus in Studies I and II was on avoiding influence or bias in the data during the design and methodological stages, based on our preunderstanding of the subject, as well as maintaining a critical stance towards these aspects during the analysis process. On the other hand, the focus in Studies III and IV was on understanding and interpreting the data from a critical perspective, without insight into the steps previously taken during the design and methodological stages.

Ethical considerations

The exploration of health in general and mental health in particular in this thesis requires ethical approval, as stipulated by the Swedish Ethical Review Act (SFS 2003:460). This was sought and granted for;

- Study I, Dnr: 2022-02164-0
- Study III; Dnr 2019-02866.

Research involving professionals and their experiences of delivering care and support to individuals with MHP as in Studies II and IV does not explicitly require ethical approval under the Swedish Ethical Review Act (SFS 2003:460), unless it involves sensitive personal data, physical or psychological intervention, or identifiable human biological material, which was not applicable in Studies II and IV.

All research involving human participants is guided by the ethical principles outlined in the Declaration of Helsinki (World Medical Association (WMA), 2025), and Good research ethics (Swedish Research Council, 2024) which were adopted in this thesis. Good research ethics involves the principles of *reliability*, *honesty*, *respect* and *accountability*. Taking responsibility for each specific study and for the thesis is central to the completion of this thesis and is approached from a critical standpoint. A risk-benefit analysis was carried out in relation to ethical considerations prior to Studies I and II, in alignment with the Declaration of Helsinki (WMA, 2025) and Good research ethics as outlined by the Swedish Research Council (2024). The anticipated benefit of participating in the scientific research, namely, sharing one's stories and experiences was considered to outweigh the potential risks, with particular attention given to respecting participants' integrity and autonomy. Each specific ethical consideration is described below.

Study I

This involved sensitive data related to the participants' health, and in accordance with the Swedish Act Concerning the Ethical Review of Research Involving Humans (SFS 2003:460), ethical approval was therefore obtained. The potential participants were approached through an informational advertisement for the project *In Dialogue for Mental Health* to respect the integrity and autonomy of individuals with perceived ill health. Those interested in taking part expressed their interest by completing a registration form on the project's homepage. It was deemed essential that the researcher avoided any undue influence during the initial contact with prospective participants. No personal data were stored or collected during this initial stage (www.lu.se/personuppgifter). Participants were formally included once they had signed the consent form and met the study's inclusion criteria. If the participant was assessed to need care and support for their MHP they were referred to the appropriate care level in accordance with the ethical approval.

Study II

The first author contacted operational managers within primary MHS to inform them about the study and invite their participation in respect of the participants' autonomy. Managers who accepted the invitation provided the names of employed PHNs to the first author (EN). The first (EN), second (LB), and third authors (SJ) approached the PHNs subsequently, and those who expressed interest in participating were given written information about the study and its aims in advance, together with an oral introduction prior to the interview. A brief, standardised background narrative was used to introduce participants to the field of interest. Face-to-face interviews were conducted in environments chosen by the participants,

where they felt comfortable to respect their integrity. Digital interviews were conducted after the emergence of COVID-19.

Study III

Potential experts were recruited in respect of their autonomy via poster notices titled *Psychiatry for the Future*, displayed in activity areas linked to the managerial units within the organisations implementing the FACT care and support model. These posters were placed in waiting rooms and included details about the date, time, and location of the interviews. Criterion sampling required participants to have experience of general psychiatry within specialist MHS as service users. Individuals with experiential knowledge of primary care, addiction, forensic, or psychosis-related services were excluded. The NSPH Skåne and its sister organisation Libra Balans Skåne further supported the recruitment process by sharing information with their members. No personal data were recorded during recruitment, as a shared decision was made to treat experiential knowledge independently of participants' gender, age, ethnicity, or diagnosis, focusing instead on their role as experts. All the individuals who expressed interest were included. The participants' names and contact information in Study III were revealed and used while setting up the interview (date, time and place of the interview) and then deleted and replaced with another name. The participants were provided with standardized written and oral information about the study aim, research questions and context as well as the principles of confidentiality and dissemination of research at the start of the interview. Ethical approval was obtained.

Study IV

All participation in this study was facilitated by a moderator (PhD in Social Work), in accordance with ethical considerations regarding the integrity and autonomy of potential participants. Due to the diversity of participants from both regional and municipal services, they were provided, both before and during the focus group interviews, with the interview guide and a vignette illustrating FACT from the service provider's perspective. This was used to introduce the topic and ensure that all the participants had a shared and fair foundation for the discussion. The moderator and the fourth (AL) and last author (UB) alternated in leading the focus group interviews, working closely together, and sharing ethical accountability for ensuring that all participants were listened to and heard. Meanwhile, the moderator, who took field notes, had a moral obligation to engage respectfully and attentively throughout the process. No conflict of interest existed between the participants and the researchers conducting the study.

Results

The results of overall aim in this thesis emerged one overarching theme *'The need to strengthen the culture and structures of services to address human vulnerability'*, which is grounded in three themes, 1) *Vulnerability as not being seen or having influence, 2) Current organisational structures can constrain the conditions for delivering meaningful care and support and 3) Strengthening a culture of safety and belonging through practical collaboration,* were essential. Together, they illustrate how individual experiences of vulnerability intersect with organisational constraints, while also showing how safety and belonging can be fostered through practical, collaborative approaches. The overarching theme thus captures the collective need for cultural and structural strengthening to support meaningful interpersonal engagement within services. The results for each study and its specific aim are presented in respectively Papers I-IV.

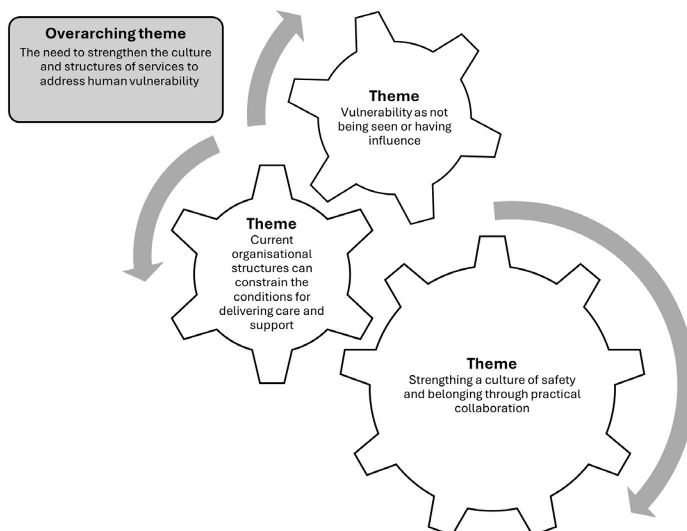

Figure 4. Results of a thematic synthesis of Studies I-IV. One overarching theme emerged: The need to strengthen the culture and structures of services to address human vulnerability. This overarching theme is described through three interdependent themes: vulnerability as not being seen or having influence; Current organisational structures can constrain the conditions for delivering meaningful care and support and Strengthening a culture of safety and belonging through practical collaboration. Each theme is essential; without all three, the necessary conditions for interpersonal relationships are absent.

The need to strengthen the culture and structures of services to address human vulnerability

The overarching theme reflects an understanding of the experiential knowledge of individuals with MHP, professionals, and mental health service providers within these services. It captures how relational, structural, and cultural dimensions interact to shape care and support experiences. This theme is grounded in three interdependent themes that together illustrate a progressive logic: 1) *Vulnerability as not being seen or having influence,* the human and relational foundation of care; *2) Current organisational structures can constrain the conditions for delivering meaningful care and support* the systematic conditions that support or hinder such relationships; *and 3) Strengthening a culture of safety and belonging through practical collaboration,* the integrative process or mechanisms through which human vulnerability and structures are strengthened. Taken together, the current organisational structure consistently portrayed services as fragmented, with the prevailing culture risking inadequate personalised care. Quality and access often depended on the professionals involved and the organisation delivering the service. This underscores the need for a more coherent approach, as navigating care was neither straightforward nor logical, creating an unsatisfactory working environment for mental health service providers. Strengthening culture and structure to address human vulnerability, where individuals and professionals feel listened to, respected, and involved in co-creating care or working practices, together with support from an interprofessional team would help reduce isolation. Consequently, the future development of services must foster safety and a sense of belonging, achieved through practical collaboration, whether structural, cultural, or within individual encounters between professionals and those in need of support. Each theme is presented below and illustrated with quotations.

Vulnerability as not being seen or having influence

The participants described experiential knowledge of participants' vulnerability in relation to both primary and specialist MHS. This included vulnerability when seeking and engaging in care, as well as the participants shared understanding regarding the organisational capacity i.e., current structure and prevailing culture to provide person-centred, recovery-oriented care and support, largely due to organisational deficiencies.

Individuals with MHP revealed their human vulnerability when describing seeking services, which was particularly challenging. Seeking services often coinciding with what they described as the lowest point in their lives. They struggled with loneliness and the exhaustion of managing symptoms alone prior to initial contact often

avoiding burdening significant others, who in some cases prompted help-seeking, while previous negative experiences and fear of encountering negative attitudes towards mental health acted as barriers. The first encounter with services was described as an initial hurdle, requiring considerable energy due to their signs and symptoms of MHP and their feelings of loneliness and isolation.

> "But no, it would have been nice if they [ed. professionals], so to speak, still have the service users' wishes in focus somewhere"
>
> Individual with MHP, Study III

Their complex needs often led to them being perceived as problematic. They sensed that the attitudes of professionals shaped the outcome of their encounters. They noted they could often sense from the outset whether a professional was open to discussing mental health, based on the latter's language and tone. These impressions influenced trust in services and sometimes discouraged help-seeking, creating feelings of doubt about professionals' motives, judgement, and treatment. Being exposed to such situations left them feeling disempowered and unable to engage actively. Professionals' attitudes contributed to feelings of not being heard and of lacking understanding of their overall situation.

> "I know I need help, even now, today. I had a severe episode of self-harming behaviour again, so I'm aware I need support, but I don't know where to turn. It feels like I don't have any options. I don't know which path to take to find the right person. It's not easy."
>
> Individual with MHP, Study I

The professionals, on the other hand, described feeling vulnerable in their role as relationship builders, lacking the necessary prerequisites to engage effectively with individuals experiencing MHP. They described managing individuals with MHP within services constrained by limited resources, structured almost like 'individual hair salons', where those with complex needs often slipped through the net. This exclusivity in current services delivery was emotionally burdensome for professionals and raised serious concerns about the wellbeing of individuals with MHP, who also experienced a clear distinction between those who received care and those who did not. PHNs within primary services expressed frustration at lacking the mandate, support, knowledge, and strategies to manage encounters effectively. They felt constrained, acting more as intermediaries than care managers. Clinical intuition was crucial when identifying individuals with MHP, supported by attentive listening, open-ended questions, guidance, referrals, and a non-judgemental attitude. Ultimately, their professional comfort zone shaped the encounter and influenced subsequent actions that followed.

> “So therefore, I can feel that is difficult to ask too many questions, because then you go too deep, and I can. I don´t feel that I can help them with any advice or so, so it is so difficult.”
>
> Professional, Study II

Efforts to improve care and support were seen as short-term projects and, therefore, lacking sustainability. All of this contributed to feelings of frustration and isolation during encounters. There was also an expectation, from society at large, from managers, and even from themselves, to resolve issues, and when this proved impossible, it sometimes resulted in staff turnover.

> “You feel like you’ve worked with someone for a long time to try and find some sort of balance, and I suppose it’s because I’m currently involved with someone in particular. I’m thinking specifically about this person, and I can see that he’s really hit rock bottom now, because we’re not quite there to meet him. And psychiatry… well, he’s turned away at the door because he’s not in such a bad state that he’s at risk of taking his own life”
>
> Mental health service provider, Study IV

Current organisational structures can constrain the conditions for delivering meaningful care and support

Professionals, mental health service providers and individuals with MHP all emphasised the need for the prerequisites to enable meaningful service delivery to inform current future care and support. While both individuals with MHP and professionals described current services as being structured around standardised protocols. Service providers further characterised these services as akin to passing through a ‘narrow eye of a needle’. Professionals noted that individuals often exaggerated symptoms to be perceived as high-risk and gain access to care, while individuals themselves described feeling compelled to do so, sometimes indicating suicidality, in order to receive support. This structure of care was described as reactive, ‘extinguishing fires’, rather than delivering health-promotive or preventive services. Providing such would require more collaborative and interprofessional conditions.

> So yes, I have a lot of knowledge, and you still end up at the individual level, because I need everyone around me to be able to raise the awareness. On as well as organizational level and... So that you feel that there is a lack of tools to, as it were, raise it up to a level and work with groups, i.e., based on public health… Yes, I have none and… I need more collaboration in some way.
>
> Professional, Study II

Individuals with MHP lacked the structural framework afforded to those with perceived physical needs, creating ethical dilemmas for PHNs and shifting focus to physical complaints. Meanwhile, specialist service providers reported growing administrative burdens that limited physical interactions and reflected on how this reduced the quality of their assessments and thereby their actions to address individual needs. Descriptions of strained resources, productivity pressures, and inequitable resource allocation emerged.

> "I wouldn't say there are any explicit demands from managers, for high productivity, but it happens automatically because there are so many people in need of our services. You simply must manage what's here in practical terms, so it becomes a matter of production just because of that. And then it's also interesting to consider the content of what we do, because when things become strained and there's no time to properly reflect, you end up solving things as they come."
>
> Mental health service provider, Study IV

Individuals with MHP described experiences of being 'ticked off a box', categorised, and sorted according to their signs and symptoms. This created feelings of being treated as less than human and often left them feeling like 'just a number'. This restricted the participants' ability to express themselves during interactions with professionals. Opportunities for mutual dialogue were limited, and they were rarely invited to share their thoughts or concerns about their health or future care. Similar experiences were reported within primary services where professionals were expected to ask about mental health, even when they appeared uncomfortable dealing with the responses.

> "When you're in crisis, I find it incredibly difficult to express what I need. These people (professionals) are supposed to be able to see what I can't put into words myself".
>
> Individual with MHP, Study III

The managers were regarded as pivotal in facilitating future developments and creating conditions for collaboration. However, they reported struggling within fragmented services, attempting to structure care and support from a holistic perspective. They emphasised the need for professionals to navigate existing constraints, promote development initiatives, and deliver care within their professional remit, while managers remained responsible for maintaining the broader perspective.

> "This collaboration cake, with all its different slices that we're supposed to piece together… everyone, everyone wants to do their best. Yes. Exactly. People want to do a good job, they want to do what's best for the individual, but then there's the issue of lack of knowledge, and what authority and mandate one has. Mmm. And then everyone goes back to their little corner and delivers, but the cake still ends up

completely uneven. I think it's such a vivid metaphor". Mmm. And that's what we're constantly struggling with."

Manager, Study IV

Strengthening a culture of safety and belonging through practical collaboration

This lack of necessary structure to enhance a culture aligned with the service providers, professionals' and individuals' preferences and wishes for service delivery was evident. Individuals with MHP emphasised the importance of being met with respect and acceptance. Trust and safety were crucial for engaging in care, supported by professionals who demonstrated knowledge, a positive attitude, and structured approaches. Feeling safe enabled participants to articulate symptoms, participate in decisions, and feel taken seriously. When professionals validated their stories into a narrative they could understand, this fostered collaboration; participants experienced comfort, hope, and relief, resulting in active partnership in care.

> "And you're invited in, I invite someone, and perhaps together we can find solutions to this. It's someone who genuinely sees it, and I believe that builds a relationship that is fundamentally different"
>
> Mental health service provider, Study IV

Early engagement was seen to instil hope, with both individuals and professionals expressing a strong desire for meaningful relationships, a proactive approach contrasting sharply with current culture. Professionals and mental health service providers stressed the need for continuous care, earlier intervention, and stronger interpersonal relationships to prevent deterioration and optimise resources.

> "It's also an extremely important task because, as we are now reducing inpatient beds, they need the opportunity to be admitted for a brief stabilisation. Perhaps we can support them there and, together with housing support and other services, respond quickly, that's really good"
>
> Mental health service provider, Study IV

Furthermore, individuals with MHP highlighted the professional's vital role, being at times their sole source of support. Being encountered by a professional who knew them and who could make informed decisions according to their wishes and needs was relieving. They felt safe, lucky, privileged, and grateful when being exposed to scattered islands of good care and support i.e., exposed to interpersonal relationships. When their vulnerability was acknowledged and respected, it was described as if a door had opened towards better health.

> "I've learnt so much on my journey, and I wish everyone with MHP could receive support and someone to talk to. Mental health problems come and go, yet no one says it's okay to feel unwell, it's always framed as a problem. Society often shapes how you feel, and in services, the focus must be on how to support these patients properly"
>
> Individual with MHP, Study I

The participants emphasised embedding this relational focus within the organisational capacity across primary and specialist MHS. One way to operational this was thru the interprofessional team. This was viewed as a means of reducing professional isolation and supporting individuals with MHP by minimising the need to repeatedly share their story, thereby addressing vulnerability. Therefore, structuring future care and support within an organised framework and through collaboration via the interprofessional team, with the individual's story as a prerequisite for decision-making, was regarded as enabling professionals to address individual needs and preferences. Although, individuals with MHP raised concerns regarding this culture transformation, as it would require a different form of professional responsibility during encounters, all the participants stressed the need to be supported through an interprofessional team. Such a team would foster continuity of care and help address power imbalances, thereby contributing to greater empowerment for all members.

> "For my part, I know that panic attacks and depression come in waves; I do not expect to recover completely. I expect life to involve pain, otherwise it would be rather dull, and you could never truly appreciate when things are good. But if it becomes so bad that you cannot manage everyday life, then you need that help"
>
> Individual with MHP, Study III

Providing delivery of services closer to the individual's environment was considered essential for enhancing existing culture. The professionals would be better positioned to understand individuals with MHP by bringing services closer to individuals' everyday lives. While some individuals expressed concerns about being visited in their homes, they emphasised the need to be valued for their expertise, with home visits viewed as a way to support this transformation. The recovery-oriented, integrated care model, such as FACT, was therefore seen as promising for safety and a sense of belonging through collaboration by positioning individuals with MHP as active members of the interprofessional team.

> "So, it's very far away from one's own reality when you go there it's not... being met in everyday life I think is very important, because it's in everyday life that you have to manage and deal with it, and you almost need to bring the support to your own home"
>
> Individual with MHP, Study III

Discussion

Methodological considerations

This thesis comprises a thematic synthesis inspired by Thomas and Harder (2008), encompassing four explorative qualitative Studies I-IV. Each Study aiming to provide an understanding of how experiential knowledge of MHS was narrated by individuals with MHP and by service providers, and their views on future development needs for services. In seeking to view the participant's world through the researcher's lens, it is essential to offer respect and, to the best of one's ability, understanding (Charmaz, 2006; Swedish Research Council, 2024). Both Martinsen (2000) and Charmaz (2006) maintain that, although professionals or researchers may strive to understand, they cannot fully grasp the thoughts and experiences of patients, service users, professionals, or mental health service providers, that is the participants in this thesis. Applying a thematic synthesis closely aligned with the results of the primary Studies I-III and the preliminary results of Study IV, may offer a basis for developing or refining new concepts and hypotheses, and for considering or confirming those already established (Thomas & Harden, 2008). As this is a compilation thesis, the number of articles included was limited, which in turn restricted the amount of data in this thematic synthesis.

Enhancing trustworthiness and rigour is a recognised approach in qualitative research (Cypress, 2017, Grossoehme, 2014; Rendle et al., 2019) and is particularly relevant given that the qualitative paradigm itself is often questioned due to the diverse interpretations of how such research should be conducted (Cohen & Crabtree, 2008; Rolfe, 2006). The methodological considerations in this thesis will be discussed in relation to each of the seven strategies for evaluating qualitative studies by Cohen and Crabtree (2008) (presented in bold).

Conducted ethical research. The specific research (Studies I–IV) in this thesis was conducted in accordance with established ethical guidelines (SFS 2003:460; Swedish Research Council, 2024; WMA, 2025). As this thesis involves individuals who, due to their MHP, may be marginalised and thus in vulnerable positions (Giebel et al., 2020; Morgan et al., 2017), special consideration needs to be given (Swedish Research Council, 2024). This can only be achieved if the researcher takes these ethical principles into account (Swedish Research Council, 2024). Ethical approval was sought and obtained for Studies I and III (see Ethical Considerations). Based on these ethical approvals, the ethical considerations will be discussed in

alignment with the concept of *Reliability,* as found in the ethical approval. It can also be reasoned with Swedish Research Council's *Good research practice* (2024), in which conducting what is considered high quality research is referred to as using appropriate design, methods, analysis, and resources in alignment. Qualitative methodology was deemed the most appropriate methodology to explore experiential knowledge, while each specific study was deemed to be strengthened by presenting this thesis as a thematic synthesis. It is argued in qualitative research that the way in which a researcher demonstrates respect for participants becomes an integral part of the data collection process and significantly influences the nature of the data gathered. This may vary depending on the ontological and epistemological perspectives adopted by the researcher (Braun & Clarke, 2022; Charmaz, 2006; Giorgi, 2005; Graneheim & Lundman, 2017). The concept of *Honesty* involves reporting and communicating research in an open, fair, complete, and objective manner. The participants were informed in writing of each specific study aim and methodology as well as verbally communicated during the data collection process. Conducting research with *Respect* applies to colleagues, research participants, society at large, and the surrounding environment. All the participants in this thesis were informed that they could withdraw from the study at any stage of the research process without further questioning. If, during interviews, participants showed signs or symptoms of illness, the interview was halted and guidance on where to seek care and support was provided by the interviewer.

Accountability encompasses the entire research process, from initial idea to publication, and includes responsibility for its broader consequences, which was applied when shifting from focus group discussion towards dyadic interviews, in respect to the participants' choice of methodology. Dyadic interview methodology is considered appropriate when it is difficult to engage participants in focus group settings, or as in the case of Study III, when focus groups become too large to facilitate meaningful interaction for the participants. Continuous efforts have thus been made throughout this thesis to ensure reliability, honesty, respect and accountability and to reflect on safeguarding the integrity and autonomy of the participants.

Highlighted the significance of the research. It is essential that individuals with MHP are given a voice (Baldwin et al., 2025; WHO, 2025), as well as service providers, with the aim that their experiential knowledge of MHS will contribute to strengthening their position in society and informing future service delivery (WHO, 2025). Therefore, I emphasise the importance of exploring their experiential knowledge matters both theoretically and practically for the development of service provision.

Maintained clarity and coherence in the research report. By following Cohen and Crabtree's (2008) guidelines for reporting qualitative research, this thesis aims to present its content in a logically structured manner, with clear arguments and a coherent narrative that guides the reader through the research journey. According to

Harris (1987), good writing emerges when the worlds of the writer and the reader intersect, initiating an interplay between writer, text, and reader.

Employed appropriate and rigorous methods. The methodology for each specific study was carefully chosen, not only due to the educational nature of the research journey but also to ensure that the results aligned with the study's specific aims and the overall aim of this thesis. Drawing on Braun and Clarke's (2024) reflections on their original methodological paper (2006), it is acknowledged that qualitative research is shaped not only by the use of reporting guidelines, such as COREQ (Studies I and IV) (Tong et al., 2007), GUREGT (Study II) (Berthelsen et al., 2018) and RTARG (Study III) (Braun & Clark, 2024) but also by disciplinary traditions and expectations. Being part of an interprofessional research group has therefore influenced the interpretive process during the data analysis. By remaining firmly grounded in each study's specific methodology, and by addressing and openly discussing our preunderstandings and prior experiences of the chosen methodological approaches, this has contributed to the rigour of the Studies. In the absence of prior experience, the review process of submitted manuscripts has also provided valuable support for underpinning our understanding of chosen methodology.

The use of qualitative quality standards in each specific study, as well as for the overall aim, demonstrates that merely applying such guidelines as a general quality checklist is insufficient (Braun & Clarke, 2024). They also emphasise the importance of recognising the diversity of theoretical assumptions underpinning qualitative research. The ontological and epistemological positions varied according to the methodology of each study as described above. The authors adopted an open stance in Study III, aligning with bounded relativism (Moon & Blackman, 2014). which holds that reality is individually constructed yet shaped by cultural and cognitive boundaries. This view resonates with Martinsen's (2000) notion of knowledge being passed across generations. The phenomenological approach adopted in this thesis reflects a subjective epistemology, in which individuals' experiences within primary MHS are regarded as real because they are lived.

Demonstrated reflexivity and addressed researcher bias. I have actively reflected on this positionality and potential preunderstandings throughout this thesis, acknowledging how these may have influenced both the research process and its results. In line with Rolfe's (2006) view that all scientific work is a form of practice best understood within real-world contexts, the results of Study II were interpreted and evaluated by the participants themselves through a process known as reinterviewing. While this approach was unique to Study II, Studies I, III and IV used investigator triangulations among the authors, a widely recognised concept in qualitative research, to add breadth to the phenomenon of interest in each study (Carter et al., 2014). As Carter et al. (2014) and Patton (1999) argue, no single method can fully address competing explanations.

My role as a doctoral student varied across the Studies. I was closely involved in the design, methodology, and data collection in Studies I and II, shaping both my reflexive stance and my relationship with participants. On the other hand, Studies III and IV were pre-designed and conducted by others, limiting my insight into earlier methodological decisions. My reflexivity was thus situation - dependent: my focus in Studies I and II was on minimising bias during design and analysis, whereas in Studies III and IV the aim was to critically interpret pre-existing data without prior involvement. I remained committed to representing the participants' experiences accurately throughout, while maintaining scientific rigour, acknowledging that my preunderstanding and position, formed by prior and ongoing knowledge, have influenced and will continue to influence the research trajectory and its questions. Interpreting interpersonal dynamics in audio-recorded interviews without being present posed additional challenges, with the risk that my interpretations might not fully reflect the participants' experiences. By being transparent in each specific study (Studies I and IV) and by providing reflections on preunderstanding and reflexivity throughout this thesis, I have sought to demonstrate how these factors may have influenced the results.

Established validity and credibility: To enhance the validity of the result in this thesis and for each specific study, each study method section is described to contribute to the validity of the thesis. Triangulation was employed in Studies I, III, and IV (Carter et al., 2014) to enhance data validation, while participant validation was used in Study II (Grossoehme, 2014), where three participants were re-interviewed to confirm the results. The results of this thesis are verified and supported by providing quotations for each theme, thereby enhancing transparency and credibility. The interviews conducted in physical meetings are still regarded as the gold standard of qualitative interviewing, offering valuable insights into a phenomenon through clear and direct responses (Krouwel et al., 2019). However, since the Covid-19 pandemic this golden standard has been altered (Boland et al., 2022). A wide range of data sources has emerged as alternatives to traditional physical face-to-face interviews in qualitative research since the emergence of online content (Davies et al., 2020). However, due to physical restrictions during the Covid-19 pandemic and the accumulated experience by the research group from that period, digital interviewing was considered appropriate and applicable, and provided *thoughtful descriptions* (Brown et al., 2025). *Thoughtful descriptions* support a deeper understanding of contextual dynamics and the multifaceted nature of phenomena, such as experiential knowledge within MHS.

To enhance the credibility of the results, this thesis employed strategies such as constructing the interview guide, vignettes and triangulation. To capture the phenomenon for each specific aim while focusing on topics meaningful to participants, it is worth considering whether the use of semi-structured interview guides in Studies I-IV enabled the expression of diverse experiences and perspectives, including those that are complex or emotionally sensitive (Kallio et

al., 2016). This approach aimed to fully reflect participants' experiences and thereby enhance the reliability and credibility of this thesis. The use of semi-structured interview guides was chosen because they are particularly suitable for exploring topics that participants may not be accustomed to discussing, such as values, intentions, and ideals related to the subject matter (Kallio et al., 2016). Furthermore, the construction of an interview guide follows specific phases, which align with the approach adopted in this thesis (Studies I-IV) when developing semi-structured interview guides. The final phase involves publishing the completed guide within the study itself (Kallio et al., 2016), a step that has been undertaken in all Studies included in this thesis.

In addition to the semi-structured interview guides, two vignettes were also employed in Studies III and IV. According to Alexander and Becker (1978), one advantage of presenting vignettes to participants during interviews is that they activate a controlled social scenario across participants, while simultaneously making the vignettes presented to feel more realistic. This was achieved by providing a vignette inspired by previously published research on the implementation of FACT. According to Murphy et al. (2021) and Tremblay et al. (2022), a vignette is regarded as a methodological technique that allows researchers to explore the varied meanings attached to ideas, scenarios, or stories without explicitly imposing their own interpretations during the interview process. It is therefore emphasised that validating the vignette is essential, including its relevance, reliability, effectiveness, completeness, familiarity, and intelligibility (Tremblay et al., 2022). The vignette was considered reliable and relevant in this study by the researchers involved in the project; however, it should ideally have been tested with participants prior to the interviews, to enhance its completeness, familiarity and intelligibility. There is a risk that providing the vignette may have favoured FACT, thereby excluding consideration of other care and support models, with recovery - oriented focus, which may have resulted in a more positive portrayal of the FACT model.

Ensured verification and reliability: Measures were taken to verify the consistency and dependability of the data and results in this thesis, thereby reinforcing the reliability of the research. These measures included: various sampling techniques, such as purposive and convenience sampling (Bornstein, 2013), and by including all potential participants who could contribute with their experience relevant to each specific study aim. Given that convenience sampling was applied, it is open to discussion whether this approach may have excluded certain potential participants, as it relied on the providers' willingness and availability to take part in focus group interviews and thereby limited the result (Bornstein, 2013; Gill, 2020). Recruitment difficulties were encountered in Study II, and it was discussed whether these challenges were linked to the PHNs' frustration, their views and attitudes towards mental health, their expressed uncertainty, and/or their lack of knowledge regarding how to identify, manage, and

promote mental health. Interviews with participants are the most characteristic method of data collection when building knowledge through a qualitative approach (Barrett & Twycross, 2018). Due to the design of Studies III and IV, no sociodemographic data were collected; however, such data were gathered for Studies I and II, providing readers some insight into the verification of this experiential knowledge to their own settings. The absence of sociodemographic information in Studies III and IV may raise questions about the verification of these results to other contexts, although some qualitative researchers argue that sociodemographic details are not essential if the study provides sufficiently *thoughtful descriptions* of the phenomenon (Brown et al., 2025).

There are also various approaches that can be adopted when describing participants in a qualitative study depending on the research design and objectives (Brown et al., 2025; Gill, 2020). This thesis is a result of 71 participants' experiences in MHS. Saturation is typically achieved in studies involving relatively homogeneous populations and narrowly defined objectives, often requiring between nine and 17 interviews or four to eight focus group discussions. Whereas in a phenomenological design the phenomenon itself is the primary focus, accurately portraying it does not require many participants (Giorgi, 2005; Grossoehme 2014). The interviews in this thesis ranged from 23 minutes to 1 hour and 39 minutes (Table 5). It is therefore suggested that providing thoughtful descriptions strengthens the validity and the credibility of this thesis (Brown et al. 2025). The emergent themes in the thematic analysis were represented across all the included Studies, supporting the validity of the results.

Discussion of the results

This thesis aimed to understand current practices and provide a foundation for future initiatives, while bridging the gap in experiential knowledge within the mental health context (WHO, 2025). The comprehensive understanding of the included data resulted in an overarching theme, *The need to strengthen the culture and structures of services to address human vulnerability*. This theme illustrates how the interplay converges around a central understanding, human vulnerability in MHS requires coherence between relational, organisational and collaborative dimensions. This result is in accordance with the foundations of person-centredness (Kristensson-Uggla, 2022, Ricouer, 1992), caring (Martinsen, 2000), recovery-oriented services (Delaney et al., 2012) and the WHO framework on integrated people-centred MHS (WHO, 2016). Furthermore, it reveals progression from the experience of vulnerability and invisibility to the structural conditions necessary for

delivering meaningful care, and finally to the process of collaboration to foster safety and belonging.

Drawing on person-centredness and caring stance underpinning this thesis, the discussion will commence with the human conditions of care and support. Considered both from the perspective of individuals in need of care and from that of those working to support people with MHP. This introduces the first theme describing human *vulnerability as not being seen or having influence* highlights the human and ethical condition of care.

The prevailing culture and structure within services resulted in experiential knowledge characterised by vulnerability. For individuals with MHP, this vulnerability is situated within the distinction between perceived health and health problems (Rogers, 1997). While professionals expressed feelings of frustration and isolation, describing their vulnerability primarily from ethical and environmental perspectives, both groups revealed an organisational culture that reinforced their shared human vulnerability. When discussing mental health and vulnerability, loneliness emerges as a notion closely intertwined with both (Erdner et al., 2005), reflecting the complexity of experiences associated with it (Mansfield et al., 2021).

The reported feelings of loneliness by individuals with MHP was reinforced when combined with experiences in MHS of being cared for in inhuman ways as described in the result. Their loneliness could be interpreted as both social and existential, while social loneliness stems from dissatisfaction with relationships and a gap between actual and desired social contact. Existential loneliness, however, refers to a sense of isolation, often arising during serious illness, trauma, or when confronting mortality (Mansfield et al., 2021), as may be the case for those with MHP seeking care and support for their MHP. The vulnerability of individual's with MHP was also described as stemming from their signs and symptoms of MHP, which contributed to a diminished ability to clearly communicate their needs and preferences. Garnow et al. (2024) suggest that vulnerability can function as self-protection when sharing personal experiences. Similarly, a limited understanding of their existential loneliness and their difficulty to fully express themselves made seeking support more difficult. Their experiential knowledge of encountering stigma or professionals' uncertainty about how to support individuals with MHP, whether in primary or specialist services, also contributed to resistance in seeking care, which can be interpreted as self-preservation.

The service providers experienced a mismatch between the needs for service provision among individuals with MHP and the capacity of professionals and mental health service providers to deliver meaningful care and support within a constrained organisational context in alignment with policies of person-centred and recovery-oriented services (Bejerholm et al., 2022; WHO, 2008; 2025). They lacked the necessary structure and knowledge to manage the encounter with individuals with MHP.

It is thus vital to create a caring stance within MHS in accordance with Martinsen (2000) that involves cultivating a relational and ethical practice grounded in empathy, presence, and an understanding of the other's experiential knowledge. The vulnerability of individuals with MHP can serve as a foundation for trust and collaboration. However, this proved difficult to foster and professionals expressed a need for future initiatives to strengthen their capacity by providing the necessary prerequisites.

The influence of current structure on encounters in mental health services

While vulnerability forms the interpersonal foundation of care and support, the results also point to the organisational structural conditions required to transform vulnerability into meaningful encounters. This corresponds to the second theme; *Current organisational structures can constrain the conditions for delivering meaningful care and support.* It is therefore argued that the vulnerability experienced by individuals with MHP, as well as by professionals and service providers, could be alleviated by ensuring organisational and structural conditions that foster a sense of meaningfulness. Vulnerability also influenced the working environment and affected professionals' ability to be included in future areas of development. Current short-term projects were perceived as linked to personal attributes, excluding some professionals and creating feelings of unfairness and reduced resilience. At the same time, they faced situations where they could not provide care as trained. The experiential knowledge in MHS portrays the current organisational structure as a 'narrow eye of a needle', through which only a few individuals with MHP can access care and support. This created feelings of frustration and isolation among both individuals with MHP and service providers. Thibault (2019) maintains that medicine has drifted from its ethical commitment to prioritising individual well-being, leading to the dehumanisation of healthcare. However, it can be argued that professionals continue to advocate an idealistic vision of the Swedish public sector and its capacity to create social and economic justice (Selberg & Mulinari, 2022a). The consequences of the gap between organisational capacity and theory creates a professional practice with ethical dilemmas (Abelsson et al., 2024). In addition, most Swedish healthcare policies lack descriptions on practical implications for service providers, leaving them in an ethical void (Falkenström & Höglund (2023).

As described by Nussbaum (2013) in a society's ability to support individuals with MHP in achieving everyday functioning, physical health, and practical reason. In this vision of social justice, the interpersonal relationship is positioned as the centre of the organisation (Nussbaum, 2013; Selberg & Mulinari, 2022a). However, it can be discussed if current market values position the economics efficiently rather than care at the centre of the organisation as also outlined by the results. Moreover, Thibault (2019) also views market values as a contributing factor of current medical practice. The growing influence of business and finance, the fragmentation of

experiential knowledge, reduced time for clinical encounters, reliance on technology over human interaction, and a declining emphasis on the humanities in medical education influences the delivery of services to a great extent. Moreover, professionals linked the present organisational structure on the current economic strain on services, shortages of in-patient beds which resulted in ethical and moral dimensions into the encounter and reinforcing the prevailing culture within services. However, service capacity and organisational structures vary across regions and services (Ashcroft et al., 2021; NBHW, 2025a), and delivery differs by age group (NBHW, 2025a; Ulfarsson et al., 2025). Rosen et al. (2020) argue that the shortages of inpatient beds should not be seen as opposing outreach or community care; instead, all MHS should be community-centred and integrated.

Furthermore, the result also revealed concerns regarding the shortages and the lack of trained professionals influencing the interpersonal relationships for the individual with MHP and the working conditions for the professionals and service providers. Shortage of professionals is a considerable challenge within healthcare (NBHW, 2023; Selberg & Mulinari, 2022b), and particularly within MHS (Adams et al., 2021; Ballout, 2025). Evidence suggests that nurses in these settings encounter unique factors in their everyday work that influence their turnover rates (Adams et al., 2021; Comparcini et al., 2025), while organisational culture more broadly plays a key role in professional retention (Long et al., 2023). Furthermore, professionals', in alignment with the results, emphasise the importance of maintaining a reliable task burden and staff levels to facilitate high quality care and support (Long et al., 2023; Selberg & Mulinari, 2022b). Investing in professional training, future initiatives, and protected supervision enables professionals to feel valued and better equipped to deliver "good" care and support. When organisational policies and practices are informed by and congruent with professional values, and prioritise individuals with MHP well-being, employees feel valued and supported (Gustavsson et al., 2025; Long et al., 2023; Selberg & Mulinari, 2022b), which may support retention.

The managers described their vulnerability as inherent to their role, emphasising the need for professionals to navigate existing constraints, promote development initiatives, and support the delivery of care within their professional responsibility. Doernberg and Truog (2023) acknowledge these ongoing influences on everyday professional practice, however they also emphasise the evolving role of morality. This shift requires professionals to reflect on their ethical stance and adapt their actions according to the intended outcomes of their work.

Managers vital role in setting the standards for the delivery of person-centred and recovery-oriented services

The organisational dimension of care was closely linked to leadership and management capacity. Supporting managers to facilitate recovery-oriented and person-centred MHS is essential for creating the conditions that enable

collaboration and belonging, the focus of the final theme *Strengthening a culture of safety and belonging through practical collaboration.* The results highlight the need to adapt the intervention to equip managers with the necessary tools for implementing a recovery-oriented, integrated model of care and support, FACT within specialist general MHS. Organisational capacity and management play a crucial role in the successful implementation of recovery-oriented practices (Lorien et al., 2020). Preparing managers during the implementation phase is essential, given their pivotal role (Birken et al., 2018). Managers must align with its core values when embedding person-centredness (Santana et al., 2018). This was also emphasised by individuals with MHP who emphasised the importance of creating conditions that enable professionals to support and guide individuals within person-centred and recovery-oriented services (Gustavsson et al., 2025; Lorien et al., 2020; Menear et al., 2024), thereby fostering strong interpersonal relationships.

Person-centred leaderships involve an interconnected process (Cardiff et al., 2018, which manifests across situations, varying in timing, configuration and intensity. The managers' engagement generates insights, enabling them to position themselves in relation to others (stancing), while the creation of safe and critical learning spaces supports the development of shared vision and goals. Transformational and distributed leadership among managers in recovery-oriented services is emphasised, recognising and accepting that managers differ, and will develop and apply varying leadership styles and capacities, which evolve over time and across different circumstances (Cleary et al. 2017). Both leadership approaches promote responsiveness to the need of the individual at the centre of care and support (Cardiff et al., 2018; Cleary et al., 2017). However, these results indicate a lack of skills and tools to support this process. Their experiential knowledge of being managers during development processes consisted of a lack of shared language, despite recognising its importance. One way to address this is to incorporate experiential knowledge at all stages of future initiatives, in alignment with the concept of co-creation, when designing interventions to inform subsequent developments (Vargas et al., 2022).

It is essential to support managers to encourage both individuals with MHP and professionals to engage in service design. Furthermore, both service providers and professionals, need to be aware of human vulnerability and its relevance, either personal or environmental in nature when working to provide care and support for vulnerable groups with society such as people with perceived illness. It is therefore crucial to consider the professionals' MHL and experiential knowledge to promote equality and strengthen the capabilities when shaping future primary and specialist MHS.

Strengthening culture and supporting individuals' sense of safety and belonging

MHL among service providers is shaped by workplace culture but may increase through direct exposure to individuals with MHP or personal experience

(Mårtensson et al., 2014). Being labelled as a service user having complex MHP can widen the gap between self-perception and ideal self-image (Erdner et al., 2005). Individuals with MHP thus emphasised the importance of recognising them as humans. Recognising individuals with MHP as capable in alignment with person-centred ethics (Kristensson-Uggla, 2022) and embedding their experiential knowledge, enables reflections on expertise within healthcare services (Hultman & Hultman, 2023; Okoroji et al., 2023). Conversely, as outlined by the results, actively involving individuals with MHP in decision-making and providing care in their own environments can significantly improve outcomes and enhance service providers' understanding, thereby strengthening the individuals' sense of being understood.

Implementing integrated care and support models, such as FACT, facilitates interpersonal relationships by focusing on personal recovery (Borgh et al., 2024), grounded in the CHIME framework by Leamy et al. (2011). Enabling hope and fostering a sense that improvement is possible is fundamental and occurs within professional encounters that nurture such relationships (Martinsen et al., 2000; Murphy et al., 2023). By promoting dialogue about mental health for individuals with MHP, the results indicate that by involving the individual with MHP could serve as a means of enhancing social support for people with MHP. Being valued for their expertise and included in services, from which individuals with MHP previously felt excluded from, and forming interpersonal relationships on their own terms, is essential for those experiencing vulnerability (Erdner et al., 2005). By being exposed to "small things", such as experiences of encounters with the "right person", is portrayed by Topor et al. (2018) as supporting the person's recovery process and the rebuilding of their sense of self. However, 'small things' are the core in the tradition of caring (Martinsen, 2000). Its relational and ethical dimensions cannot be reduced to small things; it is an acknowledged scientific field, grounded in love for the other, and should therefore be recognised as such (Martinsen, 2000). Implementing FACT grounded in caring from person-centredness stance could thus foster both collaboration and recovery-oriented services and create conditions for person-centredness.

Person-centred interventions have proven to be cost saving (Kebede et al., 2025) and improve health outcomes (Alsén et al., 2025; Cederberg et al., 2022; Kebede et al., 2025) compared with usual service provision. However, person-centredness could increase financial costs and the risk of excluding certain groups (Summer Meranius et al., 2020). Those with stronger voices may dominate, while individuals with MHP or those unwilling to participate in decisions may be disadvantaged. It is therefore important that managers of services establish the conditions that enable professionals to deliver interpersonal relationships grounded in the person-centred ethics within recovery-oriented services in alignment with the EBP model (Melnyk et al., 2010). A framework grounded in Ekman's model of person-centred care (Gabrielsson & Looi, 2019) was applied in a Swedish general emergency department. This framework emphasised the importance of active listening,

providing holistic care, and looking beyond psychiatric diagnoses to support the transition towards person-centred care (Derblom et al., 2021; Derblom et al., 2025).

Implementing FACT, was considered preferable by individuals in need of these services, as well as by professionals and service providers, compared to the current provision of care and support. However, individuals with MHP questioned whether this would be sufficient to support the transition towards equality in services, given the prevailing organisational culture.

This underscores the importance of validating experiential knowledge and balancing power imbalances among all parties when adapting person-centred, recovery-oriented, and integrated services. Person-centredness within interprofessional teams have proven to be vital for individuals at risk of suicidality (Rex et al., 2025). It is therefore argued that the experiential knowledge revealed in this thesis strengthens future initiatives by emphasising the importance of co-creative processes that integrate individuals, professionals, and systems (Skivington et al., 2021; Vargas et al., 2022). This form of collaboration emerges as the mechanism that transforms vulnerability and structural constraints into safety, a sense of belonging, and supports meaningful encounters and care (Bejerholm et al., submitted). The human need for belonging and social connectedness is a well-established protective factor against both the signs and symptoms of MHP (Baumeister & Leary, 1995; Wickramaratne et al., 2022).

This thesis highlights how primary and specialist MHS often fail to support individuals with MHP in achieving everyday functioning, physical health, and practical reason, as outlined by Nussbaum (2013), and proposes an alternative approach to restructuring care, which emphasises the importance of interpersonal relationships. It contributes scientifically by advocating the promotion of equity and equality in mental health for both individuals with MHP and service providers (Newbigging & Ridley, 2018). Extending Rogers' (1997) call for broader knowledge, it incorporates experiential insights from those receiving and delivering care. Services should offer welcoming, respectful environments that safeguard integrity, anonymity, and safety for all. Aligning care with professionals' ideals and individuals' needs may reduce moral distress and improve professionals' retention (Gustavsson et al., 2025). Integrating experiential knowledge into person-centred, recovery-oriented care and support models within future service development is essential for enhancing EBP (Melnyk et al., 2010).

Conclusion and clinical implications

The overall aim of this thesis was to understand the experiential knowledge of individuals who require care and support for their MHP, as well as that of the mental health service providers who deliver such care and support within primary and

specialist MHS. This aim has been achieved through a thematic synthesis of the results of Studies I-IV.

Study I explored the lived experience of encounters with primary health care of a person with MHP, which was marked in their everyday lives by continual challenges and a persistent uncertainty about whether services would provide the support they needed.

Study II constructed a theory that explained the process PHN experience when encountering people with MHPs, based on their MHL, which was a personal and complex decision-making process that depended on their professional comfort zone and acquired MHL.

Study III explored service users' experiences of their current MHS and their reflections on the FACT model and its role in future practice, they emphasized a call for greater collaboration to empower and provide inclusive tailored care and support, which they stressed as essential for the future of MHS.

Study IV explored mental health service providers' experiences of current general psychiatry in specialist MHS, and their views on what is needed for the implementation of a recovery-oriented and integrated care and support model, FACT, in which they described current services as overwhelming when attempting to deliver care tailored to service users' needs.

Taken together, the synthesis of results underscores human vulnerability as central to meaningful mental health care. This vulnerability is evident in the experiences of both individuals living with MHP and the service providers who support them, and it shapes how care is offered, received, and interpreted. Strengthening the structures and culture of services therefore calls for more than organisational reform; it also requires relational attentiveness and moral awareness across all those involved. On this basis, the thesis advances a relational framework for understanding and improving mental health services, grounded in insights from both individuals with MHP and service providers.

The clinical implications extend beyond questions of service organisation to the ethical and relational foundations of everyday practice. By bringing together individuals with MHP and professional perspectives, highlights mental health services as a human practice shaped by vulnerability, interdependence, and responsibility. This framing supports service development that prioritises ethically informed relationships, aligning with person-centred, recovery-oriented, and integrated models of care and support.

- Experiential knowledge reveals addressing human vulnerability as central to mental health care, shared by both those seeking support and mental health service providers, and essential for understanding how care is experienced and delivered

- Meaningful mental health services depend not only on organisational structures but also on relational and cultural conditions, highlighting the importance of trust, and moral and ethical awareness in everyday care practices
- Strengthening mental health services requires the integration of experiential knowledge in order to develop care and support that are relationally grounded, responsive to experience-based knowledge, and aligned with person-centred and recovery-oriented principles

Implications for future research

Although the aim of this thesis was to bridge the gap in experiential knowledge within the mental health field, further research is required. There is a need to examine and understand more fully how the implementation of FACT influences prevailing organisational culture; specifically, how the requirements of person-centred ethics, a caring stance, and recovery orientation shape professional boundaries, and how this may promote social justice for individuals with MHP within MHS.

In addition, models for integrated, recovery-oriented care and support must embed person-centredness in order to address the human vulnerability highlighted in the results. Further knowledge is also required to develop and strengthen the role of PHN within primary services for individuals with MHP, drawing on their health-promoting and disease-preventive expertise. This must be understood in light of the expressed need among individuals with MHP to be met with from person-centred, caring stance and to be offered EBP, principles that form the foundation of nursing and constitute the core professional responsibility of both RN and PHN.

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References

Aarons, G. A., Hurlburt, M., & Horwitz, S. M. (2011). Advancing a conceptual model of evidence-based practice implementation in public service sectors. *Administration and Policy Mental Health*, 38(1), 4–23. https://doi.org/10.1007/s10488-010-0327-7

Abelsson, T., Karlsson, A.-K., Morténius, H., Baigi, A., & Bergman, S. (2024). The dilemma of the split between theory and reality as experienced by primary healthcare professionals: a mixed methods study of evidence-based practice in a primary care context. *BMC Primary Care*, *25*(1), 13. https://doi.org/10.1186/s12875-023-02237-9

Aberg-Wistedt, A., Cressell, T., Lidberg, Y., Liljenberg, B., & Osby, U. (1995). Two-year outcome of team-based intensive case management for patients with schizophrenia. *Psychiatric Services*, *46*(12), 1263–1266. https://doi.org/10.1176/ps.46.12.1263

Adams, R., Ryan, T., & Wood, E. (2021). Understanding the factors that affect retention within the mental health nursing workforce: a systematic review and thematic synthesis. *International Journal of Mental Health Nursing*, 30(6), 1476–1497. https://doi.org/10.1111/inm.12904

Ahuvia, I. L., Sotomayor, I., Kwong, K., Lam, F. W., Mirza, A., & Schleider, J. L. (2024). Causal beliefs about mental illness: A scoping review. Social Science and Medicine, 345, 116670. https://doi.org/10.1016/j.socscimed.2024.116670

Alexander, C. S., & Becker, H. J. (1978). The Use of Vignettes in Survey Research. *The Public Opinion Quarterly*, *42*(1), 93–104.

Allerby, K., Gremyr, A., Ali, L., Waern, M., & Goulding, A. (2023). Increasing person-centeredness in psychosis inpatient care: care consumption before and after a person-centered care intervention. *Nordic journal of psychiatry*, *77*(6), 600–607. https://doi.org/10.1080/08039488.2023.2199726

Alsén, S., Cederberg, M., & Fors, A. (2025). A person-centred care intervention provided via eHealth to reduce fatigue in patients with common mental disorders - secondary outcome analysis from a randomized controlled trial. *Scandinavian journal of primary health care*, 1–10. Advance online publication. https://doi.org/10.1080/02813432.2025.2533997

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, *16*(4), 11–23. https://doi.org/10.1037/h0095655

Arvidsdotter, T., Marklund, B., Kylén, S., Taft, C., & Ekman, I. (2016). Understanding persons with psychological distress in primary health care. *Scandinavian Journal of Caring Sciences*, *30*(4), 687–694. https://doi.org/10.1111/scs.12289

Ashcroft, R., Menear, M., Silveira, J., Dahrouge, S., Emode, M., Booton, J., & McKenzie, K. (2021). Inequities in the delivery of mental health care: a grounded theory study of the policy context of primary care. *International Journal of Equity and Health*, *20*(1), 144. https://doi.org/10.1186/s12939-021-01492-5

Baldwin, H., Greenburgh, A., Weir, H., Asif, Z., Laporte, D., Bertram, M., Crawford, A., Duberry, G., Lauter, S., Lloyd-Evans, B., Lovelock, C., Das-Munshi, J., & Morgan, C. (2025). Targeted interventions to improve the social and economic circumstances of people with mental ill-health from marginalised communities: a systematic review. *Psychological medicine*, *55*, e217. https://doi.org/10.1017/S0033291725101128

Ballard, C., Corbett, A., Orrell, M., Williams, G., Moniz-Cook, E., Romeo, R., Woods, B., Garrod, L., Testad, I., Woodward-Carlton, B., Wenborn, J., Knapp, M., & Fossey, J. (2018). Impact of person-centred care training and person-centred activities on quality of life, agitation, and antipsychotic use in people with dementia living in nursing homes: A cluster-randomised controlled trial. *PLoS medicine*, *15*(2), e1002500. https://doi.org/10.1371/journal.pmed.1002500

Ballout, S. (2025). Trauma, Mental Health Workforce Shortages, and Health Equity: A Crisis in Public Health. *International journal of environmental research and public health*, *22*(4), 620. https://doi.org/10.3390/ijerph22040620

Barrett, D., & Twycross, A. (2018). Data collection in qualitative research. *Evidence Based Nursing*, *21*(3), 63–64. https://doi.org/10.1136/eb-2018-102939

Baumeister, R. F., & Leary, M. R. (1995). The need to belong: desire for interpersonal attachments as a fundamental human motivation. *Psychological bulletin*, *117*(3), 497–529.

Baxter, S., Johnson, M., Chambers, D., Sutton, A., Goyder, E., & Booth, A. (2018). The effects of integrated care: a systematic review of UK and international evidence. *BMC Health Service Research*, *18*(1), 350. https://doi.org/10.1186/s12913-018-3161-3

Beacham, A. O., Herbst, A., Streitwieser, T., Scheu, E., & Sieber, W. J. (2012). Primary care medical provider attitudes regarding mental health and behavioral medicine in integrated and non-integrated primary care practice settings. *Journal of clinical psychology in medical settings*, *19*(4), 364–375. https://doi.org/10.1007/s10880-011-9283-y

Bejerholm U, Allaskog C, Andersson J, Nordström L, Roe D (2022). Implementation of the Recovery Guide in inpatient mental health services in Sweden-A process evaluation study. *Health Expectations.*25(4): 1405–1417. doi: 10.1111/hex.13480

Bejerholm, U., Areberg, C., Hofgren, C., Sandlund, M., & Rinaldi, M. (2015). Individual placement and support in Sweden - a randomized controlled trial. *Nordic journal of psychiatry*, *69*(1), 57–66. https://doi.org/10.3109/08039488.2014.929739

Bejerholm, U., & Roe, D. (2018). Personal recovery within positive psychiatry. *Nordic Journal of Psychiatry*, *72*(6), 420–430. https://doi.org/10.1080/08039488.2018.1492015

Bejerholm U, Westling S, Lindqvist D, Argentzell E, Lexén A, Knutagård M. Building care in the heart of the moment – Exploring the process of collaboration for the making of Flexible Assertive Community Treatment (forthcoming)

Benton, D., & Shaffer, F. (2016). How the nursing profession can contribute to sustainable development goals. *Nursing Management (Harrow)*, *23*(7), 29–34

Bergmark, M., Bejerholm, U., Svensson, B., & Markström, U. (2018). Complex Interventions and Interorganisational Relationships: Examining Core Implementation Components of Assertive Community Treatment. *International journal of integrated care*, *18*(4), 11. https://doi.org/10.5334/ijic.3547

Berthelsen, C., S. Grimshaw-Aagaard, and C. Hansen. 2018. Developing a Guideline for Reporting and Evaluating Grounded Theory Research Studies (GUREGT). *International Journal of Health Sciences* 6, 1: 64–76. https://doi.org/10.15640/ijhs.v6n1a8.

Bhowmick, A., van der Zande, M. M., & Harris, R. (2025). Knowledge-seeking and knowledge sharing of health services across social networks and communities: a scoping review. *BMC Health Service Research*, *25*(1), 443. https://doi.org/10.1186/s12913-025-12525-y

Biringer, E., Davidson, L., Sundfør, B., Ruud, T., & Borg, M. (2017). Service users' expectations of treatment and support at the Community Mental Health Centre in their recovery. *Scandinavian Journal of Caring Sciences*, *31*(3), 505–513. https://doi.org/10.1111/scs.12364

Birken, S., Clary, A., Tabriz, A. A., Turner, K., Meza, R., Zizzi, A., Larson, M., Walker, J., & Charns, M. (2018). Middle managers' role in implementing evidence-based practices in healthcare: a systematic review. *Implementation Sciences*, *13*(1), 149. https://doi.org/10.1186/s13012-018-0843-5

Björkman, A., Andersson, K., Bergström, J., & Salzmann-Erikson, M. (2018). Increased Mental Illness and the Challenges This Brings for District Nurses in Primary Care Settings. *Issues Mental Health Nursing*, *39*(12), 1023–1030. https://doi.org/10.1080/01612840.2018.1522399

Björkman, A., & Salzmann-Erikson, M. (2018). When all other doors are closed: Telenurses' experiences of encountering care seekers with mental illnesses. *International Journal of Mental Health Nursing*, *27*(5), 1392–1400. https://doi.org/10.1111/inm.12438

Blay, N., & Roche, M. A. (2020). A systematic review of activities undertaken by the unregulated Nursing Assistant. *Journal of advanced nursing*, *76*(7), 1538–1551. https://doi.org/10.1111/jan.14354

Bloodworth, A. (2006), Nussbaum's 'Capabilites Approach'. *Nursing Philosophy*, 7: 58-60. https://doi.org/10.1111/j.1466-769X.2006.00240.x

Boland, J., Banks, S., Krabbe, R., Lawrence, S., Murray, T., Henning, T., & Vandenberg, M. (2022). A COVID-19-era rapid review: using Zoom and Skype for qualitative group research. *Public health research & practice*, *32*(2), 31232112. https://doi.org/10.17061/phrp31232112

Bombard, Y., Baker, G. R., Orlando, E., Fancott, C., Bhatia, P., Casalino, S., Onate, K., Denis, J. L., & Pomey, M. P. (2018). Engaging patients to improve quality of care: a systematic review. *Implementation Sciences*, *13*(1), 98. https://doi.org/10.1186/s13012-018-0784-z

Bond, G. R., & Drake, R. E. (2015). The critical ingredients of assertive community treatment. *World Psychiatry*, *14*(2), 240–242. https://doi.org/10.1002/wps.20234

Borgh, M., Bejerholm, U., Argentzell, E., & Lexén, A. (2024). 'It's like someone is holding your hand, an invisible hand': A grounded theory study of participation and personal recovery in Flexible Assertive Community Treatment. *Scandinavian Journal of Occupational Therapy*, *31*(1), 2421363. https://doi.org/10.1080/11038128.2024.2421363

Borkman, T. (1976). Experiential Knowledge: A New Concept for the Analysis of Self-Help Groups. *Social Service Review*, *50*(3), 445–456.

Bornstein, M. H., Jager, J., & Putnick, D. L. (2013). Sampling in Developmental Science: Situations, Shortcomings, Solutions, and Standards. *Development Review*, *33*(4), 357–370. https://doi.org/10.1016/j.dr.2013.08.003

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2023). Toward good practice in thematic analysis: Avoiding common problems and be(com)ing a knowing researcher. *International Journal of Transgender Health*, *24*(1), 1-6. https://doi.org/10.1080/26895269.2022.2129597

Braun, V., & Clarke, V. (2024). Supporting best practice in reflexive thematic analysis reporting in palliative medicine: A review of published research and introduction to the Reflexive Thematic Analysis Reporting Guidelines (RTARG). *Palliative Medicine*, *38*(6), 608-616. https://doi.org/10.1177/02692163241234800

Bristow, K., Edwards, S., Funnel, E., Fisher, L., Gask, L., Dowrick, C., & Chew Graham, C. (2011). Help Seeking and Access to Primary Care for People from "Hard-to-Reach" Groups with Common Mental Health Problems. *International journal of family medicine*, *2011*, 490634. https://doi.org/10.1155/2011/490634

Britten, N., Ekman, I., Naldemirci, Ö., Javinger, M., Hedman, H., & Wolf, A. (2020). Learning from Gothenburg model of person-centred healthcare. *BMJ (Clinical research ed.)*, *370*, m2738. https://doi.org/10.1136/bmj.m2738

Broom, J., & Broom, A. (2024). Qualitative research methods: powerful tools for understanding practice and informing change. *Journal of Hospital Infection*, *149*, 182–183. https://doi.org/10.1016/j.jhin.2024.02.031

Brown, M. E. L., Stalmeijer, R. E., & O'Brien, B. C. (2025). Transferability in three dimensions (3D): applicability, theoretical engagement, and resonance. *Advance Health Science Education Theory Practice*. https://doi.org/10.1007/s10459-025-10439-2

Bryant, E. A., Scott, A. M., Greenwood, H., & Thomas, R. (2022). Patient and public involvement in the development of clinical practice guidelines: a scoping review. *BMJ Open*, *12*(9), e055428. https://doi.org/10.1136/bmjopen-2021-055428

Burke, M. (2014). Modelling district nurse expertise. *British Journal of Community Nursing*, *19*(12), 608–611. https://doi.org/10.12968/bjcn.2014.19.12.608

Burns, T. (2010). The rise and fall of assertive community treatment? *International Review Psychiatry*, *22*(2), 130–137. https://doi.org/10.3109/09540261003661841

Burns, T., Fioritti, A., Holloway, F., Malm, U., & Rössler, W. (2001). Case management and assertive community treatment in Europe. *Psychiatry Service*, *52*(5), 631–636. https://doi.org/10.1176/appi.ps.52.5.631

Cardiff, S., McCormack, B., & McCance, T. (2018). Person-centred leadership: A relational approach to leadership derived through action research. *Journal of Clinical Nursing*, *27*(15-16), 3056–3069. https://doi.org/10.1111/jocn.14492

Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J., & Neville, A. J. (2014). The use of triangulation in qualitative research. *Oncology Nursing Forum*, *41*(5), 545–547. https://doi.org/10.1188/14.Onf.545-547

Casey, P. J. (2023). Lived Experience: Defined and Critiqued. *Critical Horizons*, *24*(3), 282–297. https://doi.org/10.1080/14409917.2023.2241058

Castro, E. M., Van Regenmortel, T., Sermeus, W., & Vanhaecht, K. (2019). Patients' experiential knowledge and expertise in health care: A hybrid concept analysis. *Social Theory & Health*, *17*(3), 307–330. https://doi.org/10.1057/s41285-018-0081-6

Cederberg, M., Alsén, S., Ali, L., Ekman, I., Glise, K., Jonsdottir, I. H., Gyllensten, H., Swedberg, K., & Fors, A. (2022). Effects of a Person-Centered eHealth Intervention for Patients on Sick Leave Due to Common Mental Disorders (PROMISE Study): Open Randomized Controlled Trial. *JMIR mental health*, *9*(3), e30966. https://doi.org/10.2196/30966

Charmaz, K. (2006). *Constructing Grounded Theory. A practical guide trough qualitative qnalysis.* 1 ed. London. SAGE publications.

Cerimele, J. M., Ratzliff, A., & Sexton, J. M. (2015). Collaborative care for a patient with bipolar disorder in primary care: a case example. *General hospital psychiatry*, *37*(2), 144–146. https://doi.org/10.1016/j.genhosppsych.2014.11.004

Chatwiriyaphong, R., Moxham, L., Bosworth, R., & Kinghorn, G. (2024). The experience of healthcare professionals implementing recovery-oriented practice in mental health inpatient units: A qualitative evidence synthesis. *Journal of Psychiatry Mental Health Nursing*, *31*(3), 287–302. https://doi.org/10.1111/jpm.12985

Cleary, M., Lees, D., Molloy, L., Escott, P., & Sayers, J. (2017). Recovery-oriented Care and Leadership in Mental Health Nursing. *Issues Mental Health Nursing*, *38*(5), 458–460.

Clemens, V., Deschamps, P., Fegert, J. M., Anagnostopoulos, D., Bailey, S., Doyle, M., Eliez, S., Hansen, A. S., Hebebrand, J., Hillegers, M., Jacobs, B., Karwautz, A., Kiss, E., Kotsis, K., Kumperscak, H. G., Pejovic-Milovancevic, M., Christensen, A. M. R., Raynaud, J.-P., Westerinen, H., & Visnapuu-Bernadt, P. (2020). Potential effects of "social" distancing measures and school lockdown on child and adolescent mental health. *European Child & Adolescent Psychiatry*, *29*(6), 739–742. https://doi.org/10.1007/s00787-020-01549-w

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Morgan, C., Rüsch, N., Brown, J. S., & Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychology Medicine*, *45*(1), 11–27. https://doi.org/10.1017/s0033291714000129

Cohen, D. J., & Crabtree, B. F. (2008). Evaluative criteria for qualitative research in health care: controversies and recommendations. *Annals of Family Medicine*, *6*(4), 331–339. https://doi.org/10.1370/afm.818

Comparcini, D., Simonetti, V., Totaro, M., Apicella, A., Galli, F., Toccaceli, A., Di Lorenzo, A., Tafuri, S., Cicolini, G., & Tomietto, M. (2025). Impact of Traumatic Stress on Nurses' Work Ability, Job Satisfaction, Turnover and Intention to Leave: A Cross-Sectional Study. *Journal of advanced nursing*, *81*(10), 6504–6514. https://doi-org.ludwig.lub.lu.se/10.1111/jan.16796

Connor, L., Dean, J., McNett, M., Tydings, D. M., Shrout, A., Gorsuch, P. F., Hole, A., Moore, L., Brown, R., Melnyk, B. M., & Gallagher-Ford, L. (2023). Evidence-based practice improves patient outcomes and healthcare system return on investment: Results from a scoping review. *Worldviews Evidence Based Nursing,* 20(1), 6–15. https://doi.org/10.1111/wvn.12621

Corscadden, L., Callander, E. J., & Topp, S. M. (2019). Who experiences unmet need for mental health services and what other barriers to accessing health care do they face? Results from Australia and Canada. *International Journal of Health Planning Management*, *34*(2), 761–772. https://doi.org/10.1002/hpm.2733

Coventry, P. A., Hudson, J. L., Kontopantelis, E., Archer, J., Richards, D. A., Gilbody, S., Lovell, K., Dickens, C., Gask, L., Waheed, W., & Bower, P. (2014). Characteristics of effective collaborative care for treatment of depression: a systematic review and meta-regression of 74 randomised controlled trials. *PloS one*, *9*(9), e108114. https://doi.org/10.1371/journal.pone.0108114

Cypress, B. S. (2017). Rigor or Reliability and Validity in Qualitative Research: Perspectives, Strategies, Reconceptualization, and Recommendations. *Dimension of Critical Care Nursing*, *36*(4), 253–263. https://doi.org/10.1097/dcc.0000000000000253

Dahlqvist Jönsson, P., Schön, U. K., Rosenberg, D., Sandlund, M., & Svedberg, P. (2015). Service users' experiences of participation in decision making in mental health services. *Journal of Psychiatry in Mental Health Nursing*, *22*(9), 688–697. https://doi.org/10.1111/jpm.12246

Damiano, R. F., Fricchione, G., & Miguel, E. C. (2024). Love, compassion, and attachment in psychiatric care: perspectives for research and clinical practice. *Trends in psychiatry and psychotherapy*, *46*, e20220557. https://doi.org/10.47626/2237-6089-2022-0557

Davidson, L., Rowe, M., DiLeo, P., Bellamy, C., & Delphin-Rittmon, M. (2021). Recovery-Oriented Systems of Care: A Perspective on the Past, Present, and Future. *Alcohol Research*, *41*(1), 09. https://doi.org/10.35946/arcr.v41.1.09

Davies, L., LeClair, K. L., Bagley, P., Blunt, H., Hinton, L., Ryan, S., & Ziebland, S. (2020). Face-to-Face Compared With Online Collected Accounts of Health and Illness Experiences: A Scoping Review. *Qualitative Health Research*, *30*(13), 2092–2102. https://doi.org/10.1177/1049732320935835

de Rosis, S., Barchielli, C., Vainieri, M., & Bellé, N. (2021). The relationship between healthcare service provision models and patient experience. *Journal of Health Organisation Management*, 36(9), 1–24. https://doi.org/10.1108/jhom-06-2021-0242

de Oliveira, J. L., Dal Sasso Mendes, K., de Almeida, L. Y., de Almeida, J. C. P., Souza Gonçalves, J., Strobbe, S., & de Souza, J. (2023). Mental Health Care in Primary Health Care: An Integrative Review. *Issues in Mental Health Nursing*, *44*(4), 329–337. https://doi.org/10.1080/01612840.2023.2189954

Delaney, K. R. (2012). Moving to a recovery framework of care: focusing attention on process. *Archives Psychiatry Nursing*, *26*(2), 165–166. https://doi.org/10.1016/j.apnu.2011.12.005

Derblom, K., Dahlberg, K., Gabrielsson, S., Lindgren, B. M., & Molin, J. (2025). Key Aspects of Recovery-Oriented Practice in Caring for People With Mental Ill-Health in General Emergency Departments: A Modified Delphi Study. *Journal of Clinical Nursing*, *34*(2), 565–579. https://doi.org/10.1111/jocn.17631

Derblom, K., Molin, J., Gabrielsson, S., & Lindgren, B. M. (2021). 'Acknowledge me as a capable person': How people with mental ill health describe their experiences with general emergency care staff - A qualitative interview study. *International journal of mental health nursing*, *30*(6), 1539–1549. https://doi.org/10.1111/inm.12903

Dicicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medicine Education*, *40*(4), 314–321. https://doi.org/10.1111/j.1365-2929.2006.02418.x

Dickson, C. A., Bliss, J., & Bowers, B. (2015). Shaping future delivery of care: district nurses seizing the day! *British Journal of Community Nursing*, *20*(6), 266–267. https://doi.org/10.12968/bjcn.2015.20.6.266

Dieterich, M., Irving, C. B., Bergman, H., Khokhar, M. A., Park, B., & Marshall, M. (2017). Intensive case management for severe mental illness. *Cochrane Database of System Review*, *1*(1), Cd007906. https://doi.org/10.1002/14651858.CD007906.pub3

Dodgson J. E. (2019). Reflexivity in Qualitative Research. *Journal of human lactation : official journal of International Lactation Consultant Association*, *35*(2), 220–222. https://doi.org/10.1177/0890334419830990

Doernberg, S., & Truog, R. (2023). Spheres of Morality: The Ethical Codes of the Medical Profession. *American Journal of Bioethics*, *23*(12), 8–22. https://doi.org/10.1080/15265161.2022.2160514

Dwivedi, K., Huddy, V., Oliver, P., & Burton, C. (2025). Complex mental health difficulties in primary care: a scoping review with thematic synthesis. *British Journal of General Practice open*, 9(4), BJGPO.2024.0223. https://doi.org/10.3399/BJGPO.2024.0223

Dubreucq, J., Plasse, J., & Franck, N. (2021). Self-stigma in Serious Mental Illness: A Systematic Review of Frequency, Correlates, and Consequences. *Schizophrenia Bulletin*, *47*(5), 1261–1287. https://doi.org/10.1093/schbul/sbaa181

Ekman, I. (2022). Practising the ethics of person-centred care balancing ethical conviction and moral obligations. *Nursing Philosophy*, *23*(3), e12382. https://doi.org/10.1111/nup.12382

Ekman, I., Swedberg, K., Taft, C., Lindseth, A., Norberg, A., Brink, E., Carlsson, J., Dahlin-Ivanoff, S., Johansson, I. L., Kjellgren, K., Lidén, E., Öhlén, J., Olsson, L. E., Rosén, H., Rydmark, M., & Sunnerhagen, K. S. (2011). Person-centered care--ready for prime time. *European Journal of Cardiovascular Nursing*, *10*(4), 248–251. https://doi.org/10.1016/j.ejcnurse.2011.06.008

Erdner, A., Magnusson, A., Nyström, M., & Lützén, K. (2005). Social and existential alienation experienced by people with long-term mental illness. *Scandinavian Journal of Caring Sciences*, *19*(4), 373–380. https://doi.org/10.1111/j.1471-6712.2005.00364.x

Everett, C. M., Docherty, S. L., Matheson, E., Morgan, P. A., Price, A., Christy, J., Michener, L., Smith, V. A., Anderson, J. B., Jr., Viera, A., & Jackson, G. L. (2022). Teaming up in primary care: Membership boundaries, interdependence, and coordination. *Journal of American Academy of Physician Associates*, *35*(2), 1–10. https://doi.org/10.1097/01.Jaa.0000805840.00477.58

Falkenström, E., & Höglund, A. T. (2023). The ethical void: a critical analysis of commissioned expert reports on Swedish healthcare governance. *Journal of health organization and management*, *ahead-of-print* (ahead-of-print), 10.1108/JHOM-09-2022-0261. https://doi.org/10.1108/JHOM-09-2022-0261

Farnsworth von Cederwald, A., Lilja, J. L., Hentati Isacsson, N., & Kaldo, V. (2023). Primary Care Behavioral Health in Sweden - a protocol of a cluster randomized trial evaluating outcomes related to implementation, organization, and patients (KAIROS). *BMC Health Service Research*, *23*(1), 1188. https://doi.org/10.1186/s12913-023-10180-9

First, M. B., Clarke, D. E., Yousif, L., Eng, A. M., Gogtay, N., & Appelbaum, P. S. (2023). DSM-5-TR: Rationale, Process, and Overview of Changes. *Psychiatric Services*, *74*(8), 869–875. https://doi.org/10.1176/appi.ps.20220334

Fogarty, F., McCombe, G., Brown, K., Van Amelsvoort, T., Clarke, M., & Cullen, W. (2021). Physical health among patients with common mental health disorders in primary care in Europe: a scoping review. *Irish Journal of Psychological Medicine*, 38(1), 76–92. https://doi.org/10.1017/ipm.2020.2

Frank, P., Batty, G. D., Pentti, J., Jokela, M., Poole, L., Ervasti, J., Vahtera, J., Lewis, G., Steptoe, A., & Kivimäki, M. (2023). Association Between Depression and Physical Conditions Requiring Hospitalization. *JAMA Psychiatry*, *80*(7), 690–699. https://doi.org/10.1001/jamapsychiatry.2023.0777

Freund, T., Everett, C., Griffiths, P., Hudon, C., Naccarella, L., & Laurant, M. (2015). Skill mix, roles and remuneration in the primary care workforce: who are the healthcare professionals in the primary care teams across the world? *International Journal of Nursing Studies*, *52*(3), 727–743. https://doi.org/10.1016/j.ijnurstu.2014.11.014

Frisch, N. C., & Rabinowitsch, D. (2019). What's in a Definition? Holistic Nursing, Integrative Health Care, and Integrative Nursing: Report of an Integrated Literature Review. *Journal of Holistic Nursing*, *37*(3), 260–272. https://doi.org/10.1177/0898010119860685

Fusar-Poli, P., Salazar de Pablo, G., De Micheli, A., Nieman, D. H., Correll, C. U., Kessing, L. V., Pfennig, A., Bechdolf, A., Borgwardt, S., Arango, C., & van Amelsvoort, T. (2020). What is good mental health? A scoping review. *European neuropsychopharmacology : the journal of the European College of Neuropsychopharmacology*, *31*, 33–46. https://doi.org/10.1016/j.euroneuro.2019.12.105

Gabriel, F. C., de Melo, D. O., Stein, A. T., Fontes-Mota, G. C. H., Dos Santos, I. B., Rodrigues, C. D. S., Rodrigues, M. C., Ribeiro, T. B., Fráguas, R., Florez, I. D., Telles-Correia, D., & Ribeiro, E. (2023). Factors associated with higher quality of clinical practice guidelines and their recommendations for the pharmacological treatment of depression: a systematic review. *BMJ Open*, *13*(3), e067390. https://doi.org/10.1136/bmjopen-2022-067390

Gabrielsson, S., & Looi, G. E. (2019). Recovery-Oriented Reflective Practice Groups: Conceptual Framework and Group Structure. *Issues in Mental Health Nursing*, *40*(12), 993–998. https://doi.org/10.1080/01612840.2019.1644568

Gaebel, W., Stricker, J., & Kerst, A. (2020). Changes from ICD-10 to ICD-11 and future directions in psychiatric classification. *Dialogues in Clinical Neuroscience*, *22*(1), 7–15. https://doi.org/10.31887/DCNS.2020.22.1/wgaebel

Galvin, K. (2021). 'Getting back to the matters': Why the existential matters in care. *Scandinavian Journal of Caring Sciences*, *35*(3), 679–684. https://doi.org/10.1111/scs.13022

Garnow, T., Einberg, E. L., Edberg, A. K., & Garmy, P. (2024). Adolescents' Experiences of Existential Loneliness Regarding Receiving and Providing Support. *Issues in mental health nursing*, *45*(11), 1176–1184. https://doi.org/10.1080/01612840.2024.2386404

Giebel, C., McIntyre, J. C., Alfirevic, A., Corcoran, R., Daras, K., Downing, J., Gabbay, M., Pirmohamed, M., Popay, J., Wheeler, P., Holt, K., Wilson, T., Bentall, R., & Barr, B. (2020). The longitudinal NIHR ARC North West Coast Household Health Survey: exploring health inequalities in disadvantaged communities. *BMC public health*, *20*(1), 1257. https://doi.org/10.1186/s12889-020-09346-5

Gill, S. L. (2020). Qualitative Sampling Methods. *Journal of Human Lactation*, *36*(4), 579–581. https://doi.org/10.1177/0890334420949218

Giorgi, A. (2000). The status of Husserlian phenomenology in caring research. *Scandinavian Journal of Caring Sciences*, *14*(1), 3–10. https://doi.org/10.1111/j.1471-6712.2000.tb00554.x

Giorgi, A. (2005). The phenomenological movement and research in the human sciences. *Nursing Science Quartely*, *18*(1), 75–82. https://doi.org/10.1177/0894318404272112

Global Burden of Diseases. (2019). 2019 Mental Disorders Collaborators Global, regional, and national burden of 12 mental disorders in 204 countries and territories, 1990-2019: a systematic analysis for the Global Burden of Disease Study 2019. (2022). *Lancet Psychiatry*, *9*(2), 137–150. https://doi.org/10.1016/s2215-0366(21)00395-3

Graneheim, U. H., Lindgren, B. M., & Lundman, B. (2017). Methodological challenges in qualitative content analysis: A discussion paper. *Nurse Educ Today*, *56*, 29–34. https://doi.org/10.1016/j.nedt.2017.06.002

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Educ Today*, *24*(2), 105–112. https://doi.org/10.1016/j.nedt.2003.10.001

Greenhalgh, T. M., & Dijkstra, P. (2024). How to Read a Paper: The Basics of Evidence-based Healthcare. John Wiley & Sons.

Griffith, R., & Tengnah, C. (2013). District nurse clinics: accountability and practice. *British Journal of Community Nursing*, *18*(2), 94–97. https://doi.org/10.12968/bjcn.2013.18.2.94

Grim, K., Näslund, H., Allaskog, C., Andersson, J., Argentzell, E., Broström, K., Jenneteg, F. G., Jansson, M., Schön, U. K., Svedberg, P., Svensson, S., Wåhlstedt, S., & Rosenberg, D. (2022). Legitimizing user knowledge in mental health services: Epistemic (in)justice and barriers to knowledge integration. *Frontier Psychiatry*, *13*, 981238. https://doi.org/10.3389/fpsyt.2022.981238

Grossoehme D. H. (2014). Overview of qualitative research. *Journal of health care chaplaincy*, *20*(3), 109–122. https://doi.org/10.1080/08854726.2014.925660

Grundberg, Å., Hansson, A., Hillerås, P., & Religa, D. (2016). District nurses' perspectives on detecting mental health problems and promoting mental health among community-dwelling seniors with multimorbidity. *Journal of Clinical Nursing*, *25*(17-18), 2590–2599. https://doi.org/10.1111/jocn.13302

Grundman, S. H., Edri, N., & Stanger Elran, R. (2021). From lived experience to experiential knowledge: a working model. *Mental Health and Social Inclusion*, *25*(1), 23–31. https://doi.org/10.1108/MHSI-06-2020-0041

Gustavsson, K., Fors, A., van Diepen, C., Axelsson, M., Bertilsson, M., Bångsbo, A., Hensing, G., & Lood, Q. (2025). Higher levels of person-centred care are associated with lower levels of stress of conscience in hospital and municipal care: cross-sectional results from the PCC@Work project. *BMC Health Service Research*, *25*(1), 937. https://doi.org/10.1186/s12913-025-13077-x

Gyllensten, H., Cederberg, M., Alsén, S., Blanck, E., Ali, L., Fors, A., Hedman, H., Nørmark, L. P., Swedberg, K., & Ekman, I. (2025). Person-Centred Care: State-of-the-Art and Future Perspectives. *Current Heart Failure Reports*, *22*(1), 15. https://doi.org/10.1007/s11897-025-00702-3

Haddad, M., Plummer, S., Taverner, A., Gray, R., Lee, S., Payne, F., & Knight, D. (2005). District nurses' involvement and attitudes to mental health problems: a three-area cross-sectional study. *Journal of Clinical Nursing*, 14(8), 976–985. https://doi.org/10.1111/j.1365-2702.2005.01196.x

Hagquist, C., Due, P., Torsheim, T., & Välimaa, R. (2019). Cross-country comparisons of trends in adolescent psychosomatic symptoms - a Rasch analysis of HBSC data from four Nordic countries. *Health and Quality of Life Outcomes*, *17*(1), 27. https://doi.org/10.1186/s12955-019-1097-x

Halloy, A., Simon, E., & Hejoaka, F. (2023). Defining patient's experiential knowledge: Who, what and how patients know. A narrative critical review. *Sociology Health Illness*, *45*(2), 405–422. https://doi.org/10.1111/1467-9566.13588

Hanisch, S. E., Twomey, C. D., Szeto, A. C., Birner, U. W., Nowak, D., & Sabariego, C. (2016). The effectiveness of interventions targeting the stigma of mental illness at the workplace: a systematic review. *BMC Psychiatry*, *16*, 1. https://doi.org/10.1186/s12888-015-0706-4

Harkko, J., Sipilä, N., Nordquist, H., Lallukka, T., Appelqvist-Schmidlechner, K., Donnelly, M., & Kouvonen, A. (2023). External context in individual placement and support implementation: a scoping review with abductive thematic analysis. *Implementation science : IS*, *18*(1), 61. https://doi.org/10.1186/s13012-023-01316-w

Harris, J. (1987). The Plural Text/The Plural Self: Roland Barthes and William Coles. *College English*, *49*(2), 158–170. https://doi.org/10.2307/377871

Hartley, S., Raphael, J., Lovell, K., & Berry, K. (2020). Effective nurse-patient relationships in mental health care: A systematic review of interventions to improve the therapeutic alliance. *International Journal of Nursing Studies*, *102*, 103490. https://doi.org/10.1016/j.ijnurstu.2019.103490

Harvey, C., Brophy, L., Tibble, H., Killaspy, H., Spittal, M. J., Hamilton, B., Ennals, P., Newton, R., Cruickshank, P., Hall, T., & Fletcher, J. (2019). Prevention and Recovery Care Services in Australia: Developing a State-Wide Typology of a Subacute Residential Mental Health Service Model. *Frontier Psychiatry*, *10*, 383. https://doi.org/10.3389/fpsyt.2019.00383

Harvey, C., Zirnsak, T. M., Brasier, C., Ennals, P., Fletcher, J., Hamilton, B., Killaspy, H., McKenzie, P., Kennedy, H., & Brophy, L. (2023). Community-based models of care facilitating the recovery of people living with persistent and complex mental health needs: a systematic review and narrative synthesis. *Frontier Psychiatry*, *14*, 1259944. https://doi.org/10.3389/fpsyt.2023.1259944

Hauger, B., Martinsen, R., Hestad, K., & Ødbehr, L. S. (2025). Nurses' perspectives on clinical competence to identify loneliness and depression in older people in home care: a qualitative study. *BMC Health Service Research*, *25*(1), 370. https://doi.org/10.1186/s12913-025-12428-y

Heaslip, V., Glendening, N., & Snowden, J. (2023). Promoting young people's mental health: the role of community nurses. *Nursing Standards*, *38*(1), 43–49. https://doi.org/10.7748/ns.2022.e11967

Hedman, H. (2020). Patientens- personens röst. I Ekman, I. (red), *Personcentrering inom hälso- och sjukvård från filosofi till praktik*. (2 ed. p.11-25). Liber

Hennink, M., & Kaiser, B. N. (2022). Sample sizes for saturation in qualitative research: A systematic review of empirical tests. *Social Science and Medicine*, *292*, 114523. https://doi.org/10.1016/j.socscimed.2021.114523

Hillborg, H., Lövgren, V., Bejerholm, U., & Rosenberg, D. (2024). Supporting Education With IPS: Advancing a Career-Oriented Model for Integrating Work and Study Support for Young Adults in Sweden. *Psychiatric Rehabilitation Journal*, *47*(1), 37–45. https://doi-org.ludwig.lub.lu.se/10.1037/prj0000597

Holmstrand, C., Bogren, M., Mattisson, C., & Brådvik, L. (2015). Long-term suicide risk in no, one or more mental disorders: the Lundby Study 1947-1997. *Acta Psychiatrica Scandinavica*, *132*(6), 459–469. https://doi.org/10.1111/acps.12506

Hultman, L., & Hultman, M. (2023). "Believe me, only I know how I feel." An autoethnographic account of experiences of epistemic injustice in mental health care. *Frontiers in psychiatry*, *14*, 1058422. https://doi.org/10.3389/fpsyt.2023.1058422

Håkansson Eklund, J., Holmström, I. K., Kumlin, T., Kaminsky, E., Skoglund, K., Höglander, J., Sundler, A. J., Condén, E., & Summer Meranius, M. (2019). "Same same or different?" A review of reviews of person-centered and patient-centered care. *Patient Education and Counseling*, *102*(1), 3–11. https://doi.org/10.1016/j.pec.2018.08.029

Höglander, J., Holmström, I. K., Lövenmark, A., Van Dulmen, S., Eide, H., & Sundler, A. J. (2023). Registered nurse-patient communication research: An integrative review for future directions in nursing research. *Journal of Advanced Nursing*, *79*(2), 539–562. https://doi.org/10.1111/jan.15548

Janlöv, A. C., Johansson, L., & Clausson, E. K. (2018). Mental ill-health among adult patients at healthcare centres in Sweden: district nurses experiences. *Scandinavian Journal of Caring Sciences*, *32*(2), 987–996. https://doi.org/10.1111/scs.12540

Janlöv, N., Blume, S., Glenngård, A. H., Hanspers, K., Anell, A., & Merkur, S. (2023). Sweden: Health System Review. *Health Systematic Transit*, *25*(4), 1–236.

Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., Rodgers, B., & Pollitt, P. (1997). "Mental health literacy": a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. *Medicine Journal of Autism*, *166*(4), 182–186. https://doi.org/10.5694/j.1326-5377.1997.tb140071.x

Joseph-Williams, N., Edwards, A., & Elwyn, G. (2014). Power imbalance prevents shared decision making. *BMJ*, *348*, g3178. https://doi.org/10.1136/bmj.g3178

Josephsson, S., Öhlén, J., Mondaca, M., Guerrero, M., Luborsky, M., & Lindström, M. (2022). Using Ricoeur's notions on narrative interpretation as a resource in supporting person-centeredness in health and social care. *Nursing Philosophy*, *23*(3), e12398. https://doi.org/10.1111/nup.12398

Jørgensen, K., Lerbæk, B., Frederiksen, J., Watson, E., & Karlsson, B. (2024). Patient Participation in Mental Health Care - Perspectives of Healthcare Professionals and Patients: A Scoping Review. *Issues in Mental Health Nursing*, *45*(8), 794–810. https://doi.org/10.1080/01612840.2024.2358931

Jørgensen, K., Rasmussen, T., Hansen, M., Andreasson, K., & Karlsson, B. (2021). User Involvement in the Handover between Mental Health Hospitals and Community Mental Health: A Critical Discourse Analysis. *International journal of environmental research and public health*, *18*(7), 3352. https://doi.org/10.3390/ijerph18073352

Jørgensen, K., & Rendtorff, J. D. (2018). Patient participation in mental health care - perspectives of healthcare professionals: an integrative review. *Scandinavian Journal of Caring Sciences*, *32*(2), 490–501. https://doi.org/10.1111/scs.12531

Kallio, H., Pietilä, A. M., Johnson, M., & Kangasniemi, M. (2016). Systematic methodological review: developing a framework for a qualitative semi-structured interview guide. *Journal of Advanced Nursing*, *72*(12), 2954–2965. https://doi.org/10.1111/jan.13031

Kane, C. F. (2015). The 2014 Scope and Standards of Practice for Psychiatric Mental Health Nursing: Key Updates. *Online Journal of Issues in Nursing*, *20*(1), 1.

Karlsson, J., Hammar, L. M., & Kerstis, B. (2021). Capturing the Unsaid: Nurses' Experiences of Identifying Mental Ill-Health in Older Men in Primary Care-A Qualitative Study of Narratives. *Nursing Report*, *11*(1), 152–163. https://doi.org/10.3390/nursrep11010015

Kaskoun, J., & McCabe, E. (2022). Perceptions of School Nurses in Addressing Student Mental Health Concerns: An Integrative Review. *Journal of School Nurses*, *38*(1), 35–47. https://doi.org/10.1177/10598405211046223

Kates, N., Arroll, B., Currie, E., Hanlon, C., Gask, L., Klasen, H., Meadows, G., Rukundo, G., Sunderji, N., Ruud, T., & Williams, M. (2019). Improving collaboration between primary care and mental health services. *World Journal of Biological Psychiatry*, *20*(10), 748–765. https://doi.org/10.1080/15622975.2018.1471218

Kebede, T. T., Cederberg, M., Alsén, S., Fors, A., & Gyllensten, H. (2025). A Person-Centered eHealth Intervention for Patients With Common Mental Disorders: Cost-Effectiveness Analysis Within a Randomized Controlled Trial. *Value in health : the journal of the International Society for Pharmacoeconomics and Outcomes Research*, *28*(6), 875–883. https://doi.org/10.1016/j.jval.2025.03.011

Kieling, C., Buchweitz, C., Caye, A., Silvani, J., Ameis, S. H., Brunoni, A. R., Cost, K. T., Courtney, D. B., Georgiades, K., Merikangas, K. R., Henderson, J. L., Polanczyk, G. V., Rohde, L. A., Salum, G. A., & Szatmari, P. (2024). Worldwide Prevalence and Disability From Mental Disorders Across Childhood and Adolescence: Evidence From the Global Burden of Disease Study. *JAMA Psychiatry*, *81*(4), 347–356. https://doi.org/10.1001/jamapsychiatry.2023.5051

Kim, B., Benzer, J. K., Afable, M. K., Fletcher, T. L., Yusuf, Z., & Smith, T. L. (2023). Care transitions from the specialty to the primary care setting: A scoping literature review of potential barriers and facilitators with implications for mental health care. *Journal of Evaluation of Clinical Practice*, *29*(8), 1338–1353. https://doi.org/10.1111/jep.13832

Kirkevold M. (1997). Caring as a multidisciplinary research field. *Scandinavian journal of caring sciences*, *11*(2), 65–66. https://doi.org/10.1111/j.1471-6712.1997.tb00434.x

Klodnick, V. V., Malina, C., Fagan, M. A., Johnson, R. P., Brenits, A., Zeidner, E., & Viruet, J. (2021). Meeting the Developmental Needs of Young Adults Diagnosed with Serious Mental Health Challenges: the Emerge Model. *Journal of Behavioural Health Service Research*, *48*(1), 77–92. https://doi.org/10.1007/s11414-020-09699-0

Krouwel, M., Jolly, K., & Greenfield, S. (2019). Comparing Skype (video calling) and in-person qualitative interview modes in a study of people with irritable bowel syndrome - an exploratory comparative analysis. *BMC Medicine Research Methodology*, *19*(1), 219. https://doi.org/10.1186/s12874-019-0867-9

Kristensson Uggla, B. (2011). *Homo Capax. Texter av Paul Ricouer om etik och filosofisk antropologi i urval av Bengt Kristensson Uggla. (Homo Capax. Lyrics by Paul Ricouer om ethics and philosophical antropology in selection of Bengt Kristensson Uggla).* Bookwell AB.

Kristensson Uggla, B. (2022). What makes us human? Exploring the significance of Ricoeurs ethical configuration of personhood between naturalism and phenomenology in health care. *Nursing Philosophy*, *23*(3), e12385. https://doi.org/10.1111/nup.12385

Kuek, J. H. L., Raeburn, T., Chow, M. Y. Z., & Wand, T. (2023). Lived experiences of mental health conditions in Singapore: A constructivist grounded theory study. *International Journal of Social Psychiatry*, *69*(3), 735–743. https://doi.org/10.1177/00207640221135111

Kuipers, S. J., Cramm, J. M., & Nieboer, A. P. (2019). The importance of patient-centered care and co-creation of care for satisfaction with care and physical and social well-being of patients with multi-morbidity in the primary care setting. *BMC Health Service Research*, *19*(1), 13. https://doi.org/10.1186/s12913-018-3818-y

Körner, M., Bütof, S., Müller, C., Zimmermann, L., Becker, S., & Bengel, J. (2016). Interprofessional teamwork and team interventions in chronic care: A systematic review. *Journal of Interprofessional Care*, *30*(1), 15–28. https://doi.org/10.3109/13561820.2015.1051616

Le Boutillier, C., Chevalier, A., Lawrence, V., Leamy, M., Bird, V. J., Macpherson, R., Williams, J., & Slade, M. (2015). Staff understanding of recovery-orientated mental health practice: a systematic review and narrative synthesis. *Implementation Sciences*, *10*, 87. https://doi.org/10.1186/s13012-015-0275-4

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *British Journal of Psychiatry*, *199*(6), 445–452. https://doi.org/10.1192/bjp.bp.110.083733

Lexén, A., Emmelin, M., Hansson, L., Svensson, B., Porter, S., & Bejerholm, U. (2021). Changes in rehabilitation actors' mental health literacy and support to employers: An evaluation of the SEAM intervention. *Work*, *69*(3), 1053–1061. https://doi.org/10.3233/wor-213535

Lexén, A., & Svensson, B. (2016). Mental health professional experiences of the flexible assertive community treatment model: a grounded theory study. *Journal of Mental Health*, *25*(4), 379–384. https://doi.org/10.1080/09638237.2016.1207236

Lidén, E., Björk-Brämberg, E., & Svensson, S. (2015). The meaning of learning to live with medically unexplained symptoms as narrated by patients in primary care: a phenomenological-hermeneutic study. *International Journal of Qualitative Studies in Health & Well-being*, *10*, 27191. https://doi.org/10.3402/qhw.v10.27191

Liljeholm U, Argentzell, Bejerholm U. (2020). An integrated mental health and vocational intervention: A longitudinal study on mental health changes among young adults. *Nursing Open.*; 7(6): 1755-1765. doi: 10.1002/nop2.560

Liljeholm U, Bejerholm U. (2020) Work identity development in young adults with mental health problems. *Scandinavian Journal of Occupational Therapy.*; 27(6): 431-440. doi: 10.1080/11038128.2019.1609084

Liljeholm, U, Argentzell E, Hillborg H, Lövgren V, Rosenberg D, Bejerholm U. (2022). The Journey to My Student Identity: A Grounded Theory Study on Supported Education for Young Adults with Mental Health Problems. *Journal of Psychosocial Rehabilitation and Mental Health.*; 9(2): 203–219. doi: 10.1007/s40737-021-00253-5

Lindwall, L., & Lohne, V. (2021). Human dignity research in clinical practice - a systematic literature review. *Scandinavian Journal of Caring Sciences*, *35*(4), 1038–1049. https://doi.org/10.1111/scs.12922

Ljungberg, A., Denhov, A., & Topor, A. (2016). Non-helpful relationships with professionals - a literature review of the perspective of persons with severe mental illness. *Journal of Mental Health*, *25*(3), 267–277. https://doi.org/10.3109/09638237.2015.1101427

Long, J., Ohlsen, S., Senek, M., Booth, A., Weich, S., & Wood, E. (2023). Realist synthesis of factors affecting retention of staff in UK adult mental health services. *BMJ open*, *13*(5), e070953. https://doi.org/10.1136/bmjopen-2022-070953

Lorien, L., Blunden, S., & Madsen, W. (2020). Implementation of recovery-oriented practice in hospital-based mental health services: A systematic review. *International Journal of Mental Health Nursing*, *29*(6), 1035–1048. https://doi.org/10.1111/inm.12794

Lovén Wickman, U., & Schmidt, M. (2023). Experiences of primary care among young adults with mental illness - A systematic literature review. *Scandinavian Journal of Caring Sciences*, *37*(3), 628–641. https://doi.org/10.1111/scs.13167

Ludvigsson, J. F., Bergman, D., Lundgren, C. I., Sundquist, K., Geijerstam, J. A., Glenngård, A. H., Lindh, M., Sundström, J., Kaarme, J., & Yao, J. (2025). The healthcare system in Sweden. *European journal of epidemiology*, *40*(5), 563–579. https://doi.org/10.1007/s10654-025-01226-9

Lundin Gurné, F., Jakobsson, S., Lidén, E., & Björkman, I. (2023). District nurses' perspectives on health-promotive and disease-preventive work at primary health care centres: A qualitative study. *Scandinavian Journal of Caring Sciences*, *37*(1), 153–162. https://doi.org/10.1111/scs.13100

Lundberg, K., Jong, M., Jong, M. C., & Porskrog Kristiansen, L. (2020). Patients' experiences of the caring encounter in health promotion practice: a qualitative study in Swedish primary health care. *BMC Family Practice*, 21(1), 232. https://doi.org/10.1186/s12875-020-01296-6

Lyne, J., Connellan, L., Ceannt, R., O'Connor, K., & Shelley, E. (2023). Public mental health: a psychiatry and public health perspective. *Irish Journal of Psychology Medicine*, *40*(1), 84–88. https://doi.org/10.1017/ipm.2021.77

Löyttynen, J., Graneheim, U. H., & Hörnsten, Å. (2023). District Nurses' Experiences of Practice in Caring for People with Mental Ill-Health in Swedish Primary Care. *Issues in Mental Health Nursing*, *44*(5), 396–405. https://doi.org/10.1080/01612840.2023.2193639

MacNaughton, K., Chreim, S., & Bourgeault, I. L. (2013). Role construction and boundaries in interprofessional primary health care teams: a qualitative study. *BMC Health Service Research*, *13*, 486. https://doi.org/10.1186/1472-6963-13-486

Mahomed, F. (2020). Addressing the Problem of Severe Underinvestment in Mental Health and Well-Being from a Human Rights Perspective. *Health Human Rights*, *22*(1), 35–49.

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample Size in Qualitative Interview Studies: Guided by Information Power. *Qualitative Health Research*, *26*(13), 1753–1760.

Mansfield, L., Victor, C., Meads, C., Daykin, N., Tomlinson, A., Lane, J., Gray, K., & Golding, A. (2021). A Conceptual Review of Loneliness in Adults: Qualitative Evidence Synthesis. *International Journal of Environmental Research and Public Health*, *18*(21). https://doi.org/10.3390/ijerph182111522

Manwell, L. A., Barbic, S. P., Roberts, K., Durisko, Z., Lee, C., Ware, E., & McKenzie, K. (2015). What is mental health? Evidence towards a new definition from a mixed methods multidisciplinary international survey. *BMJ open*, *5*(6), e007079. https://doi.org/10.1136/bmjopen-2014-007079

Mareya, S., Watts, M. C., Zhao, L., & Olasoji, M. (2024). Exploring the Stepped Care Model in Delivering Primary Mental Health Services-A Scoping Review. *International Journal of Mental Health Nursing*, *33*(6), 2026–2042. https://doi.org/10.1111/inm.13427

Markström, U., Bejerholm., U., Svensson, B., & Bergmark, M. (2015). Implementeringen av nationella riktlinjer för psykosociala insatser vid schizofreni – exemplen IPS och ACT. (The Implementation of National Guidelines for Psychosocial Interventions in Schizophrenia – The Examples of IPS and ACT). Umeå universitet. https://umu.diva-portal.org/smash/get/diva2:788946/FULLTEXT01.pdf

Martinsen, K. (2000). *Øyet og kallet.* Bergen: Fagbokforlaget. [*The eye and the call.* Bergen: Fagbokforlaget.]

Martel, S., Dowedoff, P., Marcinow, M., Arora, R., Kerr, J., Shulman, R., & Mansfield, E. (2021). Patient and Family Caregiver Experience with a Collaborative Care Pilot Project to Support Seniors Managing Multi-Morbidity in a Primary Care Setting. *Canadian Journal of Community Mental Health*, *40*(1), 53–66. https://doi.org/10.7870/cjcmh-2021-003

Matua, G. A. (2015). Choosing phenomenology as a guiding philosophy for nursing research. *Nurse Research*, *22*(4), 30–34. https://doi.org/10.7748/nr.22.4.30.e1325

McGrath, J. J., Al-Hamzawi, A., Alonso, J., Altwaijri, Y., Andrade, L. H., Bromet, E. J., Bruffaerts, R., de Almeida, J. M. C., Chardoul, S., Chiu, W. T., Degenhardt, L., Demler, O. V., Ferry, F., Gureje, O., Haro, J. M., Karam, E. G., Karam, G., Khaled, S. M., Kovess-Masfety, V.,…Kessler, R. C. (2023). Age of onset and cumulative risk of mental disorders: a cross-national analysis of population surveys from 29 countries. *Lancet Psychiatry*, *10*(9), 668–681. https://doi.org/10.1016/s2215-0366(23)00193-1

McLure, J., Forrester-Bowling, T., Peeters, A., Berk, M., Moylan, S., & Carolin, R. (2023). Person-centred growth-oriented language and care: Fundamental to successful mental health reform. *Australia's Psychiatry*, *31*(5), 598–600. https://doi.org/10.1177/10398562231189437

Melnyk, B. M., Fineout-Overholt, E., Stillwell, S. B., & Williamson, K. M. (2010). Evidence-based practice: step by step: the seven steps of evidence-based practice. *American Journal of Nursing*, *110*(1), 51–53. https://doi.org/10.1097/01.NAJ.0000366056.06605.d2

Melnyk, B. M., Gallagher-Ford, L., Long, L. E., & Fineout-Overholt, E. (2014). The establishment of evidence-based practice competencies for practicing registered nurses and advanced practice nurses in real-world clinical settings: proficiencies to improve healthcare quality, reliability, patient outcomes, and costs. *Worldviews Evidence Based Nursing*, *11*(1), 5–15. https://doi.org/10.1111/wvn.12021

Menear, M., Ashcroft, R., Dahrouge, S., Silveira, J., Booton, J., Emode, M., & McKenzie, K. (2024). Person-centered care for common mental disorders in Ontario's primary care patient-centered medical homes: a qualitative study of provider perspectives. *BMC primary care*, *25*(1), 278. https://doi.org/10.1186/s12875-024-02519-w

Merner, B., Schonfeld, L., Virgona, A., Lowe, D., Walsh, L., Wardrope, C., Graham-Wisener, L., Xafis, V., Colombo, C., Refahi, N., Bryden, P., Chmielewski, R., Martin, F., Messino, N. M., Mussared, A., Smith, L., Biggar, S., Gill, M., Menzies, D.,…Hill, S. (2023). Consumers' and health providers' views and perceptions of partnering to improve health services design, delivery and evaluation: a co-produced qualitative evidence synthesis. *Cochrane Database Systematic Review*, *3*(3), Cd013274. https://doi.org/10.1002/14651858.CD013274.pub2

Meyer, A. M., Davis, M., & Mays, G. P. (2012). Defining organizational capacity for public health services and systems research. *Journal of Public Health Management Practice*, *18*(6), 535–544. https://doi.org/10.1097/PHH.0b013e31825ce928

Miah, J., Dawes, P., Edwards, S., Leroi, I., Starling, B., & Parsons, S. (2019). Patient and public involvement in dementia research in the European Union: a scoping review. *BMC Geriatrics*, *19*(1), 220. https://doi.org/10.1186/s12877-019-1217-9

Millar, S. L., Chambers, M., & Giles, M. (2016). Service user involvement in mental health care: an evolutionary concept analysis. *Health expectations : an international journal of public participation in health care and health policy*, *19*(2), 209–221. https://doi.org/10.1111/hex.12353

Milos Nymberg, V., Nymberg, P., Pikkemaat, M., Calling, S., Stenman, E., Grundberg, A., Smith, J. G., & Sundquist, K. (2023). Lifestyle and cardiovascular risk factors in a Swedish primary care population with self-reported psychiatric symptoms. *Preventive medicine reports*, *37*, 102547. https://doi.org/10.1016/j.pmedr.2023.102547

Moon, K., & Blackman, D. (2014). A guide to understanding social science research for natural scientists. *Conservation Biology 28*(5), 1167–1177. https://doi.org/10.1111/cobi.12326

Moore, L., Britten, N., Lydahl, D., Naldemirci, Ö., Elam, M., & Wolf, A. (2017). Barriers and facilitators to the implementation of person-centred care in different healthcare contexts. *Scandinavian Journal of Caring Sciences*, *31*(4), 662–673. https://doi.org/10.1111/scs.12376

Moreno, F. A., & Chhatwal, J. (2020). Diversity and Inclusion in Psychiatry: The Pursuit of Health Equity. *Focus (American Psychiatric Publishing)*, *18*(1), 2–7. https://doi.org/10.1176/appi.focus.20190029

Morgan, D. L., Eliot, S., Lowe, R. A., & Gorman, P. (2016). Dyadic Interviews as a Tool for Qualitative Evaluation. *American Journal of Evaluation*, *37*(1), 109–117. https://doi.org/10.1177/1098214015611244

Moser, A., & Korstjens, I. (2018). Series: Practical guidance to qualitative research. Part 3: Sampling, data collection and analysis. *European Journal of General Practice*, *24*(1), 9–18. https://doi.org/10.1080/13814788.2017.1375091

Moyes, A., McGough, S., & Wynaden, D. (2024). Hidden and unacknowledged: The mental health and psychosocial interventions delivered by school nurses in Western Australia. *International Journal of Mental Health Nursing*, *33*(2), 463–472. https://doi.org/10.1111/inm.13261

Murphy, J., Hughes, J., Read, S., & Ashby, S. (2021). Evidence and practice: a review of vignettes in qualitative research. *Nurse researcher*,*29*(3), 8–14. https://doi.org/10.7748/nr.2021.e1787

Murphy, J., Mulcahy, H., Mahony, J. O., & Bradley, S. (2023). Exploring individuals' experiences of hope in mental health recovery: An interpretative phenomenological analysis. *Journal of Psychiatry Mental Health Nursing*, *30*(1), 101–109. https://doi.org/10.1111/jpm.12833

Mutschler, C., Bellamy, C., Davidson, L., Lichtenstein, S., & Kidd, S. (2022). Implementation of peer support in mental health services: A systematic review of the literature. *Psychology Services*, *19*(2), 360–374. https://doi.org/10.1037/ser0000531

Mårtensson, G., Jacobsson, J. W., & Engström, M. (2014). Mental health nursing staff's attitudes towards mental illness: an analysis of related factors. *Journal of Psychiatry Mental Health Nursing*, *21*(9), 782–788. https://doi.org/10.1111/jpm.12145

NBHW. National Board of Health and Welfare. (2021a). Långsiktiga konsekvenser av att få depression eller ångestsyndrom som ung. https://www.socialstyrelsen.se/contentassets/c5033b238904489987b9476518d09a2a/2021-12-7721.pdf

NBHW. National Board of Health and Welfare. (2021b). *Läkarnas specialiseringstjänstgöring Målbeskrivningar 2021. Physicians' educational specialist training Educational goal 2021.* Föreskrifter och allmänna råd. ISBN 978-91-7555-554-6

NBHW. National Board of Health and Welfare. (2023). *Bedömning av tillgång och efterfrågan på legitimerad personal i hälso- och sjukvård samt tandvård Nationella planeringsstödet 2023. Assessment of Supply and Demand for Licensed Healthcare and Dental Care Professionals - National Planning Support 2023. https://www.socialstyrelsen.se/contentassets/f30aac4aaa2942e9afc3f12d4e49d270/2023-2-8352.pdf*

NBHW. National Board of Health and Welfare. (2024a). https://www.socialstyrelsen.se/kunskapsstod-och-regler/omraden/e-halsa/nationell-informationsstruktur-och-nationella-informationsmangder/nationella-informationsmangder/brukare/

NBHW. National Board of Health and Welfare. (2024b). *Agreement between the state and Sweden's Municipalities and Regions about efforts in the area mental health and suicide prevention - The National Board of Health and Welfare's progress report 2023*. https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/ovrigt/2023-9-8741.pdf

NBHW. National Board of Health and Welfare (2025). https://www.socialstyrelsen.se/kunskapsstod-och-regler/omraden/evidensbaserad-praktik/

NBHW. National Board of Health and Welfare (2025a). *Primary health care's work on mental health. Final Report on the Assignment to implement measures to promote, support, and monitor the transition to Good Quality – Local Health Care reform, in order to improve Primary health care's management of mental ill health.* https://www.socialstyrelsen.se/contentassets/057250a6e6094c5fba711f1f8008341d/2025-3-9528.pdf

Nerurkar, L., van der Scheer, I., & Stevenson, F. (2024). Engagement with emotional concerns in general practice: a thematic analysis of GP consultations. *BJGP Open*, *8*(1). https://doi.org/10.3399/bjgpo.2023.0202

Newbigging, K., & Ridley, J. (2018). Epistemic struggles: The role of advocacy in promoting epistemic justice and rights in mental health. *Social science & medicine (1982)*, *219*, 36–44. https://doi.org/10.1016/j.socscimed.2018.10.003

Newman, D., O'Reilly, P., Lee, S. H., & Kennedy, C. (2015). Mental health service users' experiences of mental health care: an integrative literature review. *Journal of Psychiatry Mental Health Nursing*, *22*(3), 171–182. https://doi.org/10.1111/jpm.12202

Nielsen, C. M., Hjorthøj, C., Killaspy, H., & Nordentoft, M. (2021). The effect of flexible assertive community treatment in Denmark: a quasi-experimental controlled study. *Lancet Psychiatry*, *8*(1), 27–35. https://doi.org/10.1016/s2215-0366(20)30424-7

Nilsson, E. (2023). *"Experiences of mental health encounters among Public Health Nurses and patients: In the context of Primary Health Care".* [Licentiat avhandling, Lunds universitet]. Lic_Avhandling_Emmy_Nilsson.pdf

NSPH. Nationell Samverkan för Psykisk Hälsa. Swedish Partnership for Mental Health. (2024). *NSPH-rapporten 2024: "Det blir dyrare att leva ju sjukare jag är". En rapport från NSPH om livsvillkoren för personer med psykisk ohälsa och deras anhöriga och om brukarinflytande*. (NSPH Report 2024: "The Sicker I Am, the More Expensive Life Becomes. A report from NSPH on the living conditions of people with mental ill-health and their relatives, and on user involvement. https://nsph.se/wp-content/uploads/2024/10/NSPH_rapporten-2024.pdf

Nussbaum, M. C. (2013). *Creating Capabilities: The Human Development Approach*. Harvard University Press. https://doi.org/10.2307/j.ctt2jbt31

Nutbeam, D., Harris, E., & Wise, M. (2024). In *Theory in a Nutshell: a practical guide to health promotion theories, 4th Edition*. McGraw Hill Education.

Nygren Zotterman, A., Skär, L., Olsson, M., & Söderberg, S. (2015). District nurses' views on quality of primary healthcare encounters. *Scandinavian Journal of Caring Sciences*, *29*(3), 418–425. https://doi.org/10.1111/scs.12146

O'Brien, B. C., Harris, I. B., Beckman, T. J., Reed, D. A., & Cook, D. A. (2014). Standards for reporting qualitative research: a synthesis of recommendations. Academic medicine: *Journal of the Association of American Medical Colleges*; *89*(9), 1245–1251. https://doi.org/10.1097/ACM.0000000000000388

O'Shea, A., Boaz, A. L., & Chambers, M. (2019). A Hierarchy of Power: The Place of Patient and Public Involvement in Healthcare Service Development. *Frontier Sociology*, *4*, 38. https://doi.org/10.3389/fsoc.2019.00038

Ocloo, J., & Matthews, R. (2016). From tokenism to empowerment: progressing patient and public involvement in healthcare improvement. *BMJ Quality & Safety*, *25*(8), 626–632. https://doi.org/10.1136/bmjqs-2015-004839

Ohrnberger, J., Fichera, E., & Sutton, M. (2017). The relationship between physical and mental health: A mediation analysis. *Social Science of Medicine*, *195*, 42–49. https://doi.org/10.1016/j.socscimed.2017.11.008

Okoroji, C., Mackay, T., Robotham, D., Beckford, D., & Pinfold, V. (2023). Epistemic injustice and mental health research: A pragmatic approach to working with lived experience expertise. *Frontiers in psychiatry*, *14*, 1114725. https://doi.org/10.3389/fpsyt.2023.1114725

Olafsdottir, S. (2019). Mental health: Current trends and challenges in the Nordic countries and beyond. *Scandinavian Journal of Public Health*, *47*(2), 87–89. https://doi.org/10.1177/1403494819830340

Oliver, P., Huddy, V., McInerney, C., Achinanya, A., Horspool, M., Dwivedi, K., & Burton, C. (2026). Complex mental health difficulties: a mixed-methods study in primary care. *The British journal of general practice : the journal of the Royal College of General Practitioners*, *76*(762), e899–e909. https://doi.org/10.3399/BJGP.2024.0818

Olsson, S., Hensing, G., Burström, B., & Löve, J. (2021). Unmet Need for Mental Healthcare in a Population Sample in Sweden: A Cross-Sectional Study of Inequalities Based on Gender, Education, and Country of Birth. *Community Mental Health Journal*, *57*(3), 470–481. https://doi.org/10.1007/s10597-020-00668-7

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful Sampling for Qualitative Data Collection and Analysis in Mixed Method Implementation Research. Administration Policy in Mental Health, 42(5), 533–544. https://doi.org/10.1007/s10488-013-0528-y

Parker, D., Byng, R., Dickens, C., & McCabe, R. (2020). Patients' experiences of seeking help for emotional concerns in primary care: doctor as drug, detective and collaborator. *BMC Family Practice*, *21*(1), 35. https://doi.org/10.1186/s12875-020-01106-z

Patel, V., Saxena, S., Lund, C., Kohrt, B., Kieling, C., Sunkel, C., Kola, L., Chang, O., Charlson, F., O'Neill, K., & Herrman, H. (2023). Transforming mental health systems globally: principles and policy recommendations. *Lancet*, *402*(10402), 656–666. https://doi.org/10.1016/s0140-6736(23)00918-2

Patel, V., Saxena, S., Lund, C., Thornicroft, G., Baingana, F., Bolton, P., Chisholm, D., Collins, P. Y., Cooper, J. L., Eaton, J., Herrman, H., Herzallah, M. M., Huang, Y., Jordans, M. J. D., Kleinman, A., Medina-Mora, M. E., Morgan, E., Niaz, U., Omigbodun, O.,…UnÜtzer, J. (2018). The Lancet Commission on global mental health and sustainable development. *Lancet*, *392*(10157), 1553–1598. https://doi.org/10.1016/s0140-6736(18)31612-x

Patton, M. Q. (1999). Enhancing the quality and credibility of qualitative analysis. *Health Services Research*, *34*(5 Pt 2), 1189–1208.

Patton, M. Q. (2014). *Qualitative research & evaluation methods: Integrating theory and practice*. Sage publications.

PHAS, Public Health Agency of Sweden. (2024). *Statistik om psykisk hälsa i Sverige*. (*Statistics on Mental Health in Sweden).* https://www.folkhalsomyndigheten.se/vara-amnesomraden/psykisk-halsa-och-suicidprevention/statistik-psykisk-halsa/

PHAS, Public Health Agency of Sweden. (2022). *Utvecklingsbehov inom psykisk hälsa och suicidprevention. Sammanställning av analyser från myndigheter och organisationer och föreningar. (Development Needs in Mental Health and Suicide Prevention: A Compilation of Analyses from Authorities, Organisations, and Associations).* National health and welfare board & PHAS. https://www.folkhalsomyndigheten.se/contentassets/6dc318f9399b49fe968f5dd444dc3231/psykisk-halsa-suicidprevention.pdf

Phelan, S. M., Salinas, M., Pankey, T., Cummings, G., Allen, J. P., Waniger, A., Miller, N. E., Lebow, J., Dovidio, J. F., van Ryn, M., & Doubeni, C. A. (2023). Patient and Health Care Professional Perspectives on Stigma in Integrated Behavioral Health: Barriers and Recommendations. *Annual Family Medicine*, *21*(Suppl 2), S56–s60. https://doi.org/10.1370/afm.2924

Phillippi, J., & Lauderdale, J. (2018). A Guide to Field Notes for Qualitative Research: Context and Conversation. *Qualitative Health Research*, *28*(3), 381–388. https://doi.org/10.1177/1049732317697102

Piao, J., Huang, Y., Han, C., Li, Y., Xu, Y., Liu, Y., & He, X. (2022). Alarming changes in the global burden of mental disorders in children and adolescents from 1990 to 2019: a systematic analysis for the Global Burden of Disease study. *European Child & Adolescent Psychiatry*, *31*(11), 1827–1845. https://doi.org/10.1007/s00787-022-02040-4

Pilgrim, D., & Waldron, L. (1998). User involvement in mental health service development: How far can it go? *Journal of Mental Health*, *7*(1), 95–104. https://doi.org/10.1080/09638239818373

Pinho, L. G., Engström, M., Silva, M. R., Fonseca, C., Lindberg, M., Jelinek, L., Börsting, J., Afonso, A., Jacinto, G., Nilsson, A., Schröder, J., & Schneider, B. C. (2025). Help-seeking preferences and barriers for mental health problems among university students in Portugal, Germany, and Sweden. *Journal of affective disorders*, *379*, 782–792. https://doi.org/10.1016/j.jad.2025.03.044

Pope, M. A., Malla, A. K., & Iyer, S. N. (2018). Who should be responsible for supporting individuals with mental health problems? A critical literature review. *International Journal of Social Psychiatry*, 64(3), 293–302. https://doi.org/10.1177/0020764017752019

Potrebny, T., Wiium, N., & Lundegård, M. M. (2017). Temporal trends in adolescents' self-reported psychosomatic health complaints from 1980-2016: A systematic review and meta-analysis. *PLoS One*, *12*(11), e0188374. https://doi.org/10.1371/journal.pone.0188374

Powell, P. A., & Rowen, D. (2022). What Matters for Evaluating the Quality of Mental Healthcare? Identifying Important Aspects in Qualitative Focus Groups with Service Users and Frontline Mental Health Professionals. *The patient*, *15*(6), 669–678. https://doi.org/10.1007/s40271-022-00580-0

Powell, R. A., & Single, H. M. (1996). Focus groups. *International Journal of Qualitative Health Care*, *8*(5), 499–504. https://doi.org/10.1093/intqhc/8.5.499

Price-Robertson, R., Angela, O., & and Morgan, B. (2017). Relational recovery: beyond individualism in the recovery approach. *Advances in Mental Health*, *15*(2), 108–120. https://doi.org/10.1080/18387357.2016.1243014

Puschner, B., Becker, T., Mayer, B., Jordan, H., Maj, M., Fiorillo, A., Égerházi, A., Ivánka, T., Munk-Jørgensen, P., Krogsgaard Bording, M., Rössler, W., Kawohl, W., & Slade, M. (2016). Clinical decision making and outcome in the routine care of people with severe mental illness across Europe (CEDAR). *Epidemiology Psychiatric Sciences*, *25*(1), 69–79. https://doi.org/10.1017/s204579601400078x

Raj, C. T. (2022). The effectiveness of mental health disorder stigma-reducing interventions in the healthcare setting: An integrative review. *Archives of Psychiatry Nursing*, *39*, 73–83. https://doi.org/10.1016/j.apnu.2022.03.005

Region Stockholm. (2021). Step up erbjuder kurser om psykisk ohälsa. (Step up offers courses about mental health). https://janusinfo.se/nyheter/tidningenevidens/nr342021temaoronnasahals/3/stepuperbjuderkurserompsykiskohalsa.5.49d8318c17d3925563962ce6.html

Rehm, J., & Shield, K. D. (2019). Global Burden of Disease and the Impact of Mental and Addictive Disorders. *Current Psychiatry Reports*, *21*(2), 10. https://doi.org/10.1007/s11920-019-0997-0

Rendle, K. A., Abramson, C. M., Garrett, S. B., Halley, M. C., & Dohan, D. (2019). Beyond exploratory: a tailored framework for designing and assessing qualitative health research. *BMJ open*, *9*(8), e030123. https://doi.org/10.1136/bmjopen-2019-030123

Rex, M., Waern, M., Carlström, E., Joneken, I., Tell, S., Brezicka, T., & Ali, L. (2025). Person-centred suicide prevention: key elements from the perspective of people living with suicidality. *International Journal of Qualitative Studies on Health Well-being*, *20*(1), 2549752.

Richards, J. E., Hohl, S. D., Whiteside, U., Ludman, E. J., Grossman, D. C., Simon, G. E., Shortreed, S. M., Lee, A. K., Parrish, R., Shea, M., Caldeiro, R. M., Penfold, R. B., & Williams, E. C. (2019). If You Listen, I Will Talk: the Experience of Being Asked About Suicidality During Routine Primary Care. *Journal of General Internal Medicine*, *34*(10), 2075–2082. https://doi.org/10.1007/s11606-019-05136-x

Ricoeur, P. (1992). Oneself as Another. The University of Chicago Press. Chicago and London.

Ridgway P. (2001). Restorying psychiatric disability: learning from first person recovery narratives. *Psychiatric rehabilitation journal*, *24*(4), 335–343. https://doi.org/10.1037/h0095071

Robinson, P., & Englander, M. (2008). Appliceringen av den deskriptiva fenomenologiska humanvetenskapliga metoden. *Vård i Norden*, *28*(4), 49–51. https://doi.org/10.1177/010740830802800412

Rocelli, M., Aquili, L., Giovanazzi, P., Puecher, A., Goglio, M. M., & Faccio, E. (2024). 'ALL ABOUT MY IDEAL MENTAL HEALTH SERVICE': Users, family members and experts by experience discussing a co-designed service. *Health Expectations*, *27*(2), e13999. https://doi.org/10.1111/hex.13999

Roche, M. A., Glover, S., Luo, X., Joyce, M., & Rossiter, C. (2021). Extending the role of nursing assistants in mental health inpatient settings: A multi-method study. *International journal of mental health nursing*, *30*(5), 1070–1079. https://doi.org/10.1111/inm.12859

Roennfeldt, H., Hill, N., Byrne, L., & Hamilton, B. (2024). Exploring the lived experience of receiving mental health crisis care at emergency departments, crisis phone lines and crisis care alternatives. *Health Expectations*, *27*(2), 1–10. https://doi.org/10.1111/hex.14045

Rogers, A. C. (1997). Vulnerability, health and health care. *Journal of Advanced Nursing*, *26*(1), 65–72. https://doi.org/10.1046/j.1365-2648.1997.1997026065.x

Rogers, C. R. (1963). Toward a Science of the Person. *Journal of Humanistic Psychology.* 3(2): 72–92.

Rolfe, G. (2006). Validity, trustworthiness and rigour: quality and the idea of qualitative research. *Journal of Advanced Nursing*, *53*(3), 304–310. https://doi.org/10.1111/j.1365-2648.2006.03727.x

Rosen, A., Gill, N. S., & Salvador-Carulla, L. (2020). The future of community psychiatry and community mental health services. *Current opinion in psychiatry*, *33*(4), 375–390. https://doi.org/10.1097/YCO.0000000000000620

Ross, L. E., Vigod, S., Wishart, J., Waese, M., Spence, J. D., Oliver, J., Chambers, J., Anderson, S., & Shields, R. (2015). Barriers and facilitators to primary care for people with mental health and/or substance use issues: a qualitative study. *BMC Family Practice*, *16*, 135. https://doi.org/10.1186/s12875-015-0353-3

Rossiter, C., Levett-Jones, T., & Pich, J. (2020). The impact of person-centred care on patient safety: An umbrella review of systematic reviews. *International journal of nursing studies*, *109*, 103658. https://doi.org/10.1016/j.ijnurstu.2020.103658

Rosted, E., Christensen, H. G., Lanther, T., McCormack, B., & Kjerholt, M. (2025). Enhancing clinical practice through action research: fostering a person-centred culture in healthcare. *Frontiers in health services*, *5*, 1583478. https://doi.org/10.3389/frhs.2025.1583478

Rotenberg, M., Zhuang, L., Williams, R., Versace, D., DeSanti, M., Harren, D., Raben, A., Naeem, F., Abela-Dimech, F., Kurdyak, P., Farrokhi, F., & Foussias, G. (2025). Outcomes of Flexible Assertive Community Treatment Versus Assertive Community Treatment or Intensive Case Management. *Psychiatry Services, 76*(5), 430–436. https://doi.org/10.1176/appi.ps.20240163

Roy, M., Lavoie-Trudeau, É., Roy, M. A., Clapperton, I., Couturier, Y., Lane, J., Bibeau, L., Ouellette, M., Benkhalti, M., & Camden, C. (2020). Barriers and Facilitators to Implementing Community Outreach Work, and Inter-professional Collaboration with Regional Partners. *Journal of Community Health*, *45*(5), 979–986. https://doi.org/10.1007/s10900-020-00816-w

Rugkåsa, J., Tveit, O. G., Berteig, J., Hussain, A., & Ruud, T. (2020). Collaborative care for mental health: a qualitative study of the experiences of patients and health professionals. *BMC Health Service Research*, *20*(1), 844. https://doi.org/10.1186/s12913-020-05691-8

Russell, G. M., Miller, W. L., Gunn, J. M., Levesque, J. F., Harris, M. F., Hogg, W. E., Scott, C. M., Advocat, J. R., Halma, L., Chase, S. M., & Crabtree, B. F. (2018). Contextual levers for team-based primary care: lessons from reform interventions in five jurisdictions in three countries. *Family Practice*, *35*(3), 276–284. https://doi.org/10.1093/fampra/cmx095

SAHCA - Swedish Agency for Health and Care Analysis. (Myndigheten för vård och omsorgsanalys). (2025a). Swedish Agency for Health and Care Analysis. https://www.vardanalys.se/digital%E2%80%93publikation/omtag-for-omstallning/

SAHCA - Swedish Agency for Health and Care Analysis. (Myndigheten för vård och omsorgsanalys). (2025b). Swedish Agency for Health and Care Analysis. ISBN: 978-91-89933-24-8. www.vardanalys.se

Sadler, M. S., Meagor, E. L., & Kaye, K. E. (2012). Stereotypes of mental disorders differ in competence and warmth. *Social Sciences of Medicine*, *74*(6), 915–922. https://doi.org/10.1016/j.socscimed.2011.12.019

Saha, S., Lim, C. C. W., Cannon, D. L., Burton, L., Bremner, M., Cosgrove, P., Huo, Y., & J, J. M. (2021). Co-morbidity between mood and anxiety disorders: A systematic review and meta-analysis. *Depression and Anxiety*, *38*(3), 286–306. https://doi.org/10.1002/da.23113

SALAR- The Swedish Association of Local Authorities and Regions. (2023). *Ersättningsformer i Primärvård.* (Health economics in Primary healthcare). Sveriges kommuner och regioner. The Swedish Agency of Local Authorities and Regions. https://skr.se/download/18.42c794218babc4983b114a9/1699524149798/A4_Ersattningsmodeller-Nara-vard_Revidering_webb.pdf

SALAR. The Swedish Association of Local Authorities and Regions. (2024a). *Municipalities and regions*. https://skr.se/skr/englishpages/municipalitiesandregions.1088.html

SALAR. The Swedish Association of Local Authorities and Regions. (2024b). *Primärvård i Sverige Uppdrag, organisation, kontinuitet och prioriteringar.* (*Primary Care in Sweden: Mission, Organisation, Continuity, and Priorities)*. Sveriges Kommuner och Regioner. ISBN: 978-91-8047-325-5

Sandelowski, M. (2004). Using Qualitative Research. *Qualitative Health Research*, *14*(10), 1366–1386. https://doi.org/10.1177/1049732304269672

Santana, M. J., Manalili, K., Jolley, R. J., Zelinsky, S., Quan, H., & Lu, M. (2018). How to practice person-centred care: A conceptual framework. *Health Expectations*, *21*(2), 429–440. https://doi.org/10.1111/hex.12640

Saunders, H., Gallagher-Ford, L., Kvist, T., & Vehviläinen-Julkunen, K. (2019). Practicing Healthcare Professionals' Evidence-Based Practice Competencies: An Overview of Systematic Reviews. *Worldviews Evidence Based Nursing*, *16*(3), 176–185. https://doi.org/10.1111/wvn.12363

Scogin, F. R., Hanson, A., & Welsh, D. (2003). Self-administered treatment in stepped-care models of depression treatment. *Journal of Clinical Psychology*, *59*(3), 341–349. https://doi.org/10.1002/jclp.10133

Searby, A., Burr, D., Carolin, R., & Hutchinson, A. (2025). Barriers and Facilitators to Mental Health Service Integration: A Scoping Review. *International Journal of Mental Health Nursing*, *34*(1), 1–22. https://doi-org.ludwig.lub.lu.se/10.1111/inm.13449

Selberg, R., Mulinari, P. (2022a). Leaderless Management as the Solution to Struggles Over the Moral Center of Healthcare? Ward Nurses' Critique of Management as "Real Utopias" in the Public Sector. In: Hertel, F., Örtenblad, A., Jørgensen, K.M. (eds) Debating Leaderless Management. Palgrave Debates in Business and Management. Palgrave Macmillan, Cham. https://doi.org/10.1007/978-3-031-04593-6_5

Selberg, R., & Mulinari, P. (2022b). Exit Spirals in Hospital Clinics: Conceptualizing Turnover Contagion Among Nursing Staff. *Scandinavian Journal of Public Administration*, *26*(1), 87–107. https://doi.org/10.58235/sjpa.v26i1.7045

SFS 2003:460. Swedish Act Concerning the Ethical Review of Research Involving Humans (SFS 2003:460). Ministry of Education and Research. The Swedish parliament. https://www.riksdagen.se/sv/dokument-och-lagar/dokument/svensk-forfattningssamling/lag-2003460-om-etikprovning-av-forskning-som_sfs-2003-460/

Sheridan Rains, L., Echave, A., Rees, J., Scott, H. R., Lever Taylor, B., Broeckelmann, E., Steare, T., Barnett, P., Cooper, C., Jeynes, T., Russell, J., Oram, S., Rowe, S., & Johnson, S. (2021). Service user experiences of community services for complex emotional needs: A qualitative thematic synthesis. *PLoS One*, *16*(4), e0248316. https://doi.org/10.1371/journal.pone.0248316

Shim, R., & Rust, G. (2013). Primary care, behavioural health, and public health: partners in reducing mental health stigma. *American Journal of Public Health*, *103*(5), 774–776. https://doi.org/10.2105/ajph.2013.301214

Shorey, S., & Ng, E. D. (2022). Examining characteristics of descriptive phenomenological nursing studies: A scoping review. *Journal of Advanced Nursing*, *78*(7), 1968–1979. https://doi.org/10.1111/jan.15244

Silfverhielm, H., & Kamis-Gould, E. (2000). The Swedish mental health system. Past, present, and future. *International Journal of Law and Psychiatry*, *23*(3-4), 293–307. https://doi.org/10.1016/s0160-2527(00)00039-x

Silfverhielm, H., & Stefansson, C. G. (2006). Sweden. *International Psychiatry*, *3*(1), 9–12.

Singh, S., & Estefan, A. (2018). Selecting a Grounded Theory Approach for Nursing Research. *Global qualitative nursing research*, *5*, 2333393618799571. https://doi.org/10.1177/2333393618799571

Sjöström, N., Waern, M., Johansson, A., Weimand, B., Johansson, O., & Ewertzon, M. (2021). Relatives' Experiences of Mental Health Care, Family Burden and Family Stigma: Does Participation in Patient-Appointed Resource Group Assertive Community Treatment (RACT) Make a Difference? *Issues in Mental Health Nursing*, *42*(11), 1010–1019. https://doi.org/10.1080/01612840.2021.1924322

Skivington, K., Matthews, L., Simpson, S. A., Craig, P., Baird, J., Blazeby, J. M., Boyd, K. A., Craig, N., French, D. P., McIntosh, E., Petticrew, M., Rycroft-Malone, J., White, M., & Moore, L. (2021). A new framework for developing and evaluating complex interventions: update of Medical Research Council guidance. *BMJ (Clinical research ed.)*, *374*, n2061. https://doi.org/10.1136/bmj.n2061

Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., Perkins, R., Shepherd, G., Tse, S., & Whitley, R. (2014). Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry*, *13*(1), 12–20. https://doi.org/10.1002/wps.20084

Slade, M., Leamy, M., Bacon, F., Janosik, M., Le Boutillier, C., Williams, J., & Bird, V. (2012). International differences in understanding recovery: systematic review. *Epidemiology Psychiatry Sciences*, *21*(4), 353–364. https://doi.org/10.1017/s2045796012000133

Smith, S., & Bevan, A. (2020). Role of school nurses in identifying and supporting children and young people with mental health issues. *Nursing Children &Young People*, *32*(2), 23–28. https://doi.org/10.7748/ncyp.2020.e1253

Spurrier, G. F., Shulman, K., Dibich, S., Benoit, L., Duckworth, K., & Martin, A. (2022). Physical symptoms as psychiatric manifestations in medical spaces: A qualitative study. *Frontier Psychiatry*, *13*, 1074424. https://doi.org/10.3389/fpsyt.2022.1074424

Staniszewska, S., Mockford, C., Chadburn, G., Fenton, S. J., Bhui, K., Larkin, M., Newton, E., Crepaz-Keay, D., Griffiths, F., & Weich, S. (2019). Experiences of in-patient mental health services: systematic review. *British Journal of Psychiatry*, *214*(6), 329–338. https://doi.org/10.1192/bjp.2019.22

Stumbo, S. P., Yarborough, B. J. H., Yarborough, M. T., & Green, C. A. (2018). Perspectives on Providing And Receiving Preventive Health Care From Primary Care Providers and Their Patients With Mental Illnesses. *American Journal of Health Promotion*, 32(8), 1730–1739.

Sturman, N. J., Williams, R., Wyder, M., & Lynch, J. (2022). Heard, known, and safe in general practice? An interview study with patients with severe and persistent mental illness. *BJGP open*, *6*(2), BJGPO.2021.0201. https://doi.org/10.3399/BJGPO.2021.0201

Sudbeck, D., Jorgensen, S., & Dixon, L. B. (2024). Assertive Community Treatment. *Psychiatry Services*, *75*(5), 508–509. https://doi.org/10.1176/appi.ps.24075007

Summer Meranius, M., Holmström, I. K., Håkansson, J., Breitholtz, A., Moniri, F., Skogevall, S., Skoglund, K., & Rasoal, D. (2020). Paradoxes of person-centred care: A discussion paper. *Nursing Open*, *7*(5), 1321–1329. https://doi.org/10.1002/nop2.520

Sun, Y., Wu, Y., Fan, S., Dal Santo, T., Li, L., Jiang, X., Li, K., Wang, Y., Tasleem, A., Krishnan, A., He, C., Bonardi, O., Boruff, J. T., Rice, D. B., Markham, S., Levis, B., Azar, M., Thombs-Vite, I., Neupane, D.,…Thombs, B. D. (2023). Comparison of mental health symptoms before and during the covid-19 pandemic: evidence from a systematic review and meta-analysis of 134 cohorts. BMJ, 380, e074224. https://doi.org/10.1136/bmj-2022-074224

Sundler, A. J., Darcy, L., Råberus, A., & Holmström, I. K. (2020). Unmet health-care needs and human rights—A qualitative analysis of patients' complaints in light of the right to health and health care. *Health Expectations*, *23*(3), 614–621. https://doi.org/10.1111/hex.13038

Sundler, A. J., Hedén, L., Holmström, I. K., van Dulmen, S., Bergman, K., Östensson, S., & Östman, M. (2023). The patient's first point of contact (PINPOINT) - protocol of a prospective multicenter study of communication and decision-making during patient assessments by primary care registered nurses. *BMC Primary Care*, *24*(1), 249. https://doi.org/10.1186/s12875-023-02208-0

Sundler, A. J., Råberus, A., Carlsson, G., Nilsson, C., & Darcy, L. (2022). 'Are they really allowed to treat me like that?' – A qualitative study to explore the nature of formal patient complaints about mental healthcare services in Sweden. *International Journal of Mental Health Nursing*, *31*(2), 348–357. https://doi.org/10.1111/inm.12962

Sundquist, J., Ohlsson, H., Sundquist, K., & Kendler, K. S. (2017). Common adult psychiatric disorders in Swedish primary care where most mental health patients are treated. *BMC Psychiatry*, *17*(1), 235. https://doi.org/10.1186/s12888-017-1381-4

Supper, I., Catala, O., Lustman, M., Chemla, C., Bourgueil, Y., & Letrilliart, L. (2015). Interprofessional collaboration in primary health care: a review of facilitators and barriers perceived by involved actors. *Journal of Public Health (Oxf)*, *37*(4), 716–727. https://doi.org/10.1093/pubmed/fdu102

Svensson, B., & Hansson, L. (2016). How mental health literacy and experience of mental illness relate to stigmatizing attitudes and social distance towards people with depression or psychosis: A cross-sectional study. *Nordic Journal of Psychiatry*, *70*(4), 309–313. https://doi.org/10.3109/08039488.2015.1109140

Svensson, B., Hansson, L., Markström, U., & Lexén, A. (2017). What matters when implementing Flexible Assertive Community Treatment in a Swedish healthcare context: A two-year implementation study. *International Journal of Mental Health*, *46*(4), 284–298. https://doi.org/10.1080/00207411.2017.1345041

Svensson, B., Hansson, L., & Lexén, A. (2018). Outcomes of clients in need of intensive team care in Flexible Assertive Community Treatment in Sweden. *Nordic Journal of Psychiatry*, *72*(3), 226–231. https://doi.org/10.1080/08039488.2018.1430168

Swedish Association of Health and Social Care Providers (Vårdföretagarna). (2022). Privat Vårdfakta 2022. Fakta och statistik om den privat drivna vård- och omsorgsbranschen. Private Healthcare Facts 2022: Facts and Statistics on the Privately Operated Health and Social Care Sector. https://www.vardforetagarna.se/vardfakta-2022/sjukvard/

Swedish Government of official reports. (SOU 2020:19). *The Good quality, local healthcare -A primary care reform*. Stockholm. Swedish Government of official reports

Swedish Research Council. (Vetenskapsrådet) (2024). *God forsknings ed 2024. (Good research practice 2024).* World Medical Association Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Participants. (2025). *JAMA*, *333*(1), 71–74. https://doi.org/10.1001/jama.2024.21972

Swedish Standards Institute, (SIS). (2020). *Patientdelaktighet i hälso- och sjukvård – Minimikrav för personcentrerad vård* (Participation in health care—minimum requirements for person-centred care). (SS-EN 17398:2020).

Swedish Social Act (SFS 2025:400). Socialtjänstlag (2025:400) | Sveriges riksdag, the Departement of Social Affairs.

Swedish Society of Nursing. (2019). *Kompetensbeskrivning för distriktssköterskor. (Professional competency framework for District Nurses).*

Swedish Society of Nursing (2025). *Distriktssköterskeföreningen i Sverige. Kompetensbeskrivning avancerad nivå distriktssköterska. District Nurse Association of Sweden. Competency description advanced level district nurse*. Svensk sjuksköterskeföreningen och distriktssköterskeföreningen i Sverige. ISBN-NR: 978-91-85060-88-7

Tenny, S., Brannan, J. M., & Brannan, G. D. (2025). *Qualitative Study*. In *StatPearls*. StatPearls Publishing.

Thibault, G. E. (2019). Humanism in Medicine: What Does It Mean and Why Is It More Important Than Ever? *Academic Medicine*, *94*(8), 1074–1077. https://doi.org/10.1097/acm.0000000000002796

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*, *8*, 45. https://doi.org/10.1186/1471-2288-8-45

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal of Qualitative Health Care*, *19*(6), 349–357. https://doi.org/10.1093/intqhc/mzm042

Topor, A., Bøe, T. D., & Larsen, I. B. (2018). Small Things, Micro-Affirmations and Helpful Professionals Everyday Recovery-Orientated Practices According to Persons with Mental Health Problems. *Community mental health journal*, *54*(8), 1212–1220. https://doi.org/10.1007/s10597-018-0245-9

Trane, K., Aasbrenn, K., Rønningen, M., Odden, S., Lexén, A., & Landheim, A. (2021). Flexible assertive community treatment teams can change complex and fragmented service systems: experiences of service providers. *Interantional Journal of Mental Health System*, *15*(1), 38. https://doi.org/10.1186/s13033-021-00463-1

Tremblay, D., Turcotte, A., Touati, N., Poder, T. G., Kilpatrick, K., Bilodeau, K., Roy, M., Richard, P. O., Lessard, S., & Giordano, É. (2022). Development and use of research vignettes to collect qualitative data from healthcare professionals: a scoping review. *BMJ Open*, *12*(1), e057095. https://doi.org/10.1136/bmjopen-2021-057095

Trevillion, K., Stuart, R., Ocloo, J., Broeckelmann, E., Jeffreys, S., Jeynes, T., Allen, D., Russell, J., Billings, J., Crawford, M. J., Dale, O., Haigh, R., Moran, P., McNicholas, S., Nicholls, V., Foye, U., Simpson, A., Lloyd-Evans, B., Johnson, S., & Oram, S. (2022). Service user perspectives of community mental health services for people with complex emotional needs: a co-produced qualitative interview study. *BMC Psychiatry*, *22*(1), 55. https://doi.org/10.1186/s12888-021-03605-4

Ulfarsson, T., Ahlborg, G., Jr., & Jonsdottir, I. H. (2025). Healthcare consumption among patients with stress-related exhaustion: a register-based study in Swedish primary care. *Scandinavian Journal of Primary Health Care*, 1–11. https://doi.org/10.1080/02813432.2025.2543290

Unützer, J., & Park, M. (2012). Strategies to improve the management of depression in primary care. *Primary care*, *39*(2), 415–431. https://doi.org/10.1016/j.pop.2012.03.010

van Duijn, S., Zonneveld, N., Lara Montero, A., Minkman, M., & Nies, H. (2018). Service Integration Across Sectors in Europe: Literature and Practice. *International Journal of Integrative Care*, *18*(2), 6. https://doi.org/10.5334/ijic.3107

van Veldhuizen, J., & Bahler, M. (2015). *Manual Flexible Assertive Community Treatment (FACT)*. https://doi.org/10.13140/RG.2.1.3925.1683

van Weeghel, J., van Zelst, C., Boertien, D., & Hasson-Ohayon, I. (2019). Conceptualizations, assessments, and implications of personal recovery in mental illness: A scoping review of systematic reviews and meta-analyses. *Psychiatry Rehabilitation Journal*, *42*(2), 169–181. https://doi.org/10.1037/prj0000356

Vandewalle, J., Van Bos, L., Goossens, P., Beeckman, D., Van Hecke, A., Deproost, E., & Verhaeghe, S. (2020). The perspectives of adults with suicidal ideation and behaviour regarding their interactions with nurses in mental health and emergency services: A systematic review. *International Journal of Nursing Studies*, *110*, 103692. https://doi.org/10.1016/j.ijnurstu.2020.103692

van Os, J., Guloksuz, S., Vijn, T. W., Hafkenscheid, A., & Delespaul, P. (2019). The evidence-based group-level symptom-reduction model as the organizing principle for mental health care: time for change? *World psychiatry : official journal of the World Psychiatric Association (WPA)*, *18*(1), 88–96. https://doi.org/10.1002/wps.20609

Vargas, C., Whelan, J., Brimblecombe, J., & Allender, S. (2022). Co-creation, co-design, co-production for public health - a perspective on definition and distinctions. *Public Health Research and Practice*, *32*(2). https://doi.org/10.17061/phrp3222211

Ventura, C. A. A., Austin, W., Carrara, B. S., & de Brito, E. S. (2021). Nursing care in mental health: Human rights and ethical issues. *Nursing Ethics*, *28*(4), 463–480. https://doi.org/10.1177/0969733020952102

Wainberg, M. L., Scorza, P., Shultz, J. M., Helpman, L., Mootz, J. J., Johnson, K. A., Neria, Y., Bradford, J. E., Oquendo, M. A., & Arbuckle, M. R. (2017). Challenges and Opportunities in Global Mental Health: a Research-to-Practice Perspective. *Current Psychiatry Reports*, *19*(5), 28. https://doi.org/10.1007/s11920-017-0780-z

Wakida, E. K., Akena, D., Okello, E. S., Kinengyere, A., Kamoga, R., Mindra, A., Obua, C., & Talib, Z. M. (2017). Barriers and facilitators to the integration of mental health services into primary health care: a systematic review protocol. *System Review*, *6*(1), 171. https://doi.org/10.1186/s13643-017-0561-0

Wallström, S., & Ekman, I. (2018). Person-centred care in clinical assessment. *European Journal in Cardiovascular Nursing*, *17*(7), 576–579. https://doi.org/10.1177/1474515118758139

Westberg, K. H., Nygren, J. M., Nyholm, M., Carlsson, I. M., & Svedberg, P. (2020). Lost in space - an exploration of help-seeking among young people with mental health problems: a constructivist grounded theory study. *Archives in Public Health*, *78*, 93. https://doi.org/10.1186/s13690-020-00471-6

Westerink, H. J., Oirbans, T., Garvelink, M. M., van Uden-Kraan, C. F., Zouitni, O., Bart, H. A. J., van der Wees, P. J., & van der Nat, P. B. (2023). Barriers and facilitators of meaningful patient participation at the collective level in healthcare organizations: A systematic review. *Health Policy*, *138*, 104946. https://doi.org/10.1016/j.healthpol.2023.104946

WHO. World health organisation (2003). *Investing in Mental Health*. WHO. https://apps.who.int/iris/bitstream/handle/10665/42823/9241562579.pdf

WHO. World health organisation. (2008). The World health report 2008- Primary healthcare (Now more than ever). Geneva. World health organisation.

WHO. World health organisation. (2016). *Framework on integrated, people-centred health services* https://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_39-en.pdf?ua=1&ua=1

WHO. World health organisation (2022). *World mental health report- Transforming mental health for all*. WHO. https://iris.who.int/bitstream/handle/10665/356119/9789240049338-eng.pdf?sequence=1

WHO. World health organisation. (2024). Mental health atlas 2024. https://iris.who.int/server/api/core/bitstreams/5897b3c7-2848-47a7-ba22-0a7902342a81/content

WHO. World Health Organization (2025). *Transforming mental health through lived experience. Roadmap for integrating lived and living experience practitioners into policy, services and community. https://iris.who.int/server/api/core/bitstreams/cf631365-4efc-423c-82e4-d397d21d36e2/content*

Wickramaratne, P. J., Yangchen, T., Lepow, L., Patra, B.G., Glicksburg, B., Talati, A., Adekkanattu, P., Ryu, E., Biernacka, J.M., Charney, A., Mann, J.J., Pathak, J., Olfson, M. & Weissman, M.M. (2022). Social connectedness as a determinant of mental health: A scoping review. *PLoS One 17(10): e0275004.*

World Medical Association (WMA). (2025). World Medical Association Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Participants. *JAMA*, *333*(1), 71–74. https://doi.org/10.1001/jama.2024.21972

Workbook FACT program fidelity scale. (2017). *Arbetsbok FACT programtrohetsskala. (FACT Fidelity Scale Workbook)*. https://vardgivare.skane.se/vardriktlinjer/psykiatri-och-psykisk-ohalsa/dokument-lankar/handbocker/fact-arbetsbok-och-programtrohetsskala/

Yanos, P. T., DeLuca, J. S., Salyers, M. P., Fischer, M. W., Song, J., & Caro, J. (2020). Cross-sectional and prospective correlates of associative stigma among mental health service providers. *Psychiatry Rehabilitation Journal*, *43*(2), 85–90. https://doi.org/10.1037/prj0000378

Yeo, C., Rennick-Egglestone, S., Armstrong, V., Borg, M., Franklin, D., Klevan, T., Llewellyn-Beardsley, J., Newby, C., Ng, F., Thorpe, N., Voronka, J., & Slade, M. (2022). Uses and Misuses of Recorded Mental Health Lived Experience Narratives in Healthcare and Community Settings: Systematic Review. *Schizophrenia bulletin*, *48*(1), 134–144. https://doi.org/10.1093/schbul/sbab097

Young, C., & Thompson, H. (2018). The role of the district nurse in Northern Ireland. *British Journal of Community Nursing*, *23*(7), 328–333. https://doi.org/10.12968/bjcn.2018.23.7.328

Östangård Olofsson, C., & Lovén Wickman, U. (2023). District nurses' experiences of giving initial health care assessment to young adults applying for mental illness in primary care: a qualitative interview study. *Primary Health Care Research Development*, *24*, e27. https://doi.org/10.1017/s146342362300018x