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Between belonging and exclusion

Recovery and everyday occupations among older
mental health service users

CARINA TORDAI

DEPARTMENT OF HEALTH SCIENCES | FACULTY OF MEDICINE | LUND UNIVERSITY



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older mental health service users

Carina Tordai



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DOCTORAL DISSERTATION

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 23rd of October at 09.00 in Belfragesalen, BMC D15, Klinikgatan 32, Lund

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Abstract:

Background: The global population is ageing, with an increasing proportion of older adults living with long-term mental illness and psychiatric disability, often characterised by complex and unmet support needs. Despite this, limited knowledge exists about how older mental health service users experience their everyday lives and recovery, particularly during the transition into retirement, when access to community-based support may decrease. In Sweden, such transitions may involve reduced opportunities to participate in structured activities, such as day centres (DC), which play an important role in maintaining daily routines and social interaction for the target group.

Aim: This thesis aimed to explore the transition into retirement among older mental health service users from occupational and personal recovery perspectives, focusing on everyday occupations, social interaction, occupational engagement and occupational balance, and their relevance for recovery and quality of life.

Methods: A mixed-methods approach was used. Qualitative data included interviews with DC managers and staff, together with longitudinal interviews with older mental health service users over an approximately 4.5-year period, analysed using content analysis and grounded theory. Quantitative data were collected through cross-sectional surveys assessing social interaction, occupational engagement, occupational balance, recovery, and quality of life.

Results: The findings show that the support currently provided within organisational structures in municipal services is not fully adapted to ageing service users, resulting in unmet needs and uncertainty regarding responsibilities and access to services. DCs emerged as important contexts providing structure, belonging, and opportunities for meaningful engagement, supporting occupational identity and recovery. At the same time, participants faced ongoing challenges related to declining health, limited social networks, and reduced access to support, particularly during the transition to retirement. Symptoms of anxiety and depression were consistently associated with lower occupational engagement, lower satisfaction with occupations, poorer quality of life, and lower levels of recovery. A more complex pattern was found in social interaction, with indications of positive associations with occupational engagement, particularly among women; however, these findings were not fully consistent with the qualitative results. Furthermore, aspects of occupational balance were positively associated with quality of life and recovery.

Conclusion: The findings highlight the transition into retirement as a critical and context-dependent period, shaped by the interplay between individual conditions and access to supportive environments. Strengthening recovery-oriented services that promote occupational engagement, connection, and belonging, and occupational balance appears essential to support well-being and recovery and reduce the risk of occupational injustice in later life.

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Abstract

Background: The global population is ageing, with an increasing proportion of older adults living with long-term mental illness and psychiatric disability, often characterised by complex and unmet support needs. Despite this, limited knowledge exists about how older mental health service users experience their everyday lives and recovery, particularly during the transition into retirement, when access to community-based support may decrease. In Sweden, such transitions may involve reduced opportunities to participate in structured activities, such as day centres (DC), which play an important role in maintaining daily routines and social interaction for the target group.

Aim: This thesis aimed to explore the transition into retirement among older mental health service users from occupational and personal recovery perspectives, focusing on everyday occupations, social interaction, occupational engagement, and occupational balance, and their relevance for recovery and quality of life.

Methods: A mixed-methods approach was used. Qualitative data included interviews with DC managers and staff, together with longitudinal interviews with older mental health service users over a period of approximately 4.5-years, analysed using content analysis and grounded theory. Quantitative data were collected through cross-sectional surveys assessing social interaction, occupational engagement, occupational balance, recovery, and quality of life.

Results: The findings showed that the support provided within organisational structures in municipal services was not fully adapted to ageing service users, resulting in unmet needs and uncertainty regarding responsibilities and access to services. DCs emerged as important contexts that provided structure, belonging, and opportunities for meaningful engagement, thereby supporting occupational identity and recovery. At the same time, participants faced ongoing challenges related to declining health, limited social networks, and reduced access to support, particularly during the transition to retirement. Symptoms of anxiety and depression were consistently associated with lower occupational engagement, lower satisfaction with occupations, poorer quality of life, and lower levels of recovery. A more complex pattern was found in social interaction, with indications of positive associations with occupational engagement, particularly among women; however, these findings were not fully consistent with the qualitative results. Furthermore, aspects of occupational balance were positively associated with quality of life and recovery.

Conclusion: The findings highlight the transition into retirement as a critical and context-dependent period, shaped by the interplay between individual conditions and access to supportive environments. Strengthening recovery-oriented services that promote occupational engagement, connection, belonging, and occupational balance appears essential to support well-being and recovery and reduce the risk of occupational injustice in later life.

Populärvetenskaplig sammanfattning

Bakgrund

Vi lever i en tid då allt fler människor når högre åldrar. Under de kommande decennierna förväntas antalet personer över 60 år fördubblas. Samtidigt ökar den psykiska ohälsan i befolkningen och utgör idag ett folkhälsoproblem, även bland äldre personer. För en del individer leder långvarig och allvarlig psykisk sjukdom till en psykisk funktionsnedsättning. Det innebär svårigheter som varar över tid och som begränsar möjligheterna att delta i samhällslivet på samma villkor som andra. Det kan också påverka förmågan att engagera sig i och hantera vardagens olika aktiviteter. Personer som har levt länge med psykisk sjukdom och som nu befinner sig i övergången till pensionsåldern utgör en särskilt sårbar grupp. Det är också denna grupp som står i fokus för avhandlingen. Denna målgrupp har oftast erfarenhet av långvarigt stöd från psykiatrin, men framför allt av olika former av stöd från den kommunala socialpsykiatrin. Tidigare forskning visar att äldre personer med långvarig psykisk sjukdom ofta generellt sett har ett större stödbehov än yngre personer med liknande erfarenheter. Behoven handlar både om att klara vardagen och om möjligheten att delta i meningsfulla aktiviteter och generellt kunna främja den egna återhämtningen. Dessa utmaningar förstärks ofta av fysisk ohälsa och andra förändringar som följer med åldrandet. Att uppmärksamma och möta dessa behov är viktigt för att skapa förutsättningar för s.k. personlig återhämtning för målgruppen äldre personer med långvarig psykisk sjukdom. Personlig återhämtning uppmärksammas allt mer inom psykiatrisk vård och handlar om att kunna leva ett meningsfullt och tillfredsställande liv utifrån sina egna förutsättningar, oavsett om psykiska symtom finns kvar eller inte. Detta till skillnad från klinisk återhämtning som fokuserar främst på symtomlindring. Trots att gruppen äldre med långvarig psykisk sjukdom växer finns det fortfarande begränsad kunskap om hur vardagen ser ut för målgruppen äldre som får stöd från socialpsykiatrin. Forskning saknas även gällande vilka faktorer som påverkar deras dagliga aktiviteter och personlig återhämtning. Forskning om personer med långvarig psykisk sjukdom generellt visar dock att möjligheter till meningsfull aktivitet och social delaktighet är viktiga för hälsan men är ofta begränsade, vilket kan öka risken för utanförskap och försvåra återhämtning.

För personer med psykisk funktionsnedsättning som behöver stöd i vardagen erbjuder kommunerna olika specifika insatser inom socialpsykiatrin. En av de insatser som erbjuds är så kallad meningsfull daglig sysselsättning som ges på olika verksamheter. Daglig sysselsättning syftar till att främja återhämtning genom att erbjuda struktur i vardagen, möjligheter att delta i meningsfulla och engagerande aktiviteter samt social gemenskap. Daglig sysselsättning kan ha olika inriktningar; vissa verksamheter fokuserar på arbetsliknande aktiviteter, medan andra framför allt betonar social samvaro. Oavsett inriktning fungerar de ofta som ett viktigt stöd i vardagen, särskilt för personer som står utanför arbetsmarknaden eller har

begränsade sociala nätverk. Trots att daglig sysselsättning kan vara en betydelsefull insats för återhämtning riskerar många personer i Sverige att förlora tillgången till denna verksamhet när de når pensionsåldern på grund av åldersgränser för stödet. För dem som deltagit under lång tid kan övergången till pensionsåldern innebära att de förlorar ett viktigt stöd i vardagen, inklusive social gemenskap, struktur och tillgång till engagerande och meningsfulla aktiviteter som kan ha främjat deras återhämtning. Risken för social isolering och ensamhet kan öka, samtidigt som möjligheterna till återhämtningsfrämjande aktiviteter minskar. Detta pekar på ett fortsatt behov av stöd även efter att pensionsåldern har uppnåtts.

Såväl svenska som internationella myndigheter och intresseorganisationer efterfrågar mer forskning som utgår från äldre personers egna erfarenheter för att förbättra stödet till den växande gruppen äldre med långvarig psykisk sjukdom. Trots detta är forskningen om hur de som åldras med psykisk sjukdom upplever sin vardag och sina möjligheter till återhämtning i övergången till pension fortsatt begränsad. Det saknas särskild kunskap om viktiga delar av vardagslivet, såsom sociala relationer, deltagande i aktiviteter, balans mellan olika aktiviteter, återhämtning och livskvalitet. Det finns också begränsad förståelse för hur dessa faktorer påverkar varandra. Utöver detta vet vi relativt lite om hur personal och chefer inom socialpsykiatri uppfattar de äldres behov och hur stödet till denna grupp utformas efter pensionsåldern. Denna avhandling syftar till att bidra till att fylla dessa olika kunskapsluckor. Avhandlingen utgår från ett aktivitets- och återhämtningsinriktat perspektiv. I båda perspektiven betonas betydelsen av aktivitet, delaktighet och social gemenskap för hälsa och välbefinnande. Möjligheten att delta i meningsfulla aktiviteter och sociala sammanhang ses som en viktig förutsättning för personlig återhämtning.

Syfte och delstudier

Syftet med avhandlingen är att öka kunskapen om hur personer med erfarenhet av stöd från psykiatri och som åldras med allvarlig långvarig psykisk sjukdom, som diagnostiserats tidigare i livet, upplever övergången till pensionsåldern, med särskilt fokus på vardagsliv, meningsfulla aktiviteter, sociala relationer och återhämtning. Avhandlingen består av fyra delstudier som belyser olika aspekter av denna livsfas. Den första studien undersökte hur personal och chefer inom socialpsykiatriens dagliga sysselsättningar uppfattade äldre personers behov och hur stödet till denna grupp utformades. Den andra studien fokuserade på de äldres egna erfarenheter av vardagslivet och de aktiviteter de ägnade sig åt i samband med övergången till pension. Eftersom meningsfulla aktiviteter och sociala relationer visade sig vara centrala för både återhämtning och känslan av tillhörighet, undersöktes dessa områden närmare i den tredje studien. Den fjärde studien fokuserade på aktivitetsbalans, det vill säga hur väl olika aktiviteter i vardagen samspelar, och undersökte hur detta hänger samman med livskvalitet och personlig återhämtning.

Metod

För att få en bred och fördjupad förståelse av hur personer som åldras med långvarig psykisk sjukdom med stöd från psykiatrin upplever övergången till pensionsåldern kombinerades kvalitativa och kvantitativa forskningsmetoder. Avhandlingens fyra delstudier bygger på varandra och omfattar både intervjuer och enkäter med äldre personer med långvarig psykisk sjukdom samt intervjuer med personal och chefer inom socialpsykiatri. Intervjuerna analyserades för att fånga deltagarnas erfarenheter och perspektiv, medan enkätdata användes för att undersöka samband mellan olika aspekter av vardagsliv, återhämtning och livskvalitet. Resultaten från de inledande studierna användes för att identifiera och fördjupa frågor som visade sig vara särskilt viktiga, exempelvis betydelsen av sociala relationer, vardagsaktiviteter och återhämtning. Den första delstudien baserades på intervjuer med personal och chefer inom kommunal socialpsykiatri. I den andra delstudien intervjuades äldre personer med långvarig psykisk sjukdom om sina erfarenheter av vardagslivet och övergången till pensionsåldern vid tre tillfällen under cirka fyra och ett halvt år. Resultaten från den andra studien låg till grund för den tredje och fjärde delstudien, där social interaktion, aktivitetsengagemang, aktivitetsbalans, återhämtning och livskvalitet undersöktes med hjälp av data som samlades in med standardiserade frågeformulär. Studierna genomfördes inom kommunal socialpsykiatri i södra Sverige, med ett mindre antal deltagare rekryterade från öppenvård psykiatri. Chefer och personal intervjuades i den första studien, medan de övriga studierna omfattade personer över 60 år med långvarig psykisk sjukdom. Datainsamlingen pågick mellan 2017 och 2024.

Resultat

Den första studien visade att personal och chefer inom kommunal socialpsykiatri upplevde att stödet till äldre personer med långvarig psykisk sjukdom inte var tillräckligt anpassat till gruppens behov. De beskrev att många av de äldre hade komplexa och ofta ökande stödbehov, samtidigt som ansvarsfördelningen mellan socialpsykiatri, äldreomsorg och hälso- och sjukvård upplevdes som otydlig. Övergången till pensionsåldern beskrevs också som att innebära en risk att förlora viktiga sociala sammanhang, aktiviteter och stödinsatser. För att förbättra stödet efterfrågades ökad kunskap om psykisk ohälsa i högre ålder, tydligare riktlinjer och bättre samverkan mellan olika verksamheter.

Den andra studien visade att meningsfulla aktiviteter, social gemenskap och en känsla av tillhörighet var centrala för deltagarnas identitet, vardagsliv och återhämtning. Dessa erfarenheter påverkade också hur deltagarna såg på sig själva och sin plats i tillvaron. Aktivitet, social gemenskap och tillhörighet framträdde som centrala delar i en pågående återhämtningsprocess. För många deltagare gav detta struktur i vardagen, möjlighet till social kontakt och tillgång till ett utbud av aktiviteter. Samtidigt präglades vardagen ofta av ensamhet, fysisk och psykisk ohälsa samt svårigheter att vara aktiv, särskilt i hemmet. Trots detta utvecklade

många strategier för att skapa rutiner, upprätthålla aktiviteter och fortsätta vara delaktiga i vardagslivet. Resultaten visar att sociala relationer och möjligheten till meningsfull aktivitet har betydelse för välbefinnande, aktivitetsengagemang och återhämtning.

Den tredje studien visade att de flesta deltagarna hade sociala kontakter, men att nätverken ofta var små och huvudsakligen bestod av familjemedlemmar. Högre nivåer av ångest och depression var kopplade till lägre aktivitetsengagemang. En större andel män än kvinnor tenderade att uppge begränsad tillgång till sociala kontakter, även om skillnaden inte var statistiskt säkerställd. Det fanns inte heller några skillnader mellan kvinnor och män när det gällde nätverkens storlek eller möjligheten att dela positiva känslor och personliga tankar med andra. Resultaten tyder också på att sociala relationer är viktiga för möjligheten att vara aktiv i vardagen, särskilt bland kvinnor.

Den fjärde studien undersökte sambandet mellan aktivitetsbalans, livskvalitet och återhämtning. De flesta deltagarna upplevde en relativt god balans i vardagen, men drygt en tredjedel beskrev någon form av aktivitetsobalans, oftast i form av för få aktiviteter. Brist på fritidsaktiviteter var den vanligaste typen av obalans. Högre nivåer av ångest och depression var kopplade till lägre tillfredsställelse med vardagens aktiviteter. Resultaten visar också att aktivitetsbalans har betydelse för både livskvalitet och återhämtning. Bättre livskvalitet var kopplad till högre tillfredsställelse med vardagens aktiviteter, lägre nivåer av ångest och depression samt att leva tillsammans med någon. En högre grad av återhämtning sågs bland personer med lägre nivåer av ångest och depression, större deltagande i olika aktiviteter och en bättre balans i vardagen.

Slutsatser

Avhandlingens delstudier visar att övergången till pensionsåldern för personer som åldras med långvarig psykisk sjukdom är en komplex och pågående process som formas av samspelet mellan individens förutsättningar, vardagens sammanhang och möjligheterna att delta i meningsfulla aktiviteter. Att åldras med långvarig psykisk sjukdom framstår som en livsfas där villkoren för aktivitet, delaktighet och återhämtning ständigt förändras. De äldres vardagsliv präglades ofta av en kombination av psykisk och fysisk ohälsa, begränsade sociala nätverk, låg energi och svårigheter att skapa struktur i vardagen. Trots dessa utmaningar beskrev deltagarna hur de aktivt försökte upprätthålla rutiner, sociala relationer och aktiviteter som gav mening och innehåll i livet. Resultaten visar att återhämtning inte upphör med stigande ålder utan fortsätter att utvecklas genom samspelet mellan individens egna resurser, tillgången till socialt stöd och möjligheterna att delta i meningsfulla aktiviteter. Avhandlingen visar också att aktivitetsbalans, det vill säga hur vardagens aktiviteter fördelas och upplevs, har betydelse för både livskvalitet och återhämtning. För denna ofta socialt isolerade grupp utgjorde daglig sysselsättning en källa till struktur i vardagen, social gemenskap och möjligheter att

delta i meningsfulla aktiviteter, faktorer som kunde stödja återhämtning. Genom en trygg plats att komma till, social samvaro och möjlighet att vara aktiv kunde deltagarna skapa, återskapa och upprätthålla en känsla av identitet, tillhörighet och delaktighet, vilket bidrog till deras återhämtning. Samtidigt visade resultaten att organisatoriska strukturer, lokala riktlinjer och åldersrelaterade gränser påverkade tillgången till dessa stödjande resurser. Detta står i kontrast till ett aktivitets- och återhämtningsinriktat synsätt. I samband med pensionsåldern riskerade vissa deltagare att förlora viktiga sociala sammanhang, aktiviteter och stödinsatser trots ett fortsatt behov.

Sammantaget utmanar resultaten föreställningen att äldre personer med långvarig psykisk sjukdom saknar möjligheter till utveckling och återhämtning. Avhandlingen visar i stället att förutsättningarna för aktivitet, delaktighet och återhämtning i hög grad påverkas av det stöd som finns tillgängligt och de möjligheter som erbjuds i vardagen. Resultaten pekar därför på behovet av mer individanpassade, aktivitets- och återhämtningsinriktade stödinsatser. Sådana insatser kan bidra till att äldre personer med långvarig psykisk sjukdom ges möjlighet att fortsätta vara aktiva, delaktiga och inkluderade i samhället samt att fortsätta sin återhämtningsprocess även efter pensionsåldern.

List of papers

Paper I

Tordai, C., Schmidt, S. M., Eklund, M., & Argentzell, E. (2024). Experiences of managers and staff working in community-based mental health with people ageing with severe mental health problems. *Scandinavian Journal of Caring Sciences*, 38(3), 782–791.

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Paper II

Tordai, C., Schmidt, S. M., Eklund, M., & Argentzell, E. (2025). Mental health service users' experiences of everyday occupations while attending day centres during the transition into retirement age. *Scandinavian Journal of Occupational Therapy*, 32(1), 2444594.

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Paper III

Tordai, C., Schmidt, S. M., Argentzell, E., & Eklund, M. (2026). Social interaction, occupational engagement, and related factors among older mental health service users with severe mental illness: an explorative cross-sectional study. *BMC Psychology* 14, 269.

<https://doi.org/10.1186/s40359-026-04142-z>

Paper IV

Tordai, C., Schmidt, S. M., Argentzell, E., & Eklund, M. (2026). Occupational balance, quality of life, and recovery among older mental health service users: a cross-sectional study. *Occupational Therapy in Health Care*, 1–23.

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Abbreviations

CHIME	Connectedness, Hope and optimism, Identity, Meaning in life, Empowerment
DC/DCs	Day Centre/Day Centres
HADS	Hospital Anxiety and Depression Scale
ICD 11	International Classification of Diseases, 11th Revision
ISSI-SR	Interview Schedule for Social Interaction
ISSI-bref	Short form of ISSI-SR
MANSA	Manchester Short Assessment of Quality of Life
QPR	Questionnaire about the Process of Recovery
PD	Psychiatric Disability
PEO	Person—Environment—Occupation (model)
POES	Profile of Occupational Engagement in Persons with Schizophrenia
SDO-OB	Satisfaction with Daily Occupations and Occupational Balance
SMI	Severe Mental Illness
SFS	Svensk Författnings Samling (Swedish Code of Statutes)
WHO	World Health Organization

Preface

This thesis is situated at the intersection of ageing, mental health, and everyday life—an arena in which I have worked throughout my professional career as an occupational therapist. My long-standing interest in this field has evolved through close work with individuals ageing with severe mental illness (SMI), where issues concerning everyday occupations, social participation, and access to support in later life became increasingly visible. It also became clear over time that ageing with SMI often involves vulnerabilities that extend beyond health-related factors, relating instead to how society organises support, values the right to an active life, and determines whose needs are prioritised. While changes in daily structure, routines, and social contexts are common in later life, such changes may be intensified for mental health service users through reduced access to organised activities and social arenas, pointing to a form of injustice at a stage of life when continuity and stability are especially important.

My clinical experience has at the same time shown me that positive change and increased well-being are possible well into later life when adequate supportive conditions are present. These observations challenge the misconception that ageing marks an endpoint for recovery or positive change. Through this work, I seek to draw attention to a group that is often overlooked in both research and practice, and whose perseverance in navigating everyday life has been a source of admiration and an important motivation for this thesis. Although the focus is on a specific group, the questions raised extend beyond mental health services alone. As ageing concerns everyone, examining the transition into retirement from an occupational and recovery perspective contributes to a broader understanding of how opportunities for a meaningful life can be supported throughout the life course. This thesis represents an effort to contribute to a more inclusive understanding of ageing with SMI that recognises both vulnerability and a capacity for continued development.

Introduction

The global demographic profile is undergoing a significant shift toward an increasingly ageing population, with the proportion of people aged 60 years and older estimated to double within the next thirty years, alongside a substantial and growing burden of mental illness affecting approximately 14 % of older adults (1). Mental health conditions negatively affect quality of life and engagement in everyday activities, generating a substantial need for daily support within this population (1). There is, at the same time, a call for research that incorporates the perspectives and lived experiences of older adults with mental illness in order to better understand their life situation and develop more responsive support strategies (2, 3). Both international and national health authorities, as well as national advocacy organisations, emphasise the urgent need to advance knowledge and establish suitable support for this group (1, 4-7).

The mental health condition results in a psychiatric disability (PD) regardless of age for some people living with SMI, where PD refers to a condition lasting longer than two years, in which people are unable to participate equally in society and face difficulties performing daily occupations (8). Existing international research indicates that older mental health service users living with PD often experience unmet needs, particularly in relation to engagement in and management of everyday activities, with these challenges further compounded by the presence of co-occurring physical health problems (3, 9-12). Addressing these multifaceted needs is therefore essential for supporting and sustaining everyday occupations, overall well-being, and personal recovery, referring to the possibility of living a meaningful life despite ongoing mental illness (13). Knowledge about personal recovery, specifically among older adults with SMI, is currently limited, highlighting an important gap that warrants further investigation.

Social isolation and loneliness, which are common among older people in general, are significant risk factors for developing mental illness later in life (1). The transition to traditional retirement age (65-67 years) can further contribute to uncertainty, loss of routines, and reduced engagement in meaningful occupations, thereby increasing vulnerability to social isolation and loneliness. This may also apply to older adults living with PD in Sweden, where policies within community-based mental health services result in service users losing their right to receive support upon reaching retirement age (4). Consequently, ageing mental health service users may find themselves without adequate support to manage daily life

and maintain engagement in meaningful occupations. The present thesis thus focuses on the transition into retirement from an occupational and personal recovery perspective among older mental health service users with long-term mental illness.

Setting the scene

This thesis is grounded in the understanding that engagement in daily occupations — the range of activities that people engage in throughout their daily lives — constitutes a fundamental human need and is closely linked to health and well-being (14, 15) and the possibility of personal recovery.

Due to a restricted ability to engage in everyday and community activities (8), individuals living with PD have been reported to have limited opportunities to interact with others, which in turn increases the risk of social exclusion (16). Within this context, opportunities for engagement in daily occupations become particularly important, as such engagement can help counteract social exclusion and support engagement in everyday life. Consequently, promoting such engagement represents a key objective for care and support services, as it is a core element for facilitating individuals' personal recovery processes (13).

Individuals with PD in Sweden, who need support in managing everyday life over and above the standard regional mental health care, may access community-based services such as activity-based day centres (DCs), which provide an important form of ongoing mental health support. Access to these services is, in most municipalities, granted following a needs assessment conducted by a care manager (municipal social service officers responsible for assessing needs and granting support) (17). DCs may either focus on work-related activities, such as workshops, home maintenance, and various service tasks, or be so-called meeting-place DCs with a focus on social activities (18). DCs offer meaningful occupations, daily structure and routines, and opportunities for social interaction across these forms (19-21).

This type of municipal support operates within a legislative framework that outlines how support for citizens in need should be organised. The Social Services Act (SFS 2001:453) in Sweden governs how municipalities should support citizens facing difficulties or health problems. The Act states that older adults, as well as adults with physical and/or psychiatric disabilities, should be able to live independently, participate in society, and lead active, meaningful lives in the community (22). However, the Social Services Act is a goal-oriented framework law that allows municipalities to decide how support and care should be organized, rather than regulating their exact design. Access to community-based mental health support is thus, in some municipalities, limited to individuals below retirement age, typically between 65 and 67 years, due to varying local interpretations of the legislation. Consequently, the Act may both facilitate and restrict opportunities for engagement

in occupations. Occupational injustice, which refers to inequitable or limited access to opportunities and resources that enable engagement in meaningful occupations, may arise when social policies and governance structures limit individuals' opportunities to participate in occupations (23). Exclusion from DCs at retirement age may thus reduce opportunities to engage in meaningful everyday occupations.

Empirical knowledge on this issue remains limited, particularly regarding how such changes are experienced by older service users and how they are understood and supported by staff and managers. This dual knowledge gap highlights the need for a more comprehensive understanding of both user experiences and organisational perspectives in community-based mental health services. In addition, there is a lack of empirical knowledge regarding how key aspects of everyday life, such as social interaction, daily occupations, personal recovery, and quality of life, are experienced and interrelated within this group. A deeper understanding of these aspects is important for capturing the complexity of everyday life among older mental health service users and for identifying factors that may support well-being and personal recovery.

The present thesis thus focuses on individuals ageing with long-term SMI who are in the retirement transition phase, including those approaching retirement, currently undergoing this transition, or who have recently retired. More specifically, the focus is on individuals with many years of lived experience of mental illness combined with a PD, who primarily receive municipal mental health services for care and support (Studies II-IV), here referred to as mental health service users. The thesis is thus limited to this specific group and context and does not aim to represent the broader older population. Many of the participants had attended community-based DCs for much of their adult lives, and most had been outside the labour market for many years. Several important knowledge gaps remain regarding their everyday lives and experiences given the specific circumstances and support context of this group. Addressing these gaps is critical for informing the development of more responsive and equitable forms of support for this population.

Background

Mental health

The World Health Organization (WHO) defines mental health as a state of well-being in which individuals can manage life's challenges, make use of their abilities, develop, work productively, and contribute to their communities (24). Mental health is commonly understood not merely as the absence of mental disorders, but also as a positive state that enables individuals to lead meaningful and fulfilling lives and to experience overall well-being. However, concepts within the field of mental health and their interrelationships are described in different ways, creating a risk of

conceptual ambiguity. To address this, the Swedish National Board of Health and Welfare presents a model that emphasises the multidimensional nature of mental health and illustrates how mental health can be understood (25). The model begins with the overarching concept of mental health, comprising two dimensions: *mental well-being* and *mental ill health*. Mental well-being refers to a state involving life satisfaction, emotional balance, positive relationships, and the ability to manage everyday life. Mental ill health encompasses a range of conditions, from psychological distress to psychiatric disorders, associated with suffering and difficulties in managing everyday life (25). The two-dimensional model of mental health conceptualises these as related but distinct constructs, indicating that the absence of mental ill health does not necessarily imply well-being. Individuals without mental ill health may still experience a low level of well-being, while those with mental ill health may simultaneously experience well-being, engagement, and a sense of meaning. This perspective is particularly relevant in occupational therapy and personal recovery-oriented practice, where the focus extends beyond symptom reduction to strengthening quality of life, resources, and opportunities for a meaningful life.

Mental ill health can occur periodically in anyone's life, but when it becomes persistent, severe, or functionally limiting, it may meet the criteria for a clinical diagnosis; in such cases, the term mental disorder may be applied. Mental disorder is a clinical and diagnostic term defined in the International Classification of Diseases (ICD-11) and used by WHO (26). However, in Sweden, diagnoses are still classified according to ICD-10-SE. A wide range of mental disorders has been identified in the field of psychiatry, including depression, bipolar disorder, anxiety disorders, and schizophrenia. These disorders are characterised by clinically significant difficulties in an individual's cognition, emotional regulation, or behaviour that negatively affect everyday functioning across personal, family, social, educational, occupational, or other important areas of life (26). While ICD-11 provides a diagnostic classification of mental disorders, research and practice often use the broader term SMI to describe long-term conditions associated with significant functional impairment. Such conditions are typically also associated with what is defined as PD. However, SMI lacks a stable and operational definition and is commonly understood in terms of the diagnosis, disability, and duration, although these dimensions are operationalised differently across contexts (27). One structured approach was proposed by Ruggeri and colleagues, emphasising both the duration of difficulties and the level of functional impairment. Older mental health service users are defined in line with this approach in this thesis (28), referring to difficulties persisting for more than two years and the need for various ongoing interventions and support (28).

Ageing and mental health

The average life expectancy continues to rise, resulting in a steadily growing proportion of older adults in the population. Ageing can be understood as a lifelong process of adaptation to changes in internal capacities and functions and to the social and physical environments in which individuals live, a process shaped by the dynamic interplay between individuals and their environments across the life course (29, 30). When older people can age in good health and within supportive social and physical contexts, their opportunities to engage in occupations may not differ substantially from those of younger individuals. Although genetic factors account for some variation in health outcomes among older adults, these outcomes are also shaped by social and physical environments, gender, and socioeconomic status. In addition, increasing age is associated with a greater likelihood of multimorbidity and an elevated risk of mental ill-health (31).

The mental health of older individuals is shaped by age-related factors, such as experiencing setbacks, declining capacity, and deteriorating functional ability. Social isolation and loneliness, both more prevalent in older age, are also significant risk factors for mental health problems later in life (1). These factors, in combination with socioeconomic factors, contribute to unequal mental health outcomes. The impact is particularly pronounced among older mental health service users, who experience severe psychological distress far more frequently than their peers. While individuals facing economic hardship or born outside Sweden also report such distress at twice the rate of others, those with chronic conditions remain disproportionately affected (32). A recent report has, however, indicated that most adults aged 65 and older, a heterogeneous group with diverse circumstances, generally report good mental well-being (7). Nevertheless, the use of antidepressants continues to increase in this population, particularly among individuals aged 85 and older, and suicide rates show a similar trend. Notably, these patterns also reflect gender differences, as older men, especially those aged 85 + and above, have the highest suicide rates, yet fewer than one percent of older adults with mental illness receive specialized psychiatric care (32).

The most common mental disorders among older adults in general are anxiety and depression (1). Symptoms of anxiety and depression are highly prevalent among mental health service users, not only because these diagnoses are common, but also because such symptoms occur across a wide range of psychiatric diagnoses and are frequently present regardless of the primary diagnosis and often co-exist (33, 34). Such symptoms may, in turn, influence how individuals perceive and report their everyday lives, including social interaction, occupational engagement, occupational balance, recovery, and quality of life.

Research focusing on ageing among mental health service users shows that depressive symptoms can negatively affect everyday occupations, perceived recovery, and quality of life (35, 36). However, these conditions are often

underrecognized and inadequately treated in older adults (1, 4). One factor that has been highlighted in this context is ageism, which may contribute to the underidentification and undertreatment of mental illness in later life (37-39). The WHO defines ageism as “the stereotypes (how we think), prejudice (how we feel) and discrimination (how we act) towards others or ourselves based on age” (40). Ageism may influence not only clinical decision-making, but also how older adults’ needs are understood and addressed within health and social care systems (37, 38, 41). Such age-based assumptions also shape how society views and structures later life transitions, including the transition to retirement. Ageism can, from an occupational perspective, therefore, be understood as an issue of occupational justice, which refers to a form of social justice that emphasises people’s right to engage in meaningful activities that support health, personal care, and social participation (23, 42, 43). Research in the Swedish context has highlighted how very old people may experience occupational injustice through restricted access to meaningful leisure activities (42). Such findings indicate that access to meaningful occupations in later life may be shaped by structural factors, an issue of particular relevance when considering older individuals with additional vulnerabilities.

Stereotypes about ageing may create structural barriers that restrict older adults’ opportunities to participate in occupations that support identity, daily structure, and social interaction when they influence the interpretation of needs and the organisation of services. These barriers, in turn, contribute to a particular form of vulnerability during ageing, a period already marked by major life transitions.

Transition to retirement age

Major life transitions, including the loss of close relationships, changes in social roles, and the transition into retirement, often accompany ageing. Reaching retirement age may represent a period of uncertainty or even crisis, particularly as it can entail the loss of long-established routines and meaningful occupations. A recent systematic review examining the relationship between retirement anxiety and life satisfaction demonstrates that this relationship is multifaceted (44). While retirement is associated with increased well-being for some individuals through greater autonomy and opportunities for engagement in meaningful activities, others experience diminished life satisfaction related to retirement anxiety, financial insecurity, loss of identity, and social isolation, depending on individual and structural factors (44). Restrictions that prevent older individuals with SMI from attending DCs after reaching retirement age can, in the context of this thesis, be understood as a form of “retirement” from structured daily activities and organised support. Although DCs do not constitute paid employment, they represent a form of service aimed at promoting occupational engagement and personal recovery, to which individuals are entitled throughout the life course (4, 22). Nevertheless, being required to leave DCs may, for many, resemble retirement from paid work, as it can

involve the loss of daily routines, social roles, and opportunities for meaningful engagement. For individuals who rely on DCs as a primary source of structure and support in everyday life, this transition may therefore have similar implications for identity, social participation, and recovery as retirement from work, with a risk of disrupting an ongoing recovery process. However, little is known about how older mental health service users themselves experience this transition or how it affects their daily lives. Smart et al. (2021) highlight that ageing well for mental health service users involves developing acceptance, maintaining social connections, and engaging in valued activities (45). This aligns with broader retirement research indicating that engaging in meaningful activities after retiring is crucial for both health and well-being (46, 47). Consequently, retirement from DCs, beyond the uncertainty it may introduce, may reduce opportunities to maintain identity, purpose, and social connectedness, factors identified as protective for mental health in later life. Understanding this transition is therefore essential for strengthening the support structures available to ageing mental health service users.

Everyday occupations in focus – core beliefs and theoretical framework

A core belief within occupational therapy is that humans are active and social beings with the capacity for ongoing development, and that health and well-being are shaped through engagement in meaningful activities. This perspective is captured in the occupational therapy framework of doing, being, becoming, and belonging, through which health and well-being are understood to emerge from the dynamic interaction of activity, lived experience, personal change, and social connectedness. The framework, which was originally articulated through doing, being, and becoming (14), was later expanded to include belonging, highlighting the relational and social dimensions of occupation (15).

A distinction is made between “activity” and “occupation” in occupational therapy. Activity refers to a general sense of doing, whereas occupations are activities that are personally meaningful and embedded in a specific social, cultural, and temporal context (48). The concept of occupation commonly refers to everyday activities that people do as individuals, in families, and within communities to occupy time and bring meaning and purpose to life, shaped by roles, habits, and identities (49). Both activity and occupation are used in this thesis, with activity primarily referring to concrete actions within service contexts, while occupation is applied as a theoretical concept encompassing the meaning and significance of everyday doing.

Several conceptual models guide occupational therapy practice, including the Person–Environment–Occupation (PEO) model (50). The PEO model emphasises the dynamic, interdependent relationships between the person, the environment, and the occupations individuals engage in. It assumes that people continually interact with their surroundings, and that changes in either personal capacities or environmental conditions influence occupational performance. Optimal

performance is achieved when there is a strong fit between the person, the environment, and the occupation. This perspective aligns with an understanding of ageing as a lifelong process of adapting to both shifting internal capacities and environmental changes (29, 30). The PEO model highlights how the transactional relationships between the person, the environment, and the occupation shape occupational performance across the lifespan, reflecting the extent to which individuals are able to perform and engage in meaningful activities in their everyday lives (50). Based on these assumptions, the model offers a suitable explanatory framework for this dissertation

Occupational engagement and occupational balance

The components that underpin occupational performance in the PEO model form the foundation for occupational engagement, a concept that can be defined in several ways depending on the context in which it is used (51). This dissertation adopts a definition grounded in its application within mental health settings, building on the theoretical assumptions of the PEO model, emphasizing that a person's level of occupational engagement is shaped by the types and number of occupations they engage in, how these occupations are structured across time and place, and the personal, environmental, and occupational domains involved (52). Occupational engagement also includes the extent to which a person is present and aware of themselves and their surroundings, as well as how they reflect on and interpret the experiences that arise through being active. These capabilities and experiences form the basis for meaning-making and continued engagement in occupations. Engagement is further understood as a dynamic construct that unfolds over time along a continuum ranging from low to high levels of engagement (53). Research indicates that mental health service users are at risk of leading inactive everyday lives with low levels of occupational engagement (54-57). It is likely that this pattern also applies to older mental health service users, although this has not yet been explored in research. On the other hand, everyday lives characterised by higher levels of occupational engagement are associated with improved health, well-being, and satisfaction among individuals living with SMI (58), underscoring the importance of supporting occupational engagement.

Occupational engagement is closely connected to the concept of occupational balance, which can be defined in various ways. It is often described through multiple dimensions, including performance and satisfaction within different occupational areas (such as work and leisure), the characteristics of occupations themselves (like cognitive and physical activities), and patterns of time use, such as the amount of time spent across various activities (59). The present thesis examines occupational balance from a related three-part perspective: the variety of occupations, personal satisfaction with performing or not performing the activities, and time allocation (60, 61). Although research underscores the importance of achieving adequate occupational balance, mental health service users frequently experience substantial

imbalance in their everyday lives. Time-use studies show that patterns of inactivity and general under-occupation are common among mental health service users under the age of 65, reflecting limited engagement in meaningful daily activities (54, 62-66). While this is the predominant picture, some findings suggest a more varied reality. One study reported that mental health service users engaged in a wide range of occupations, including diverse social activities outside the home (67), suggesting that occupational patterns in this group are not uniform. Research examining occupational balance in relation to anxiety and depression indicates that individuals with higher levels of these symptoms often report a low level of occupational balance. Conversely, higher levels of occupational balance are associated with better quality of life, greater satisfaction with occupational performance, and fewer depressive symptoms (68). These findings raise concerns for older adults (aged 65 and above) living with SMI, as maintaining occupational balance may be especially challenging due to age-related changes such as declining physical health, reduced mobility, and lower energy levels (1, 3, 9-12, 69, 70). This is further underscored by the fact that anxiety and depression are the most common mental disorders in later life (1), together with the high prevalence of co-occurring anxiety and depression symptoms among mental health service users (33, 34). Evidence regarding occupational balance among older mental health service users remains limited. Although occupational balance has been associated with quality of life in older adults more broadly (71, 72), and more active and balanced patterns of everyday occupations have been linked to higher levels of well-being from a time-use perspective (72), it is not yet clear whether these relationships also apply to older mental health service users. Moreover, research examining the different dimensions of occupational balance within this population is scarce. This thesis thus seeks to contribute to filling this knowledge gap.

Occupational identity

Occupational identity is understood as the sense of self that develops through engaging in meaningful occupations, shaped over time by a person's occupational history, roles, capacities, and social relationships (49). Christiansen (73) argues that identity formation is closely tied to occupational experiences, and that limited opportunities for engagement—together with performance limitations associated with ageing, environmental change, or illness—may disrupt this process and, in some cases, contribute to identity crises. Social connections also seem to play a central role in the construction of occupational identity. For example, Hansson et al. (74) showed that occupational identity is influenced by the people with whom individuals interact and feel connected. Having a defined social role has also been found to reinforce occupational identity among individuals ageing with psychosis (45). The group of older mental health service users included in this thesis often have long histories of under-occupation with limited access to work or opportunities for meaningful social activities. Their arenas for activity tend to be restricted, and they typically spend most of their time alone at home or in structured settings such as DCs, as reported in

previous research (69). Such constrained occupational histories can shape and sometimes diminish the development of occupational identity. Mulholland and Jackson (75) found that older adults living with anxiety and depression reported improved health when given opportunities to reconstruct their occupational identities, whereas limited engagement in identity-affirming occupations contributed to experiences of ageing and worsening mental ill-health. Given that past occupational experiences shape occupational identity and guide future occupational choices (49) and that occupational identity is closely tied to social contact (74), it may be that older mental health service users develop aspects of their occupational identity through participating in services such as DC, especially when other social arenas are lacking. This suggests that such settings could be important contexts for supporting identity and recovery, although this requires further investigation.

The concept of recovery

The concept of recovery is viewed in this thesis as an important and overarching concept when investigating how older mental health service users navigate changes, challenges, and possibilities in their everyday lives. Mental health care in Sweden strives to use personal recovery as a framework for organizing services and care, including DCs, building on engagement in meaningful occupations as a key component of support (33). Recovery has developed over the past three decades and can have both clinical and personal dimensions (76). Clinical recovery focuses on diagnosis, symptom reduction, and functional remission, and has traditionally been the primary aim of mental health services. Personal recovery, on the other hand, is a broader conceptual framework that extends beyond the absence of symptoms. It is described as an ongoing individual process through which individuals with mental health problems strive to regain a sense of control, cultivate a positive sense of self, and pursue a meaningful life despite ongoing challenges and the presence of symptoms (13, 77). Furthermore, personal recovery is understood as a lifelong process that continues into later life (78).

Older mental health service users have reported feeling increasingly capable of managing mental health problems as they age, drawing on accumulated life experience and coping strategies (45). Accordingly, research suggests that recovery processes vary across the life course. Recovery among older individuals has been associated with the preservation of long-standing identity, the use of coping strategies that support continuity, and the management of the combined effects of physical and mental illness (79). Although Barak et al. (36) identified a correlation between activity level and recovery outcomes in an older population, indicating that occupational balance may play an important role in later life, research specifically focusing on recovery among older mental health service users remains limited. Existing findings suggest that recovery in later life may be shaped by how individuals engage in, balance, and organise their everyday occupations within

social contexts. However, how everyday occupations and social interaction contribute to personal recovery in later life remains underexplored.

Recovery, social interaction, and quality of life can, from an occupation-centred perspective, be understood as interrelated dimensions aligned with core occupational concepts such as occupational engagement and occupational balance. Doroud et al (80) conceptualised recovery as an “occupational journey,” emphasising occupational engagement as a central dimension of recovery processes. Similar perspectives have been reported (81, 82), further emphasising the role of everyday occupations in shaping recovery experiences. A framework that articulates the psychosocial processes underlying recovery in relation to everyday life and social contexts is thus warranted. Recovery perspectives within occupational therapy can therefore in this thesis be complemented by the CHIME framework, presented below, which structures key psychosocial processes central to recovery and relevant to clinical research and practice. The framework conceptualises personal recovery as a multidimensional and ongoing process, emphasising how individuals rebuild a meaningful life and sense of self through lived experience and social context (13).

CHIME – a framework for personal recovery

CHIME is widely used as a framework for structuring support for service users. It is also used as a framework in the current thesis, with an emphasis on occupational perspectives. The CHIME is an acronym for the following constituents: connectedness, hope and optimism about the future; identity; meaning in life; and empowerment.

Connectedness refers to the experience of feeling meaningfully linked to other people. It encompasses dimensions such as peer support, support from significant others, and interpersonal relationships. At its core, connectedness reflects a sense of belonging, fostered through supportive relationships, including forms of peer support.

Hope and optimism involve motivation to make changes, holding dreams for the future, and believing that recovery is possible. This component emphasises that recovery is an active, self-driven process, something individuals engage in themselves, rather than something that is done to them.

Identity within the recovery process concerns redefining oneself beyond illness, trauma, or addiction. It involves rebuilding a sense of self that is coherent, valued, and aligned with one’s strengths and preferences, thereby supporting long-term recovery.

Meaning and purpose refer to creating a life that feels meaningful and purposeful and grounded in personally significant values, roles, and activities. This process involves engaging in occupations and relationships that contribute to a sense of coherence and fulfilment.

Empowerment encompasses personal responsibility, self-determination, and an emphasis on strengths (77). It involves having a sense of control over one's life and circumstances.

Quality of life

The recovery process is linked to quality of life (13). Higher levels of personal recovery have been associated with better quality of life, and individuals who feel confident in their personal recovery process likewise tend to report a higher quality of life (83). A commonly used definition of the concept is provided by WHO, which defines quality of life as “an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns” (84).

Quality of life can also be understood as a two-dimensional construct comprising personal factors—such as life satisfaction, health, leisure, work, and finances—and environmental factors, including safety, housing situation, and family circumstances (85). This conceptualization may be particularly relevant for older adults, as ageing can be viewed as an ongoing process of adapting to changes in internal capacities and functioning, which are interdependent on both the social and physical environments (29, 30). This perspective underpins the approach taken in this thesis. Research has highlighted the importance of environmental conditions for quality of life among older adults in general. Supportive environments are considered to influence occupational balance and well-being; for example, older adults living in urban areas have reported higher levels of occupational balance and quality of life compared with those living in rural areas, likely reflecting better access to healthcare, leisure activities, and social support (86).

A longitudinal study found that older mental health service users often report good quality of life and demonstrated its dynamic nature, with one-third of participants improving their quality of life over five years (35). Furthermore, a recent comparative study reported no significant differences in overall quality of life between older and younger mental health service users (87). Taken together, these findings indicate that quality of life among people with SMI is both variable and not necessarily dependent on age, underscoring the need for further research to explore the factors that influence quality of life in this population.

Social interaction and belonging

The personal recovery process places a strong emphasis on connectedness, highlighting how relationships and a sense of belonging support personal recovery (13). Social networks provide opportunities for social interaction, which may foster social connection and, over time, a sense of belonging, which is considered a key

protective factor for mental health and well-being that supports the recovery process (80, 88). Similarly, a person's opportunities for social interaction are shaped by their social network, comprising all individuals with whom they interact, such as household members, friends, and neighbours (89). Research indicates a reciprocal relationship between social networks and engagement in satisfying everyday occupations, which is consistent with the PEO model. Participating in meaningful occupations can help individuals maintain their social networks, while the subjective experience of occupational engagement is influenced by the nature and diversity of one's social connections (57, 90, 91).

Studies show that the most prominent unmet needs among older mental health service users relate to fundamental social domains (10-12). This is particularly notable given that social networks are essential for ageing well with conditions such as psychosis, as supportive networks may facilitate engagement in everyday occupations and promote overall well-being (45). Research has suggested that mental health service users often have social networks dominated by family members and relatives (92). In addition, gender may shape the structure and function of these networks. Studies of mental health service users suggest that women tend to have larger social networks than men (93). Research in the general population further indicates gender differences in how social relationships are valued, with kinship networks being more important for the well-being of men, while women more often seek support from a wider range of sources and are more affected by relational conflict or lack of support (94-96).

Across the life course, however, these networks may change substantially. While younger and middle-aged adult service users (under 50 years) may experience an expansion of their networks over time (56), studies focusing on adults aged 55 and older indicate the opposite: a gradual shrinking of networks over time (12). This decline limits opportunities for social interaction, and more recent studies describe experiences of loneliness, small networks (97-99), and relational challenges among older service users (9). Despite these insights, the size and quality of social networks among people ageing with long-term SMI remain insufficiently understood.

Taken together, existing research indicates that social networks among mental health service users may be shaped by multiple intersecting factors, including gender and ageing, and tend to shrink over time. This is particularly concerning given that such networks are fundamental for social participation, identity, engagement in occupations, and overall well-being. This underscores the need for further research examining how social networks evolve among older mental health service users and how these networks influence their daily activities and health. Just as social networks form the foundation for social interaction, social interaction in turn supports the development of social connections. Social connection is defined here as a subjective sense of having close and positive relationships and is considered crucial throughout the life course (100). A considerable amount of

research shows that a lack of social connection predicts early mortality at levels comparable to major health risk factors (100).

Belonging is closely related to social connection and has clear links to occupational engagement. Hammell (101) conceptualized belonging as a sense of being accepted and valued, highlighting how connection, interdependence, and contribution to others shape the meaning of occupations. Having a safe place within an accepting and caring community is a core element of this experience, where shared activities and mutual support foster connection and a sense of purpose (101). Viewed together, these perspectives position belonging as a key process through which occupational engagement is socially situated and given meaning. Belonging and connectedness are also central dimensions of personal recovery, in which social interaction constitutes an important component. Research has demonstrated associations between social interaction and occupational engagement among mental health service users across age groups (54-57, 60), suggesting that social interaction may support engagement in everyday occupations (54, 90). Engagement in satisfying occupations appears at the same time to sustain social networks and ongoing social interaction, indicating a reciprocal relationship between social connections and individuals' subjective experiences of occupations (57, 90, 91). Together, these findings highlight the close interrelationships between belonging, social interaction, and occupational engagement in mental health recovery. Despite this, knowledge remains limited regarding how these processes are experienced and manifested among older mental health service users.

Rationale

Limited knowledge exists about the everyday lives of older mental health service users and the factors that shape their daily occupations and personal recovery, despite an increasing population. Furthermore, although existing studies demonstrate important links between social interaction, everyday occupations, and recovery, little is known about how these interconnections operate for mental health service users who rely on services during the transition into retirement age. This life phase is often characterised by substantial changes in daily structure, access to activities, and social contacts, which may be strongly influenced by how community mental health services are organised. Older mental health service users are known to have complex and often overlooked needs, yet their experiences of everyday life remain largely underrepresented in research, policy, and mental health practice. Both international and national health authorities emphasise the importance of research grounded in mental health service users' own experiences to enhance understanding and ensure adequate support. Nevertheless, the voices of older mental health service users remain largely unheard.

Many older mental health service users risk losing structured support that helps them manage daily life and maintain meaningful occupations as access to community-based mental health services often decreases after retirement. Little is known about how older mental health service users experience the retirement stage of life, or how available resources, such as DCs, influence their opportunities for engaging in occupations, social interaction, and continued recovery. Similarly, limited attention has been given to how staff and managers within such services understand and organise support for older mental health service users who are ageing and approaching retirement. There is therefore a need to examine from an occupational perspective the transition into retirement age as a critical period shaping opportunities for everyday occupational experiences, social interaction, and recovery. In addition, there is a lack of empirical knowledge regarding how key aspects of everyday life—such as social interaction, occupational engagement, and occupational balance—relate to recovery and quality of life among older mental health service users. Furthermore, although occupational balance has been suggested to play a role in recovery, empirical studies examining its relationship to recovery and quality of life in later life remain limited.

Taken together, these gaps point to a broader lack of knowledge regarding the everyday lives of older mental health service users, particularly how everyday

occupations, social interaction, support services, recovery, and quality of life are experienced and related during the transition to retirement.

This thesis addresses these knowledge gaps by exploring the transition into retirement, either approaching, in the middle, or in completion of retirement, with a particular focus on how older mental health service users experience their everyday occupations and how key aspects of everyday life are interrelated. The thesis seeks, through this focus, to make an under-researched and growing population more visible, and to gain a greater understanding of what they perceive as meaningful and important in everyday life, and to be in recovery. Such knowledge is essential for identifying ways to strengthen personal recovery processes, support continued engagement in occupations, and promote well-being among older mental health service users.

Aims and research questions

The overall aim of this thesis was to explore the transition into retirement age among older mental health service users from an occupational and personal recovery perspective. The thesis comprised four studies, which together addressed different dimensions of this transition phase. The first study investigated how DC staff and managers described and supported ageing DC attendees during this life stage. After examining the organisational support and staff and managers' perspectives on ageing, the second study deepened the understanding of older mental health service users' own experiences of everyday occupations while having access to DC activities during this phase of life. As meaningful occupations and social interaction emerged as central aspects in the second study, the third study further examined how social interaction was perceived within this group and how it, together with sociodemographic factors and perceived psychiatric and physical problems, was associated with occupational engagement. Finally, the fourth study investigated how various aspects of occupational balance—such as variety of occupations, satisfaction with occupations, and time allocation—were related to perceived quality of life and personal recovery among older mental health service users.

Study I aimed to explore DC staff and managers' experiences of how people ageing with severe mental health problems are supported in DCs during the retirement process.

Study II aimed to explore the experiences of everyday occupations among older mental health service users attending DC while transitioning into retirement age.

Study III aimed to explore how people ageing with a mental illness, diagnosed at a younger age, perceived social interaction and its relationships with occupational engagement. Additionally, it addressed the influence of perceived symptoms of anxiety and depression, perceived physical problems, and gender, proceeding from the following research questions:

- a) How do people ageing with severe mental illness perceive social interaction?
- b) How are their perceptions of social interaction, perceived symptoms of anxiety/depression, and perceived physical problems related to their occupational engagement, and how do those relationships vary by gender?

Study IV aimed to explore how various aspects of occupational balance relate to quality of life and recovery among older mental health service users. Part of the aim was also to examine the potential influence of perceived anxiety/depression symptoms and of living arrangement (cohabiting vs. living alone) on these relationships. The research was guided by the following research questions:

- a) How do older mental health service users perceive their occupational balance (variation in occupations, occupational satisfaction, and time allocation)?
- b) How do symptoms of anxiety/depression and living arrangement influence these aspects of occupational balance?
- c) How are these aspects of occupational balance related to two dimensions of perceived quality of life—personal factors and environmental factors—and to personal recovery, while also taking symptoms of anxiety/depression and living arrangement into account?

Methods

Study design

This thesis employed both qualitative and quantitative methods to explore participants' experiences and to deepen the understanding of the transition into retirement age among older mental health service users from an occupational perspective. An exploratory approach (102) was used in this context, enabling the research focus to evolve as findings from earlier parts of the thesis project informed subsequent ones. This approach enabled the examination of preliminary patterns in social interaction, occupational engagement, occupational balance, recovery, and quality of life, complementing the qualitative findings. Such exploratory research will hopefully provide a foundation for future research that develops targeted interventions and support strategies.

The first study aimed to establish a contextual foundation for understanding older mental health service users' experiences by examining the organisation of support within community-based mental health services. Interviews were conducted with staff and managers. A qualitative design was adopted to gain an in-depth understanding of experiences within this context, given the limited knowledge regarding how transitions into retirement age are managed in these settings. Data were analysed using qualitative content analysis (103).

While the first study focused on perspectives from staff and managers, the second study centred on the transition to retirement age from an occupational perspective by exploring older mental health service users' own experiences of everyday occupations while attending DCs. To capture the transitional ageing process and changes in daily life over time, older service users were interviewed at baseline and followed longitudinally over approximately 4.5 years, using semi-structured interviews. The data were analysed using grounded theory (104)

Findings from the second study informed the development of the third study by identifying social interaction as an important facilitator of occupational engagement. To extend the understanding of occupational engagement among older mental health service users, the third study employed a quantitative, cross-sectional design. Furthermore, the fourth study examined how different aspects of occupational balance were related to quality of life and personal recovery in this group. A quantitative exploratory approach was considered appropriate for both studies, given the limited knowledge in the field, which restricted the potential for

hypothesis-driven analyses (102). The aim was instead to identify preliminary patterns and associations that could complement the qualitative findings and provide a foundation for future research.

An overview of the study design, participants, instruments, and methods for the four studies of the present thesis is presented in Table 1.

Table 1: Overview of the four studies

Study	Design	Participants	Data collection	Analysis
Study I	Qualitative	30 managers 12 staff members	Semi-structured telephone interviews Focus groups	Content analysis
Study II	Qualitative	14 mental health service users	Semi-structured individual interviews with two follow-up interviews, the first after one year and the second after four years	Grounded theory
Study III	Quantitative exploratory cross-sectional study	49 mental health service users, including the 14 from Study II	Paper-based questionnaires: background questionnaire, ISSI-SR, POES-S, and HADS	Descriptive statistics, Pearson correlation Chi-square test Independent-samples t test Multiple linear regression analysis Nonparametric test for single items
Study IV	Quantitative exploratory cross-sectional study	49 mental health service users, including the 14 from Study II	Paper-based questionnaires: background questionnaire, SDO-OB, MANSA, QPR, and HADS	Descriptive statistics, Pearson correlation Chi-square test Independent-samples t test Multiple linear regression analysis

Ontological and epistemological assumptions

The qualitative studies (Studies I and II) in this thesis are grounded in a relativist ontology, assuming that reality is multiple, context-dependent, and socially constructed, and an interpretivist epistemology, emphasizing that knowledge is generated through the interpretation of lived experience within specific contexts (105). Study II further adopts a constructivist grounded theory approach, highlighting the co-construction of meaning and the development of conceptual understanding (104). In contrast, the quantitative studies (Studies III and IV) are informed by a post-positivist perspective, in which reality can be investigated through empirical measurement, allowing patterns and associations to be identified through statistical analysis (106). Although the thesis does not follow a single, formally defined mixed methods design, it adopts a methodological pluralistic orientation in which qualitative and quantitative approaches are used in complementary ways. The use of different ontological and epistemological perspectives is intentional, and these approaches enable both an in-depth exploration of subjective experiences and the examination of patterns and associations within the transition into retirement age from an occupational perspective, thereby contributing to a more nuanced and comprehensive understanding.

Study contexts and recruitment

All the studies were conducted primarily within community-based mental health services in municipalities in southern Sweden, including municipally operated DCs; however, a smaller proportion of participants were recruited from outpatient psychiatric services. Managers responsible for mental health DCs were identified through municipal websites for Study I, and most of the contacted municipalities agreed to participate. Staff members from nine DCs with older attendees were recruited to participate in focus group interviews after approval from the manager.

The focus in Studies II-IV was on the experiences of the older DC attendees. Data were collected between June 2017 and February 2024, with a temporary pause due to the COVID-19 pandemic. Managers from seven DCs confirmed during the initial recruitment phase that they had attendees aged 60 years or older and granted permission for their recruitment. Participants were eligible if they were aged 60 years or older, had a mental illness, and attended an activity-based mental health service. Exclusion criteria included diagnosed dementia, intellectual disability, or an inability to communicate in Swedish. Purposive sampling (107) was chosen with the aim of gaining variation in gender, psychiatric diagnoses, and cognitive functioning in order to obtain rich and varied data and to enable an in-depth understanding of everyday occupations. Recruitment was facilitated through gatekeepers, specifically staff members at the participating DCs, who identified potential participants meeting the inclusion criteria. A total of fourteen individuals from seven DCs participated in Study II. Follow-up interviews were conducted after one year and four and a half years after the initial interview to capture experiences of ageing and transitions towards retirement age over time.

The same fourteen individuals also participated in Studies III and IV, for which data collection was conducted in parallel with Study II. Contact with municipalities was renewed, as the initial recruitment resulted in participation from only seven DCs; this resulted in responses from six additional municipalities. One municipality operated more than one DC, and thus a total of fourteen DCs were included in Studies III and IV. A total of 39 individuals attending DCs participated in these studies. To further increase the sample size, two strategically selected outpatient psychiatric clinics in southern Sweden were also included, one general mental health outpatient clinic and one outpatient clinic specializing in psychosis, with both services admitting older patients. Potential participants from the outpatient clinics were identified by gatekeepers based on the inclusion and exclusion criteria among individuals who had recently received or were currently receiving occupational therapy. Sixteen mental health users from the outpatient clinics were invited to participate, of whom ten consented and were included in Studies III and IV.

Participants

Study I

Twenty-six of the 30 managers interviewed were women. Most of these held managerial positions within community-based mental health services, while others were officials responsible for psychiatric services, social welfare officers, coordinators, or treatment assistants. Nine of the 12 staff members who participated in the focus group interviews were women. Ten staff members had more than ten years of experience working in community-based mental health services.

Study II

Ten of the fourteen participants were living alone at the time of the first interview, and the mean age was 64 years. Two participants attended DCs with an upper age limit and were therefore required to leave the service at the age of 65. Self-reported diagnoses and mental health problems at baseline included anxiety, depression, schizoaffective disorder, schizophrenia, post-traumatic stress disorder, and combinations of these conditions. Further characteristics of the participants are presented in Table 2.

Table 2: Information about the participants

Characteristics	Participants
Gender; n (%)	
Female	6 (43)
Male	8 (57)
Age; mean (min-max)	64 (59-68)
Living arrangement; n (%)	
Cohabiting	2 (14)
Living alone	12 (86)
Having children; n (%)	9 (64)
Education level; n (%)	
Completed 9 years of compulsory school	5 (36)
Completed upper secondary school	5 (36)
University or college degree	4 (28)
Psychiatric diagnoses; n (%)	
Psychosis	6 (43)
Anxiety and Affective Disorders	7 (50)
Other	1 (7)
Symptoms of anxiety/depression scores; mean (median, min-max)	13.2 (12, 0-26)
Self-reported physical problems; n (%)	
Yes	12 (86)
No	2 (14)

Studies III and IV

The study sample for Studies III and IV comprised 49 individuals, including the 14 participants from Study II; 29 were women, and 20 were men. The mean age was 64 years (range 59-76 years). Most participants (71%) were living alone, and having children was more common than not having children. Upper secondary school was the most frequently reported level of education. Anxiety and depression were the most commonly self-reported psychiatric diagnoses. In addition, most participants reported physical health problems, primarily related to pain and reduced mobility. Further details regarding participant characteristics are available in Table 3.

Table 3: Information about the participants

Characteristics	Participants
Gender; n (%)	
Female	29 (59)
Male	20 (41)
Age; mean (min-max)	64 (59-76)
Living arrangement; n (%)	
Cohabiting	14 (29)
Living alone	35 (71)
Having children; n (%)	36 (74)
Education level; n (%)	
Completed 9 years of compulsory school	16 (33)
Completed upper secondary school	20 (41)
University or college degree	13 (26)
Psychiatric diagnoses; n (%)	
Psychosis	17 (35)
Anxiety and Affective Disorders	28 (57)
Other	4 (8)
Symptoms of anxiety/depression scores; mean (median, min-max)	13.8 (14, 0-31)
Self-reported physical problems; n (%)	
Yes	35 (71)
No	14 (29)

Data collection

Data collection for Study I was conducted between April 2017 and November 2018. Telephone interviews with the 30 managers were carried out between April and November 2017 and lasted an average of 20 minutes. A semi-structured interview guide was used to explore managers' experiences of community-based mental health work with older mental health service users and the organisation of support for this group. Four focus group interviews with staff members were conducted on separate occasions between November 2017 and November 2018, involving a total of 12 participants from 9 DCs. These interviews lasted an average of 1 hour and 45 minutes and were guided by a semi-structured protocol focusing on staff members'

experiences of working with older mental health service users in community-based mental health services. All interviews were audio-recorded and transcribed verbatim by a professional transcriber.

The 14 baseline interviews for Study II were conducted between June 2017 and April 2018 and lasted between 15 and 90 minutes. All interviews took place in a quiet room at the participating DCs. Each interview began with information about the study aim, followed by general background questions regarding age and frequency of DC attendance. Interviews were conducted using a flexible semi-structured guide focusing on everyday occupations, ageing, and the transition towards retirement. Probing questions were used throughout to encourage elaboration, and follow-up interviews were conducted with an updated interview guide that allowed new questions to be added over time. Follow-up interviews were conducted with seven participants at the second time point between October 2018 and February 2019 at six of the seven initially participating DCs, with interview durations ranging from 17 to 67 minutes. The third round of interviews included six participants and was conducted between May and June 2022, with interview durations of 24 to 38 minutes. All interviews were audio-recorded and transcribed verbatim by a professional transcriber.

Data for Studies III and IV were collected between June 2017 and February 2024. Standardised instruments were used to assess social interaction, subjective experiences of occupational engagement and occupational balance, personal recovery, quality of life, self-reported symptoms of anxiety and depression, as well as socio-demographic and clinical characteristics. The instruments were administered through a structured dialogue, during which the data collector read each item and the available response options aloud. Each data collection session lasted approximately 60 minutes, with breaks offered as needed. Data collection was primarily conducted in a reserved room at the DCs or at the psychiatric outpatient clinics attended by the participants. Data collection took place in the participant's home in a few cases. Some participants required assistance in interpreting specific items, and in such cases, the data collector provided clarification while taking care not to influence the participants' responses.

Instruments

Background questionnaire

A background questionnaire, specifically designed for the project, was used to collect essential sociodemographic and clinical information to describe the sample for Studies II-IV and to complement the standardised instruments. The questionnaire included items on gender, age, educational level, living arrangement, parenthood, and perceived physical health problems. Additional questions addressed self-reported psychiatric diagnosis, perceived psychiatric symptoms, and

the use of psychotropic medication. These self-reported diagnoses were subsequently coded by a psychiatrist according to the ICD-10 classification (108). The questionnaire also included items assessing whether the participant had a close friend and whether they had met a friend during the preceding week to capture aspects of social interaction.

Social interaction

Social interaction was further assessed using a brief Swedish version of the Interview Schedule for Social Interaction (ISSI) (109). A short form with seven items, here termed ISSI-bref, combines selected items from the Availability of Social Integration (AVSI) and Availability of Attachment (AVAT) subscales. ISSI-bref was used in Study III to measure the availability of social interaction and provides an overall indication of access to social contacts and close relationships. The instrument has previously been found relevant for individuals with SMI (110). Scores range from 0 to 7, with higher values indicating greater availability of social interaction. Internal consistency in the present sample was acceptable ($\alpha = 0.68$) (111).

Occupational engagement

Occupational engagement was assessed using the self-report version of Profiles of Occupational Engagement in People with Severe Mental Illness (POES-S) (112). POES-S consists of nine items covering aspects of occupational engagement, including the daily rhythm of activity and rest, variety of occupations, social and environmental context, routines, and the experience of meaningful activity. Each item is rated on a four-point scale, with total scores ranging from 9 to 36, where higher scores indicate greater occupational engagement. The original POES demonstrates good content validity, internal consistency, and fit to the Rasch model (52, 112).

Occupational balance

Occupational balance was assessed using the self-report instrument Satisfaction with Daily Occupations and Occupational Balance (SDO-OB) (60, 61). The instrument captures key aspects of occupational balance by assessing variation in daily occupations, satisfaction with occupations, and perceived time allocation across four domains: work, leisure, household and maintenance, and self-care. SDO-OB includes items assessing whether participants engage in 13 specific activities, as well as parallel items measuring satisfaction with these activities on a seven-point scale. In addition, the instrument includes items assessing the perceived adequacy of time spent within each activity domain, with response options ranging from far too much to far too little, including just right. A global item assessing overall occupational balance uses the same response alternatives. Previous research has demonstrated acceptable internal consistency and construct validity for the instrument (61).

Quality of life

Quality of life was assessed using the Swedish version of the Manchester Short Assessment of Quality of Life (MANSA), a measure designed to assess overall life satisfaction and satisfaction across various domains in life (113). The instrument comprises 12 items and has demonstrated construct validity and good internal consistency ($\alpha = 0.81$) (113). Each item is rated on a seven-point satisfaction scale, with higher scores indicating better quality of life. Previous research has supported a two-factor structure consisting of a personal domain and an environmental domain (85), which was applied in this thesis (Study IV).

Personal recovery

Personal recovery was assessed using the Questionnaire about the Process of Recovery (QPR-Swe). The instrument comprises 16 items capturing key recovery dimensions, including self-worth, connectedness, and sense of control. Items are rated on a five-point agreement scale with a maximum score of 64, where higher scores indicate greater levels of personal recovery. The QPR-Swe has demonstrated very good internal consistency ($\alpha = 0.92$) and good construct validity (114).

Symptoms of Anxiety and Depression

The Hospital Anxiety and Depression Scale (HADS) was used to assess symptoms of anxiety and depression. HADS is a self-report instrument comprising 14 items, including seven items assessing anxiety and seven assessing depression, each rated on a four-point scale. The scale reflects symptom severity during the preceding week and has demonstrated good screening properties and satisfactory psychometric performance across somatic, psychiatric, and general populations (115). A combined total score of symptoms of anxiety and depression was used to represent overall symptom severity in the present study.

Data analysis

Qualitative analysis

Studies I and II were qualitative and interview-based but employed different analytical approaches. Data in Study I were analysed using inductive content analysis, according to Graneheim and Lundman (103), an approach considered appropriate for developing and deepening knowledge within a relatively unexplored research area. The first author repeatedly read all individual interviews to gain familiarity with the data. Meaning units were identified and coded inductively. The coding process involved continuous comparison of meaning units and codes to identify similarities and differences. Codes were then grouped into categories and subcategories based on their relevance to the study aim and their conceptual

similarity. To enhance credibility, two interviews were independently coded by the first and last authors to compare and resolve coding differences. Preliminary categories and subcategories were then developed collaboratively by all four authors. The focus group interviews were analysed using the same analytical procedure, including independent coding by the last author. Data from the individual and focus group interviews were subsequently merged, re-coded, and interpreted on a latent level. Categories, subcategories, and an overarching theme were identified through iterative discussions among the authors. All authors were involved in reviewing and refining the analytical structure to ensure consensus and strengthen the trustworthiness of the findings.

A constructivist grounded theory (GT) approach, as proposed by Charmaz (104), was applied in Study II to capture processes related to everyday occupations and the transition into retirement age. Conceptual frameworks and theories within this approach are constructed through interaction between researchers and participants, who bring experiential knowledge of the studied phenomenon. The authors' extensive experience in clinical work and/or research within mental health informed the interpretive process and contributed to the development of the emerging understanding. Grounded theory was considered appropriate given the limited prior research in this field, and the longitudinal design enabled exploration of processes and changes over time. Data were analysed using initial and focused coding, constant comparison, and memo writing. Categories were refined across the three interview occasions, informed by independent coding, iterative discussions among the authors, and member checking with two selected participants. The final conceptual framework was developed by integrating analyses across all interview rounds. All authors contributed to the review and final categorisation to ensure the credibility of the analysis.

Quantitative analysis-Statistics

Studies III and IV were exploratory quantitative cross-sectional studies and followed the same overall analytical structure. Statistical analyses were performed in SPSS (version 29 for Study III (116) and version 31 for Study IV (117), while consulting a statistician to ensure appropriate selection and application of analytical methods.

Descriptive statistics were used in Study III to summarize levels of social interaction. Composite scales were analysed using parametric methods, based on the assumption that they approximate interval-level measurement. Pearson two-tailed correlations, stratified by gender when relevant, were interpreted according to the guidelines presented by Akoglu (118). Multiple linear regression analyses were conducted to identify variables associated with occupational engagement, with diagnostic checks confirming the absence of multicollinearity and normally distributed residuals. Chi-square tests were applied to analyse categorical variables,

and gender differences in the availability of social interaction were examined using independent-samples *t* tests. Nonparametric tests (Spearman's rho and Mann-Whitney *U* test) were used for the social network size as this was measured with a single ordinal AVSI item. Responses to the two open-ended AVAT items were categorised thematically.

Descriptive statistics were used to calculate participants' perceptions of occupational balance, quality of life, and recovery in Study IV. Time allocation ratings derived from the SDO-OB were dichotomised into "balanced" (0) and "not in balance" (all other ratings), as very few participants reported being over- or under-occupied. Although all the time-allocation ratings were reported descriptively, only the general time-allocation item was included in the further analyses. The composite scale scores were analysed using parametric statistical methods. Different statistical methods were employed due to differences in measurement level. Associations involving the categorical variables living arrangement and time allocation were analysed using chi-square tests, whereas group differences in composite scale scores of satisfaction with occupations and variety of occupations were examined using independent-samples *t* tests. Pearson correlations were applied to assess associations between symptoms of anxiety/depression and the different dimensions of occupational balance, in accordance with Akoglu's recommendations (118). Finally, three multiple linear regression models were conducted to examine how occupational balance, symptoms of anxiety/depression, and living arrangement were associated with personal and environmental quality of life as well as recovery.

Preunderstanding and reflexivity

I maintained a reflexive awareness of my preunderstanding throughout the research process, entailing an ongoing reflection on how my own perspectives and assumptions might influence the research (119), which was continuously examined and discussed with my supervisors. This ongoing reflexive dialogue was a core element in supporting transparency across all phases of the research. My professional background as an occupational therapist in psychiatric services, with approximately 20 years of clinical experience working with older mental health service users in regional health care, provided me with a preunderstanding of the study context and participants' everyday life. I had observed in this context how access to community-based DCs was often restricted based on age-related eligibility criteria, requiring individuals to leave these environments upon reaching retirement age. This observation, together with the broader context of the research project of which this thesis forms a part, constituted one of the initial motivations for the studies included in this thesis, raising questions about how such organisational

structures may shape opportunities for engagement in meaningful occupations and recovery in later life.

Importantly, I had no prior relationship with any of the participants before the interviews, and none were receiving care within my own clinical practice.

Preunderstanding was not treated as something to be bracketed but rather acknowledged as a methodological resource in the grounded theory study (Study II). It supported sensitivity to emerging processes and informed the formulation of relevant follow-up questions during data collection. Continuous reflexive attention was at the same time paid to the risk of overinterpreting the data through the lens of prior clinical experience. Preliminary interpretations and developing categories were regularly discussed with my supervisors during the analysis phase to ensure that interpretations were grounded in the data rather than shaped by preconceptions. This iterative process of reflexive engagement contributed to maintaining analytic openness while allowing preunderstanding to function as an informed, yet critically examined, resource within the grounded theory approach.

My strong motivation to highlight a group that is often marginalized involved a risk of overly positive interpretations, a risk that was actively addressed throughout the research process. I increased my awareness of how my professional background and personal values may have shaped the study through continuous reflexive engagement, thereby contributing to enhanced transparency and credibility.

Ethical considerations

All studies included in this project received approval from the Regional Ethical Review Board at Lund University (reg. no. 2013/456) and were conducted in accordance with Swedish legislation (120) and the principles of the Declaration of Helsinki (121). All prospective participants were provided with both oral and written information about the study and gave informed consent before participation. The information highlighted key ethical principles, including voluntariness, confidentiality, and the right to withdraw at any time without consequences. To ensure confidentiality, pseudonyms were used when participants were cited in the first two articles, and all participants had an individual code, instead of their name, in the data collection. The code list is stored in a secure archive at Lund University, separate from the paper-based questionnaires.

Focus group interviews were conducted with staff from different DCs in a room at Lund University in Study I. Participation involved sharing professional experiences for research purposes, and the group discussions also enabled collegial exchange and reflection with peers from other DCs regarding work with older attendees, which may be considered a potential benefit and a rare opportunity for the participants.

Mental health service users participated in interviews and completed questionnaires in Studies II-IV. Older mental health service users are rarely represented in research, which underscores both the relevance of the study and its ethical importance in giving voice to a seldom-heard group. Interviews were conducted in a private room either at the DC or at the outpatient psychiatric clinic, with staff available afterwards if participants felt a need for additional support. To create a good interview climate and mitigate exhaustion, participants were offered coffee breaks during the interviews. Attention was paid to signs of fatigue, and the pace was adjusted accordingly throughout the interview process. Minor challenges in data collection occurred in a limited number of cases when participants experienced fatigue or difficulty during the interviews or questionnaire completion. Interviews were paused or discontinued on such situations as a precaution to minimise potential discomfort or harm. Those who completed the data collection received a gift card valued at 100 SEK as compensation for involvement in research.

Results

This section presents a summary of the main findings from each of the included papers. The reader is referred to Papers I–IV for detailed methodological descriptions and full results.

Managers' and staff's experiences of supporting older mental health service users

Staff and managers in community-based mental health services described their work with older mental health service users as taking place within a system that was not fully adapted to ageing service users in the first study. Their description reflected an ongoing balancing act between professional ideals of providing meaningful support and the realities of navigating a complex municipal care and support structure. This tension was captured in the main theme, *Minding the gap between ideal and reality, while working with a neglected group with complex needs*. This theme was synthesised from three categories identified in the data. The categories and subcategories are presented in Table 4 (122).

Table 4. Results with categories and subcategories

Category	Subcategories
Reasoning around unmet needs	Reflecting on the complex needs of older attendees
	Juggling reasons for low attendance
	Relating to the spoken and unspoken guidelines for the practice
Navigating in a muddled organisation	Dealing with boundaries between different care systems
	Setting limits or being limitless
Wishing for an enriched service	Needing more knowledge
	Wishing for a transformed service

The first category: *Reasoning around unmet needs*, illustrated how daily practice was shaped by difficulties described by the participants in meeting older attendees' needs, alongside a perceived decline in the attendance of older attendees at the DCs over time. Older attendees were portrayed as a vulnerable group with increasingly

complex support needs. Staff emphasised the importance of structured routines, predictable environments, enhanced motivational support, and safe social contexts with opportunities for engagement in activities. However, providing such support was described as challenging in the absence of clear policies for this group. The coexistence of explicit and implicit guidelines further required managers and staff to navigate both formal and informal expectations. The retirement age (65-67 years) served as a practical boundary in some municipalities, though it was often waived for ethical reasons. This is illustrated in the following quote (122), where a manager describes the challenges:

“...those who reach sixty- five...with mental health problems ... I have a tough time figuring out how to tell them; you are sixty-five, you must not come to the social meeting place anymore. ...so no, I...we do not throw anyone out, not when I am the manager anyway.

Manager 1

While some of the participants questioned chronological age as a relevant criterion, others viewed age-based limits as reasonable within existing retirement norms. Staff and managers understood unmet needs in relation to an implicit focus on progression towards work, together with underlying assumptions that DCs should not function as safe places without onward progression. In addition, without explicit reflection on the underlying reasons, staff and managers described how older attendees were perceived to have gradually withdrawn from the DCs from around the age of 50. These withdrawals were tentatively explained by staff and managers as a combination of “tiredness”, a wish “to be retired”, and worsening somatic health. Staff expressed concern at the same time that leaving DCs could increase the risk of social isolation, as many former attendees were known to have limited social networks.

The second category, *Navigating in a muddled organisation*, illustrated how unclear system boundaries shaped the everyday work of both managers and staff in relation to older service users. Decisions about whether older service users should remain within mental health services or transition to ordinary aged care varied considerably across municipalities, creating uncertainty around responsibility and pathways of support. Managers described a distinction between community-based mental health support, understood as promoting individual progress, and ordinary aged care, which was perceived as primarily focused on maintaining daily functioning. Consequently, support for older attendees was often framed in terms of maintenance rather than further development. Needs assessments, therefore, involved balancing several considerations, including functional ability, the predominance of physical versus mental health problems, the capacity of ordinary aged care to meet identified needs, and perceived potential for continued progress. These decisions were described in ways that could be interpreted as reflecting age-related assumptions, with some managers favouring transfer to aged care even when needs were primarily

related to mental health. Staff described differing approaches to their roles at the service level. Some struggled to maintain professional boundaries and took on additional supportive tasks in response to limited external support for the older attendees, while others maintained a more clearly defined role, focused on organising activities. This tension is reflected in the following quote (122):

“...we can make mistakes (do more than required) many times; it is pure humanity... nothing else. And they have quite great difficulties. But in times of need, we help... absolutely.”

Staff 3

Regardless of how they defined their roles, staff often described themselves as important social resources and role models for older attendees whom they perceived as having limited social networks and support. Mixed-age groups at the DCs were viewed by staff as creating opportunities for informal peer support, while also presenting age-related challenges, as different age groups were perceived to have differing preferences for activities.

Both staff and managers described a perceived need to reorganise the support for older attendees, an aspiration reflected in the third category, *Wishing for an enriched service*. They described substantial knowledge gaps regarding ageing with SMI, gaps that were understood to span across multiple levels of the support system. This limited knowledge was described as contributing to situations in which mental ill health was misinterpreted as part of normal ageing, thereby hindering the provision of adequate support. Within this context, clearer policies, more structured retirement and transition routines, and recovery-oriented models better adapted to older service users were seen as essential for improving care. Participants described how clearer guidelines would reduce reliance on individual interpretations and local practices, thereby providing more consistent direction for support provision. Suggested developments included meeting-oriented DCs tailored to older mental health service users, enhanced collaboration between mental health and aged care services, outreach efforts aimed at re-engaging older attendees, and the establishment of specialised teams with expertise in mental health in later life. The need for specialised competence and organisational support is reflected in the following quote (122):

“I think you should have special teams working with mental health for the older persons... I tried to bring this up several years ago: that we should have a team attached to us, which can be part of our group [community-based mental health], but still support their own home care service [within ordinary aged care].”

Manager 4

Together, the findings from the first study illustrate how organisational structures, professional perspectives, and systemic assumptions about ageing, progression, and

appropriate forms of support shaped the support provided to older mental health service users. While these results reflect the views of staff and managers, the second study shifts the focus to the perspectives of older adults themselves, exploring how they described their everyday lives and experiences of ageing while living with SMI.

Older mental health service users' experiences of everyday occupations

The older mental health service users' narratives described an ongoing process captured in the main theme: *A sense of belonging - creating, recreating, and maintaining my occupational identity while ageing with mental illness*, shown in Figure 1(123).

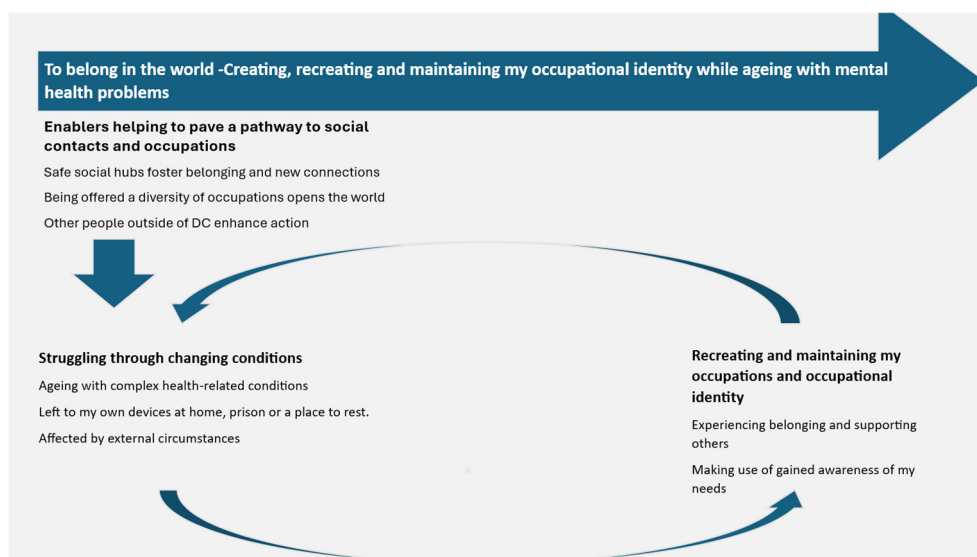


Figure 1: The process of a sense of belonging - creating, recreating, and maintaining my occupational identity while ageing

The category, *Enablers helping to pave a pathway to social contacts and occupations*, illustrates how participants' sense of belonging and occupational identity were shaped by access to supportive social environments, meaningful occupations, and relationships both within and beyond the DC. The DC was described as a safe setting that provided structure through routines, social interaction, and opportunities to feel seen and included, as illustrated by the following quote from one of the attendees (123):

“I feel like a part of something, like a family. I have contact with other people, they know me, and we say hello to each other, we talk a little, and sometimes we arrange things together, like we are going to have a New Year’s party.”

Börje

Even simple forms of engagement, such as sitting together or sharing meals, were experienced as meaningful. The DC also enabled the development of social relationships, with both fellow attendees and staff described as important sources of support. Staff were portrayed as contributing to a safe and responsive environment and, when attendance declined, actively reaching out to encourage continued attendance at the DC. Their approach was experienced as empowering and allowed support to be adapted to individual needs.

Engagement in activities was described as central to well-being, and as a key to “opening the world”. Having the freedom to choose and try new activities was also important, with staff continuously adapting opportunities to match changes in motivation and functional capacity. The possibility of moving between active and more passive forms of engagement was emphasised as important, enabling both activity and connection. In addition, social contacts outside the DC were described as motivating engagement, while limited social networks, particularly among those living alone, were often associated with inactivity. Ongoing relationships with family, friends, and others created meaningful social contexts that supported engagement; being needed by others helped sustain activity and was repeatedly highlighted in participants’ narratives.

The next category, *Struggling through changing conditions*, illustrates how creating and maintaining an occupational identity was both essential and persistently challenging, especially for participants who spent much of their time alone at home. Their everyday lives were shaped by complex, shifting needs as they adapted to changing health, ageing, and external circumstances, such as the loss of support. Many described physical decline, somatic illness, medication side effects, sleep problems, and fatigue that limited engagement in daily activities, while some also experienced improved functioning through somatic healthcare interventions, fostering greater activity and hope. Ageing brought existential reflections and worries about dependence, often intensified by witnessing peers’ decline. Being at home could mean rest, but more often involved loneliness, limited structure, and passivity, alongside an ongoing inner struggle to manage everyday tasks. This is exemplified in the following quote (123):

“... on the couch, I lie down and watch TV, then I will sleep about three to four hours, and then I will be awake again watching TV...on the weekends, it is the couch and the TV, it is ok. So, you fall asleep, then you wake up, then you fall asleep; this is how my life has become.”

Gösta

Being at home also intensified solitude and reflection, at times leaving the participants feeling mentally worse or even “trapped”. External changes, such as transitioning from disability to old-age pension, altered daily life by changing finances and expectations, while also leading to the loss of meaningful community-based support and routines, particularly when access to day centres was reduced or lost. The pandemic further amplified isolation and disrupted established structures. Despite these challenges, there were also descriptions about moments when changing circumstances led to improvements in health and finances, allowing the participants to feel hope and optimism.

The final category, *Recreating and maintaining my occupations and occupational identity*, showed how occupational identity evolved through an ongoing process. With support from various enablers, the participants navigated internal and external challenges and gradually rebuilt both their occupational patterns and sense of identity. Social connection was vital to well-being; feeling seen and belonging to settings such as the DC strengthened their sense of “being part of the world”. Relationships formed at the DC sometimes extended beyond it, and as social networks grew, the DC became less central for some. Supporting others emerged as a meaningful part of everyday life and contributed to a sense of purpose, relief, and a strengthened sense of self. Participants frequently described how they drew on their life experience to provide informal support to younger attendees, and these reciprocal interactions were experienced as deeply meaningful and a source of joy. In some cases, such relationships extended beyond the DCs, further reinforcing their significance. The same attendee, who earlier described a passive time at home, reflects here on his experiences at DC, experiences he would soon have to leave due to age restrictions (123):

“It feels good inside that you have done something good... and you think of others as well and not just being selfish. I made an impression here. I’ve been active here.”

Gösta

Participants gradually became more aware of what helped sustain their well-being through lived experience and the support available to them, which was an awareness that was often clearer and stronger when they spent time at the DC rather than at home. Remaining active was rarely effortless and was sometimes described as having to “force” oneself forward, even during more difficult periods. Still, many chose to push themselves to go for walks or attend the DC, knowing that these efforts paid off over time. Creating routines, staying engaged in activities, being social, or simply leaving the house each day emerged as a central way of holding everyday life together and protecting well-being.

The results showed that social interaction played an important role in supporting occupational engagement, while a lack of contact with others tended to lead to

passivity. The next study builds on these findings by quantitatively examining the associations between social interaction and occupational engagement.

Social interaction, occupational engagement, and related factors

Further attention was given to social interaction and how it related to occupational engagement in Study III. Most participants described having some level of social contact, although their social networks were generally small. The majority identified at least one person they regarded as a friend and had met with a friend during the past week. Many also reported having someone with whom they could share positive feelings, most often a family member, though for some this role was filled by a friend or a staff member. A similar pattern emerged regarding whom they were able to share more personal thoughts with, which was usually family members. Overall, social interaction was limited in scope: nearly all participants met or spoke with ten or fewer people per week, and almost half of the 49 participants reported contact with five or fewer individuals.

Occupational engagement among the older service users showed wide variation, with scores spanning from low to high and averaging in the upper mid-range. Social interaction, gender, and physical problems were examined together in a regression analysis to explore what might influence this variation. These factors together explained just over one-fifth of the variation in occupational engagement, but anxiety/depression emerged as the only single factor clearly associated with occupational engagement, with higher levels linked to lower occupational engagement, as seen in Table 5.

Table 5. Results from the linear regression analysis with occupational engagement as the dependent variable

Independent variable	Unstandardised beta-value	Standardised beta-value	95% confidence interval for B		P-value
			Lower	Upper	
Anxiety/Depression	-0.290	-0.453	-0.465	-0.115	0.002*
Gender	-1.334	-0.132	-4.023	1.355	0.323
Social interaction	0.423	0.143	-0.414	1.261	0.313
Physical problems	-0.830	-0.076	-3.707	2.047	0.564

*p <0.05

The size of the social network showed a borderline association with occupational engagement when considered on its own, suggesting a potential, though modest, link between the two.

A larger proportion of male than female older service users reported limited access to social interaction, although this difference did not reach statistical significance. No gender differences were found in the size of social networks or in having someone to share positive feelings or more personal thoughts with. When the analyses were separated by gender, no significant associations emerged between social interaction, anxiety/depression, and occupational engagement among men. Among women, however, a different pattern was evident: higher levels of anxiety/depression were associated with lower occupational engagement, while greater availability of social interaction was linked to higher engagement. This suggests that both symptom burden and access to social interaction were more influential in shaping occupational engagement among female service users.

To further address occupational factors and complement the examination of occupational engagement, the next study focuses on occupational balance and potential associations with quality of life and recovery.

Occupational balance, quality of life, and recovery

The focus in the final study was on occupational balance and its relationship to quality of life and recovery. The same sample as in Study III was used for this study but with different instruments; the findings showed that the older service users were engaged in a varied range of everyday occupations. Participants took part on average in seven of the thirteen occupations included in the SDO-OB. Most described a sense of satisfaction with their daily occupations, while others expressed a more neutral stance, and only a few conveyed dissatisfaction. Taken together, these results reflected variation in how occupational balance was experienced, although overall satisfaction tended to fall within a moderate to high range.

Most participants perceived their use of time as generally balanced. Among those who did not, the most common experience was having too little to do, whereas very few felt over-occupied. In total, more than one-third of the participants experienced some degree of occupational imbalance, most often characterised by under-occupation. Time was most often described as evenly distributed across work, household maintenance, and self-care. Leisure emerged as the area where under-occupation was most frequently experienced among those reporting imbalance.

Living arrangements did not appear to shape experiences of occupational balance in any substantial way. Older service users living alone and those who were cohabiting described similar patterns across all three dimensions of occupational balance explored, including how they spent their time and the range of occupations in which they were engaged. Levels of satisfaction with daily occupations, however, tended to be somewhat higher among those who were cohabiting compared with those living alone. Although this difference did not reach statistical significance, it

suggested a tendency toward greater occupational satisfaction among older service users who shared their everyday life at home with someone else.

Symptoms of anxiety/depression were not associated with the number of occupations participants engaged in or how they allocated their time; on the other hand, higher levels of anxiety/depression were associated with lower satisfaction with occupations, indicating that the symptoms were related to how everyday occupations were experienced.

Three regression models were conducted to understand whether the three aspects of occupational balance—time allocation, variety of occupations, and satisfaction with occupations—contributed to quality of life and recovery while also considering anxiety/depression (see Tables 6-8) (124). The independent variables accounted for nearly half of the variation regarding the personal quality of life aspect, with anxiety/depression negatively influencing personal quality of life, and satisfaction with daily occupations having a positive influence, emerging as key influencers. A second model focusing on the environmental aspect of quality of life explained just over one-third of the variance, indicating that anxiety/depression was negatively associated with environmental quality of life, whereas living arrangement (cohabiting) was positively associated. Satisfaction with occupations approached statistical significance, suggesting a positive association. The third and final regression model showed that perceived recovery was strongly explained by the independent variables, with close to sixty percent of the variation accounted for. Lower levels of anxiety/depression, along with greater variety in occupations and a more balanced allocation of time, were associated with stronger perceptions of recovery.

Table 6. Results from the linear regression analysis with the personal factors of quality of life as the dependent variable

	Unstandardized beta value	Standardized beta value	95% confidence interval for B		P -value
			Lower	Upper	
Anxiety/Depression	-0.562	-0.538	-0.810	-0.315	<0.001**
Cohab/living alone	-1.860	-0.105	-5.767	2.047	0.342
Variety of occupations	-0.632	-0.131	-1.828	0.565	0.293
Satisfaction with occupations	0.196	0.331	0.019	0.373	0.031*
Time allocation	-0.084	-0.005	-4.209	4.040	0.967

*p <0.05, **p <0.001

Table 7. Results from the linear regression analysis with the environmental factors of quality of life as the dependent variable

	Unstandardized beta value	Standardized beta value	95% confidence interval for B		P -value
			Lower	Upper	
Anxiety/Depression	-0.272	-0.359	-0.469	-0.075	0.008**
Cohab/living alone	-3.817	-0.295	-6.935	-0.700	0.018*
Variety of occupations	0.312	0.089	-0.642	1.267	0.513
Satisfaction with occupations	0.139	0.322	-0.003	0.280	0.054
Time allocation	-1.228	-0.100	-4.519	2.063	0.456

*p <0.05, **p <0.001

Table 8. Results from the linear regression analysis with recovery as the dependent variable

	Unstandardized beta value	Standardized beta value	95% confidence interval for B		P -value
			Lower	Upper	
Anxiety/Depression	-0.778	-0.603	-1.045	-0.511	<0.001**
Cohab/living alone	-1.287	-0.059	-5.506	2.932	0.542
Variety of occupations	1.635	0.275	0.342	2.927	0.014*
Satisfaction with occupations	0.069	0.095	-0.122	0.261	0.468
Time allocation	4.918	0.236	0.464	9.373	0.031*

*p <0.05, **p <0.001

Discussion

This thesis explores the transition into retirement age from an occupational and personal recovery perspective among older mental health service users. The discussion synthesises findings from the four studies, combining the perspectives of staff and managers with service users' experiences, together with insights into social interaction, occupational engagement, occupational balance, recovery, and quality of life. While the individual papers present the findings in detail, the present discussion synthesises them to consider their broader theoretical and practical implications. To do so, the findings are presented, together with other research and relevant concepts, guided by the PEO model (50) and, in part, by the CHIME framework (13). The PEO model provides a practical framework for understanding how everyday occupations are enabled or constrained through the interaction between individual capacities, environmental conditions, and available occupations, during a lifetime. In line with this perspective, personal recovery is not conceptualised merely as a person-level attribute but as a process that emerges through the dynamic interplay between the person, the environment, and occupational opportunities (82).

Recovery: an occupational journey in later everyday life

The results of this thesis suggest that recovery may be understood as an occupational journey in later life. Recovery appears to unfold through engagement in everyday activities within supportive contexts, in line with findings from studies of younger populations (81). Furthermore, occupational identity (49, 73, 74) and a sense of belonging (15, 101) seem to develop through such engagement and, together, contribute to shaping recovery over time. The results are discussed in detail below.

Everyday life: between vulnerability and striving in recovery

The qualitative findings from Study II illustrate how older mental health service users experience their everyday lives and the possibility of recovery, drawing on their own narratives. Life at home was experienced as an ongoing struggle, characterised by limited structure, difficulties initiating activities, and loneliness, with everyday life often confined to low-demand occupations such as resting,

sleeping, or watching television. This is in line with earlier research (9, 69) and reflects an ambivalent experience of home as both a place of rest and a form of isolation. In contrast to the isolation and under-occupation described at home, attendance at the DC emerged as a central and enabling part of everyday life, offering structure, social interaction, and opportunities for meaningful engagement.

Between burden and striving in everyday life

The interplay between long-standing mental illness, ageing, physical health conditions, medication side effects, and sleep disturbances further shaped everyday challenges. These interacting factors likely contributed to limited engagement in everyday activities (Study II). This complexity was also reflected in staff perspectives in Study I and is consistent with previous research demonstrating that older service users experience cumulative and mutually reinforcing difficulties in everyday life (1, 3, 9-12, 69, 70). Importantly, these challenges were dynamic, rather than static, varying with physical health and living circumstances, including both deterioration and occasional improvement, thereby influencing opportunities for engagement over time. The transition into retirement age can in this sense be understood as a dynamic process in which the person dimension of the PEO model is continuously reshaped by changes associated with ageing and health, influencing possibilities for engagement throughout the transition.

The narratives in Study II reflect experiences that may be interpreted as symptoms of anxiety and depression, including negative thoughts, low energy, and difficulties initiating activities. Such symptoms are prevalent among mental health service users across diagnostic categories and may influence how everyday life is perceived (33, 34). The difficulties described by participants may thus stem from insufficiently addressed mental health needs. Symptoms of anxiety and depression were a key constraint on everyday occupations, quality of life, and recovery in Studies III and IV. Even though personal recovery may occur despite remaining symptoms, the effects of symptoms have been highlighted (77), and the current findings are consistent with previous research (35, 36, 125, 126). These types of symptoms may, as previously noted, constrain engagement. This may over time contribute to a negative cycle in which reduced engagement reinforces passivity and isolation, highlighting the need for sustained social and occupational support. During the transition into retirement age, this cycle may be particularly difficult to interrupt as it emerges within a dynamic interplay between age-related changes and physical comorbidity, environmental constraints, and limited access to occupations. This underscores the importance of environments and interventions that both acknowledge symptoms and support structure and meaningful engagement in everyday life.

Self-management and emerging empowerment

Many older mental health service users described how they gradually developed routines and strategies to manage their energy and activity levels, while also struggling with their lives (Study II). This is consistent with previous research (99) and reflects an emerging awareness that engagement in everyday activities, even when requiring effort, can support recovery, which appeared to develop through contrasts between unstructured time alone at home and more active and socially oriented roles at DC. These contrasting contexts enabled participants to identify conditions that supported their recovery process. However, translating this awareness into action often required sustained effort, with participants describing the need to “force” themselves to initiate everyday doing despite a low level of energy or motivation. Many participants learned to regulate their activity patterns over time, illustrating how engagement in everyday occupations can support roles, agency, and self-management despite ongoing vulnerability (Study II). This can be understood from a recovery perspective in terms of empowerment and hope within the CHIME framework (13), highlighting recovery as an ongoing and effortful process of maintaining engagement within existing limitations. This ongoing striving in everyday life also shapes identity, another central component of that framework.

Creating and recreating an occupational identity

The ongoing reconstruction and maintenance of occupational identity emerged as a central subprocess within long-term trajectories, as illustrated in Study II. One year after leaving the DC due to retirement rules, one participant was asked what he would like to do during the day if he could choose freely. He responded: “I do not know. I feel... it is hopeless... because you don’t know what you want... And what you can do... I don’t know where my limits are... and the limits are probably low” (123). This account may represent a fragile occupational identity, in which the sense of self as an occupational being is unclear and difficult to sustain. This process unfolds within constrained everyday contexts for many participants, particularly within the home, often characterised by limited opportunities for engagement and role enactment. It is reasonable to assume that constrained occupational histories may hinder the development of a coherent occupational identity, as it can be understood as an evolving sense of self grounded in meaningful occupations and roles, and as past occupational experiences guide future occupational choices (49). Occupational identity may in this sense become dependent on access to environments that enable engagement in occupations, social interaction, and role enactment. Limited opportunities for engagement and social participation, together with performance limitations associated with ageing, environmental change, or illness, may further disrupt this process and, in some cases, contribute to identity crises (73). Previous research highlights that occupational identity is important for

well-being among older adults with SMI (75). Furthermore, “identity” is also an important part of the CHIME framework, highlighting the possibility of developing a positive sense of self that moves beyond the diagnosis, helping the individual to rediscover who they are (13). Although identity can be reconstructed despite age and health-related challenges, this appears to depend on access to supportive and socially embedded environments (45, 74, 75). Opportunities to engage in a variety of activities in contexts such as those described by the participants in Study II may be particularly important. The opportunity to try new activities adapted to individual functional capacity and motivation can enable individuals to explore and expand their occupational repertoires. This may be especially important for those with constrained occupational histories, as such experiences can support the development of occupational identity. This highlights, from an occupational therapy perspective, the importance of facilitating access to varied and meaningful occupations to support identity formation and recovery. The development and maintenance of occupational identity, and consequently recovery, may be compromised without such conditions.

Constraining and enabling contexts for occupational and recovery processes

While the previous sections have highlighted how recovery is experienced and enacted as an occupational journey by individuals in later everyday life, the following section moves the focus to how such processes are interpreted and shaped within service contexts, and hence at an environmental level (50). It examines how environmental, organisational, and normative conditions both enable and constrain opportunities for engagement in occupations, identity, and recovery, and how these conditions may create discrepancies between individuals’ lived experiences and the assumptions guiding support.

Interpreting withdrawal in institutional and structural contexts

A notable and partly unexpected finding was revealed in Study I: attendance at DCs among older service users, particularly those approaching retirement age, had declined steadily over time. This contrasts with the participants’ own accounts in Study II, where service users described continued efforts to remain active despite ongoing challenges, suggesting that reduced attendance may not reflect a lack of motivation. According to staff and managers, withdrawal often began around the age of 50 and was primarily interpreted in terms of individual factors, such as age-related fatigue, a preference for staying at home, or a perceived wish to retire similarly to other adults. This reasoning positioned withdrawal as age-appropriate

disengagement, echoing assumptions from classical disengagement theory (127), and can also be understood as reflecting ageist assumptions (40). Previous research indicates that such views are common in health and social care and may influence both assessment and access to support (37-39, 41).

In contrast, service users' accounts emphasized continued efforts and intentional striving. From a PEO perspective (50), where the environment encompasses physical, social, cultural, and institutional dimensions—including laws, policies, and the organisation of services—this discrepancy points to a potential misalignment between individuals' needs and capacities and the organisational conditions of service provision, which may result in reduced support at a time when needs are increasing. Interpretations of legislation and policy, the absence of governing documents, and expressions of ageism appeared to shape the support provided, revealing tensions between service provision and the intentions of the legislation. Such age-normative assumptions from an occupational justice perspective risk individualising withdrawal while obscuring structural influences on engagement. Framing reduced engagement as a natural aspect of ageing may therefore limit opportunities for adaptation and continued support, potentially contributing to occupational marginalisation, where individuals' opportunities for engagement are shaped and restricted by structural conditions and normative expectations, among older service users (42, 43).

The role of Day Centres: enabling and constraining environment

The empirical context of this thesis is DCs within community mental health services, which, for many participants, constitute the primary arena for everyday occupations and an important reason to leave home. Participants' narratives align with previous research, demonstrating that DCs provide access to meaningful and socially embedded activities, offering structure, social interaction, and opportunities for engagement within supportive environments (19-21, 128). Previous research has at the same time suggested that DCs may foster dependence if not guided by a clear recovery orientation, functioning as a bounded or parallel reality (129). Their centrality as an occupational arena may also constrain engagement by limiting access to other social contexts and opportunities, making engagement in occupations highly dependent on continued access to the DC. Thus, while DCs represent an important enabling context, the findings suggest that the service model itself is less decisive than how support is organised and enacted in practice. Effective support appears to depend on the extent to which the environment facilitates engagement in meaningful activities and social relationships, while also being experienced as a safe and supportive place. This includes enabling opportunities for social interaction, access to meaningful occupations across contexts, and supporting involvement in everyday life beyond service-based environments.

Belonging and recovery in social contexts

Belonging emerged as a key dimension in the recovery process, enabled through access to meaningful activities and social contexts, and functioning as a protective factor for mental health (80, 88). Opportunities to contribute, take on valued roles, and engage with others were central for fostering occupational identity, meaning, and a sense of connectedness, highlighting the importance of socially embedded occupations over time. These findings align with perspectives emphasising the relational nature of occupation, as reflected in Wilcock's framework of doing, being, becoming, and belonging (15), as well as Hammell's emphasis on connection, contribution, and social roles (101). Engagement in occupations, occupational identity, and recovery can, from this perspective, be understood as emerging from being part of social contexts. Occupational therapy can support recovery through contextually grounded forms of occupational engagement that sustain belonging over time by addressing not only individual abilities but also relational and environmental conditions.

DCs were experienced, as described in Study II, as stable and predictable contexts that supported well-being. Participants spoke of feeling seen and acknowledged, reflecting the importance of connectedness, which was also noted by staff in Study I. This function was closely linked to the relational environment, where staff and peers encouraged engagement in activities and supported re-engagement after periods of absence. Staff often constituted key social contacts for participants with limited networks, which is consistent with previous research (45), supporting both connectedness and a sense of agency and hope. Although services did not explicitly adopt a recovery-oriented framework, elements of such practice were evident in some staff's spontaneous expressions, such as "working with the heart" and an intuitive emphasis on building supportive relationships. While some staff naturally adopted recovery-oriented perspectives, other views that constrained such approaches remained prominent, alongside limited user involvement in services. This indicates that current practices may not fully support recovery-oriented care. Strengthening recovery orientation may support the development of more collaborative person-centred relationships associated with positive outcomes, as reported in previous research (130).

DCs also functioned as platforms for developing social relationships, sometimes leading to friendships, but did not necessarily facilitate broader or more enduring networks beyond the DC context. Both service users and staff described social networks outside the DC as limited, consistent with previous research regarding both those younger than 65 years of age (57, 92) and older (12). This aligns with the risk mentioned earlier, suggesting that DCs may, at times, function as a parallel reality (129), highlighting a limitation of service-based environments and the need for forms of support that extend beyond these settings. This highlights, from a recovery perspective, the importance of connectedness, understood as meaningful

relationships and a sense of belonging, which may not be sustained if social ties remain confined to a single context. Broadening opportunities for engagement across contexts may therefore reduce reliance on a single setting and support more sustainable patterns of daily occupations over time. Different levels of user involvement may enhance connectedness and facilitate meaningful relationships beyond immediate social contexts (131). The introduction of peer support workers, people with lived experience of mental ill-health employed to support service users, is one example of an organisational change that may strengthen connectedness and foster hope for the future (131). Although peer support has been implemented within Swedish mental health care services (132), its potential benefits for older service users have received limited research attention.

Supportive relationships, as illustrated in Study II, were central for reducing loneliness, enabling activity, and sustaining connection in everyday life. Most participants lived alone, and findings from Study III indicate relatively small social networks, typically centred on family members, consistent with previous research (92). Social contact was limited, with nearly half of the participants reporting interaction with no more than five individuals per week. This aligns with previous research showing that high levels of loneliness and unmet social needs are common among older mental health service users (10, 11, 97-99, 133). Such conditions may, from a PEO perspective, intensify loneliness and restrict opportunities for interaction and shared activity in everyday life, thereby limiting connectedness.

Structural barriers and inequalities in access to support

Environmental barriers, primarily identified in Study I, illustrate how organisational and structural conditions shape access to support in later life. Age-based restrictions reflect how interpretations of the Social Services Act (22) operate in practice, with retirement age functioning as an institutional boundary that may limit access to environments known to support recovery (19-21, 134). These findings indicate that access to support is not primarily organised around individual needs but structured through institutional practices combined with signs of age-based assumptions. A prevailing focus on progression into paid employment may further limit the relevance of services for ageing attendees (Study I), potentially contributing to reduced attendance or earlier withdrawal when such progression is no longer considered achievable. Notably, this was not something explicitly raised by older service users themselves; rather, staff described how older attendees sometimes sought tasks within the DC that could be framed as work training, suggesting that work-oriented norms may be implicitly internalised and continue to shape engagement in later life. Together, these findings indicate that norms of employability and progression shape both services and patterns of attendance, contributing to a misalignment with the needs of ageing users.

Findings from Study I also point to limitations in how current service structures accommodate the complex needs of older mental health service users. Divisions of responsibility between service sectors may contribute to misalignments between needs and provision at the individual level. This contradicts the intentions of the Social Services Act, which emphasizes the right to live independently, participate in society, and engage in active and meaningful activities (22). Such structural discrepancies may, from both occupational and recovery perspectives, undermine access to the conditions necessary for sustained engagement in later life and raise concerns about equitable access to supportive conditions.

Occupational engagement and occupational balance across the transition into retirement age

Occupational engagement and occupational balance are interrelated and can, in the context of ageing mental health service users, be understood as dependent on access to supportive environments and meaningful occupations.

Occupational engagement: the role of social interaction

The relationship between social context and occupational engagement appears complex rather than linear across the studies. While qualitative findings in Study II emphasised the importance of social relationships for enabling engagement, this was not clearly reflected in the quantitative analyses (Studies III-IV), suggesting that social interaction may be associated with occupational engagement. The complexity becomes still more apparent when considering gender differences. Previous research has identified gender differences in various aspects of social networks and interaction (94, 96, 135), although no such differences were found in the availability of social interaction in Study III. Nevertheless, despite the small and exploratory sample, the findings may indicate that occupational engagement among women was more closely linked to relational and emotional dimensions, while the lack of similar associations among men may reflect other underlying mechanisms. This pattern appears less consistent when considered together with the findings from the qualitative study (Study II), as the majority of participants in Study II were men, and social interaction was described as a key enabler not only for occupational engagement, but also for recovery, occupational identity, and a sense of belonging. This discrepancy suggests a potential gap between the lived experiences of men and what is captured through the quantitative measures used in Study III. This is particularly important to consider, as men are less likely to seek help or express mental health needs (136, 137), which may influence how their experiences of social interaction and engagement are reported and captured. Relevant aspects of their

experiences may thus remain under-recognised, and underlying vulnerabilities may go unnoticed. Accordingly, the discrepancy between the quantitative and qualitative findings highlights a need for continued in-depth qualitative research focusing on older men. Such approaches may be particularly important for capturing how social interaction, emotional experiences, and everyday occupations are expressed and understood in this group, and for developing a more nuanced understanding of factors influencing recovery that may not be accessible through standardized measures.

Further, the findings may be interpreted as suggesting that symptoms of anxiety and depression play a key role in shaping occupational engagement, potentially limiting individuals' capacity to make use of available social contexts. Social interaction in this sense may provide a foundation for engagement, but its impact appears neither uniform nor sufficient. This is also reflected in the lack of clear differences in occupational balance by living arrangements (Study IV), where both those living alone and those cohabiting described similar patterns of everyday occupations, although a tendency towards higher satisfaction among those cohabiting was observed. Together, these findings suggest that living arrangements alone may not fully explain variations in everyday occupations, in contrast to findings from the general older population (138). The current findings (Studies III and IV) point, however, instead to the importance of distinguishing between the availability of social contacts, interaction, and experiences of connection. Occupational factors appeared more closely linked to recovery experiences of connection and belonging than to the frequency or structure of social interaction, suggesting that relational qualities may be more central than mere access alone. Connectedness as reflected in the recovery concept may be more shaped by experiences of care and belonging than by interaction alone, which is consistent with previous research (100). Measures of social interaction may capture aspects of availability but appear insufficient to explain engagement in everyday occupations on their own. Taken together, these findings suggest that occupational engagement is shaped not only by individual capacity but also by the extent to which social contexts give rise to experiences of connection and belonging, which may not be fully captured by measures of social interaction alone. and are likely influenced by additional unmeasured factors.

Contextualising occupational engagement: variability, flexibility, and recovery

Findings from Study III indicate variability in occupational engagement among older mental health service users during the transition into retirement age, rather than uniformly low levels. This contrasts with earlier assumptions (54-57) and aligns more with recent comparative research indicating even higher engagement among older compared to younger service users (87).

This variation may be understood in relation to contextual factors, particularly access to and time spent in supportive environments that structure everyday activities, such as DCs. Although time spent in such settings was not examined in Study III, previous research indicates that the amount of time spent in such settings supports occupational engagement (139). This interpretation is further reinforced by findings from Study II, in which participants described a difference in their ability to engage in everyday activities when alone at home compared to when attending DCs.

Occupational engagement in DCs was characterized by flexibility, involving changes between active engagement and less visible forms of involvement, as described in Study II, including modes of non-doing, while still maintaining presence and connection. This aligns with research describing engagement along a continuum from disengagement to full engagement (81), where the capacity to move between these modes is central. Challenges may arise from this perspective not from specific forms of engagement but from reduced flexibility in moving between them, a difficulty often associated with mental illness. This underscores the importance of supporting diverse forms of engagement, including low-intensity and non-doing, as well as the capacity to move flexibly between them. Opportunities to engage without performance demands may support connectedness and gradual re-engagement over time, particularly in recovery-oriented contexts (81). However, such flexibility appears context-dependent. In less supportive or structured environments, non-doing may reflect withdrawal rather than a dynamic form of engagement, potentially limiting transitions into more active forms and constraining recovery (81).

Occupational balance and risk of under-occupation

Findings from Study IV suggest, on an overall level, generally balanced patterns of time use and satisfaction with everyday occupations, together with variability in how these are experienced. The reporting of imbalance was predominantly characterized by under-occupation, consistent with previous research among mental health service users (62-66). In particular, under-occupation in leisure was common, affecting more than half of the sample, mirroring earlier findings (60).

These findings, seen from a broader occupational perspective, highlight the complexity of occupational balance during the transition to retirement age. Leisure activities often lack external structure and place greater demands on personal initiative (140), which may be further constrained by a weak occupational identity, age-related changes, physical health, and psychological distress. Under-occupation in leisure among older individuals may reflect limited access to supportive structures, particularly in the absence of work and/or established daily routines, arising from the interplay between reduced capacity and constrained environmental support, rather than diminished motivation. According to previous research, leisure engagement appears more sustainable when embedded in routines that provide

predictability and support (140). These findings also highlight the importance of offering a diversity of activities, enabling individuals to explore different forms of engagement and supporting the development of occupational identity over time. Together, this points to the importance of interventions that introduce structure and external support, particularly in the leisure domain.

Qualitative findings from Study II further illustrate how reduced access to DCs may disrupt everyday routines, resulting in loss of time structure and increased inactivity. Taken together, these findings suggest that occupational engagement and occupational balance for older mental health service users are interconnected and shaped by contextual conditions. Diminished support or increased distress may contribute to under-occupation over time, highlighting the importance of environments that provide varying occupations, structure, continuity, and meaning during the transition to retirement age.

Recovery by sustaining engagement and balance

Recovery for older mental health service users can be understood as unfolding through ongoing engagement in everyday occupations that provide structure, meaning, and opportunities for connection, rather than as a linear progression towards symptom remission or employment. Findings from Study IV generally indicate moderate to high levels of personal recovery, with individual variation, consistent with research showing that recovery varies between individuals and evolves across the life course (13, 77). Qualitative accounts in Study II further illustrate how recovery is expressed through sustained efforts to maintain occupational identity, engagement, and manage ongoing physical and mental health challenges, patterns also identified in previous research on recovery in later life (79).

Occupational balance appears closely linked to recovery, with associations observed between recovery, symptom burden, and the variety and temporal distribution of occupations. Satisfaction with occupations, however, played a more limited role, consistent with previous research (141). These findings further align with previous research indicating that under-occupation negatively affects recovery (60) and that activity levels appear related to recovery outcomes in older populations (36). Such patterns may, from a CHIME perspective, support meaning and empowerment, as varied and appropriately structured occupations can foster a sense of purpose, agency, and influence over everyday life. Taken together, these findings suggest that supporting recovery requires not only enhancing meaning and satisfaction in everyday occupations but also promoting more balanced and varied patterns of activity.

Recovery, quality of life, and occupational justice: interpreting satisfaction within structural constraints

This section brings together findings related to quality of life, recovery, and occupational justice in later life, emphasizing the dynamic interplay between subjective experiences and structural conditions. It explores how recovery is experienced in relation to self-reported satisfaction with life domains, as measured by the Quality-of-Life Instrument MANSA (113), while examining how structural and environmental factors shape opportunities for engagement.

Quality of life: satisfaction within constrained contexts

Recovery is closely related to quality of life, with higher levels of personal recovery associated with better perceived quality of life (13) (83). While occupational balance was linked to both outcomes, the patterns differed, suggesting partly distinct pathways (Study IV). Notably, occupational satisfaction was associated with personal quality of life, whereas time allocation and variety of occupations were not, indicating that the subjective experience of engagement in occupations may be of most importance.

Participants generally reported moderate to high overall quality of life. Comparative research further indicates that older and younger mental health service users report comparable levels of satisfaction with everyday occupations and quality of life (87), suggesting that these outcomes may be shaped less by age itself and more by other factors.

Environment-related quality of life, encompassing safety, housing, and family circumstances, displayed greater relative variability than personal quality of life. This suggests that participants' perceptions of their environmental conditions differed more than their evaluations of personal quality of life, including aspects such as social relationships and physical and mental health. These findings suggest that different dimensions of quality of life may vary independently and should therefore be considered separately when exploring recovery among older mental health service users. This highlights the importance of addressing both personal and environmental aspects of quality of life in recovery-oriented mental health services.

The relatively high levels of occupational satisfaction among older mental health service users thus point to an apparent contradiction, where older individuals may experience balance and contentment despite restricted occupational repertoires, which is in line with the paradox of ageing (142). This may, from an ecological perspective (29, 30), reflect adaptive processes, whereby individuals gradually adjust expectations and occupational patterns in response to changing capacity and contextual constraints. Previous research on ageing with SMI suggests that such

adaptation may involve acceptance, life experience, and established coping strategies (45), which, from a CHIME perspective (13), can be understood as expressions of Identity, Meaning, Hope, and Empowerment, as illustrated by participants in Study II. This, meanwhile, warrants critical consideration: while reported satisfaction may reflect adaptation, acceptance, and increased self-knowledge, it may also represent an adjustment to constrained life circumstances. Both actual engagement and perceptions of what is possible may be restricted when access to diverse occupational opportunities is limited.

From an occupational justice perspective, attention must therefore be directed not only to individuals' satisfaction with their circumstances but also to the structural conditions that shape opportunities for engagement and participation.

Recovery as a matter of justice

The findings highlight, from an occupational justice perspective (42, 43), how occupational engagement, balance, identity, and belonging are shaped by structural conditions. Limited access to meaningful occupations beyond structured environments, such as DCs, suggests risks of occupational deprivation, where opportunities to engage in meaningful activities are restricted over time. Furthermore, age-related norms in service provision indicate processes of occupational marginalization, as older mental health service users' opportunities for engagement may be shaped by normative assumptions rather than individual needs. Patterns of engagement, often characterized by higher intensity when at the DC and lower-intensity activities at home, further reflect constraints in everyday life. These patterns suggest, on a structural level, elements of occupational apartheid insofar as opportunities for engagement in activities become structured by organizational conditions and age-based assumptions rather than individual needs (43). Together, this highlights how opportunities for engagement, identity, and recovery in later life remain unevenly distributed.

Recovery in later life: an ongoing contextual occupational journey

These findings challenge age-based assumptions of service users by demonstrating that occupational engagement and recovery remain possible in later life, underscoring that there is no age limit for recovery. Recovery can be understood as a lifelong occupational journey, shaped through engagement in meaningful and valued occupations that support connectedness, identity, meaning, hope, and empowerment (80), rather than a linear outcome. This thesis expands previous understandings by highlighting the contextual nature of recovery, shaped through the dynamic interaction between person, environment, and occupation, across life transitions, including retirement age. Recovery, from this perspective, is not solely

an individual process but is embedded within organizational conditions and age-related norms that influence access to opportunities for engagement.

While the PEO model helps explain the conditions under which recovery may occur, the CHIME framework (13) captures how it may be experienced. Together, through an occupational and recovery-oriented lens, these frameworks illustrate how structural conditions and subjective experiences interact in shaping recovery. Recovery persists as a lifelong occupational journey unfolding through doing, being, becoming, and belonging across the later years of life, rather than diminishing with age.

Methodological considerations

Overall methodological approach

Comparisons were primarily made with research within the mental health field in this thesis rather than with studies focusing on older adults in general. This reflects the recognition that older mental health service users constitute a distinct and underrepresented group, often positioned between research on ageing and mental health. International and national health authorities, as well as national advocacy organisations, have highlighted the need for increased knowledge and more appropriate mental health services in later life, pointing to gaps in how services are organised and how this population is addressed (1, 4-6, 32). Against this background, focusing on research within the mental health field was considered more appropriate for interpreting the findings, while also acknowledging the need for further research specifically targeting ageing mental health service users. These gaps in research and service organization may, from an occupational perspective, also reflect broader issues of access to meaningful occupations and support, raising questions related to equity and occupational justice.

A combination of qualitative and quantitative approaches was used to obtain a comprehensive understanding of ageing mental health service users. An exploratory approach without predefined hypotheses was adopted given the limited sample size and the scarcity of prior research specifically including older mental health service users (102). The quantitative analyses aimed to identify preliminary patterns and associations rather than testing hypotheses within a population that is often underrepresented in mental health research. Interestingly, the findings did not always differ substantially from those reported in studies of younger mental health service users, suggesting that some patterns may be shared across age groups. This underscores the importance of including older individuals in research to better understand both similarities and differences across the life course.

Access to participants and sampling

A larger number of older adults attending community-based DCs was anticipated during the planning phase. However, it became evident early in data collection that relatively few older service users were present. This limited the scope for certain comparisons, such as between individuals with continued access to DCs and those excluded due to age-related eligibility. This observation may at the same time represent an important finding in itself, suggesting that older mental health service users are underrepresented in community-based DCs.

The sampling strategy was purposively guided by the aim of including older mental health service users with variation in gender, psychiatric diagnoses, and cognitive functioning. However, in practice, it was shaped by the constraints related to accessing this population, resulting in a pragmatic combination of purposive and convenience sampling.

Recruitment required repeated efforts within the municipal services, and the sampling strategy was extended to include individuals receiving support from regional mental health services. This pragmatic approach increased heterogeneity but may also have introduced selection bias, as participants from different service contexts may differ in terms of needs, functioning, and engagement patterns. This variation may at the same time enhance the transferability of the findings within the broader mental health service system.

The sample in Studies II-IV included individuals with varied mental health conditions and cognitive limitations. This contributed to a breadth of experiences, although it also resulted in variation in data depth (Study II). Importantly, the studies captured perspectives from a rarely studied group whose voices are seldom represented in research. By including all available participants, the study enabled individuals who might otherwise have been excluded to contribute their perspectives on everyday life.

Differences in participant characteristics across the studies are also important to consider when interpreting the findings. A larger proportion of participants in the qualitative study (Study II) were men, and a greater proportion lived alone and reported physical health problems compared to the sample in Studies III and IV. This suggests that the qualitative study may have captured a more vulnerable subgroup of older mental health service users. Such differences in sample composition may influence how key phenomena are experienced, expressed, and captured across the studies. Accordingly, these aspects should be taken into account when interpreting the findings of the thesis as a whole. They may help explain discrepancies in the lived experiences of men, where social interaction was described as central in Study II, and what was captured through the quantitative measures in Study III. This, in turn, may reflect limitations in how relational aspects were operationalized in the quantitative data.

Recruitment relied on gatekeepers, which facilitated access to this hard-to-reach population, but may also have influenced the composition of the sample and the ability to reach participants over time. Limited direct contact between the researcher and participants further constrained follow-up in the longitudinal Study II. At the same time, the use of gatekeepers can be understood as an ethically appropriate and contextually necessary strategy. These factors should be considered when interpreting the findings.

The limited representation of certain groups, including individuals with immigrant backgrounds and those who had discontinued services, may have constrained the diversity of experiences captured, influencing both credibility and transferability. Previous research suggests that individuals with immigrant backgrounds may face additional challenges, indicating that their experiences may be underrepresented in the findings (143, 144), while less is known about those who have discontinued services, highlighting a need for further research. The findings should be interpreted in relation to the national welfare system and service organization as the studies were conducted within a Swedish context, and caution is warranted when considering their applicability in other settings.

Statistical limitations

Although a target of 60 participants was set based on previous research using similar instruments (145), only 49 participants were recruited despite extensive efforts, primarily due to the limited number of eligible individuals. The small sample size reduced statistical power, which increased the risk of type II error (146). It further constrained both the number of variables included in regression analyses and the ability to detect subgroup differences. Although the use of multiple statistical tests may also increase the risk of type I errors, the analyses were guided by qualitative findings. Consequently, the quantitative analyses were informed and grounded in patterns identified in participants' lived experiences, which may strengthen the interpretability of the findings. The quantitative studies contributed at the same time to identifying preliminary patterns and associations between key variables, such as social interaction, occupational engagement, occupational balance, recovery, symptoms, and quality of life, and provided an overview of variation within the population. The quantitative findings thus offer a complementary perspective to the qualitative results, providing an initial empirical indication of patterns that would otherwise remain largely unexplored. Taken together, the findings should be interpreted with caution and understood as indicative rather than confirmatory, contributing to hypothesis generation in an under-researched field.

Trustworthiness and data quality

Methodological rigor was addressed through considerations of trustworthiness. Credibility and dependability were strengthened in the qualitative studies (Studies I-II) through independent analysis of selected transcripts by two authors, systematic analysis across time points, and ongoing discussions within the research team, contributing to reflexivity throughout the process. Participant validation further supported the resonance and relevance of the findings in Study II.

The use of standardized instruments administered consistently by the same data collector in the quantitative studies strengthened internal validity and reliability, while the use of established measures supported construct validity. By administering the instruments through a structured dialogue, where each item and its response options were read aloud, the study enabled the inclusion of participants with varying levels of cognitive and mental health-related difficulties, thereby supporting broader representation. The use of multiple methods and data sources enabled triangulation, contributing to a more comprehensive understanding. However, the relatively small sample size and recruitment strategy limit the robustness and generalizability of the findings.

Study-specific considerations

Study I

Study I provided important contextual insights into how support for older mental health service users is understood and organized by both DC staff and managers within community-based mental health services. Including both perspectives enriched the data and strengthened credibility by capturing variation in how support is conceptualized and enacted. However, the limited direct experience among managers suggests that some reflections may be more speculative than experience-based, reflecting broader structural conditions such as the absence of clear policies regarding users approaching retirement. Trustworthiness was addressed in terms of credibility, dependability, and transferability in line with qualitative content analysis as described by Graneheim and Lundman (103). Credibility and dependability were strengthened through independent analysis of selected transcripts by two authors and ongoing discussions within the research team. The inclusion of both staff and manager perspectives, together with data collection across multiple municipalities, contributed to a richer and more nuanced dataset. Although the number of participants in the focus groups was smaller than intended due to late dropouts, the interviews still followed the same focus group format, allowing for interaction between the participants that in total represented nine DCs.

Study II

Study II included all participants identified through gatekeepers due to the limited number of eligible individuals. The use of grounded theory was well-suited to the exploratory nature of the research, allowing for the development of a preliminary conceptual understanding. The study met the requirements of credibility, originality, resonance, and usefulness in line with grounded theory (104). The longitudinal design and systematic analysis strengthened credibility, while the study contributed original insights into a rarely studied group. Resonance was supported through participant validation, although this involved only a small subset of participants. The findings may be considered useful for both practice and future research.

Studies III and IV

The quantitative studies were exploratory and limited by sample size, which reduced statistical power and constrained the scope of analyses. They complemented the qualitative findings at the same time by providing a broader understanding of variation and relationships between key variables.

Overall assessment

Taken together, the methodological approach reflects a prioritization of exploration and understanding in a field with limited prior research. While limitations, including sample size and recruitment procedures, constrain the strength and generalizability of the findings, the combination of qualitative and quantitative approaches enabled a comprehensive and contextually grounded analysis. The study contributes to knowledge development and provides a foundation for future research on older mental health service users and their everyday lives by integrating perspectives from multiple data sources and methods.

Use of AI tools and author responsibility

Language editing and phrasing support in the writing of this thesis were provided using Microsoft Copilot, an AI-based software (147). The tool was used to enhance clarity of expression, and all outputs were critically reviewed and revised. Responsibility for the content, interpretations, and conclusions remains solely with the author.

Conclusion and implications

Conclusion

Proceeding from an occupational and recovery perspective, this thesis provides new insights into the transition into retirement age among older mental health service users, conceptualizing it as a dynamic and contextually shaped process in which occupational engagement and recovery emerge through the interplay between individual conditions, everyday contexts, and access to meaningful occupations.

A core contribution is the understanding of ageing with SMI as an ongoing transition characterized by a changing person–environment fit over time. Access to structured and socially supportive environments within this process appears to be important for enabling engagement, belonging, and recovery-related processes.

Everyday life at the individual level was often characterized by vulnerability, reflecting the complex interplay between physical and mental health conditions, including symptoms of anxiety and depression, limited energy, and restricted social networks. Participants demonstrated agency at the same time through sustained efforts to maintain routines and remain engaged in meaningful activities, highlighting recovery as an ongoing and effortful process shaped by both personal capacities and surrounding conditions.

Organizational structures, age-related assumptions, and variations in service provision played a central role in shaping access to support. Reduced attendance at DCs appears to reflect not only individual factors but also structural conditions, including eligibility criteria and implicit norms related to ageing and employability, pointing to a misalignment between individual needs and service provision during the transition into retirement age.

Occupational engagement and balance were characterized by variability rather than uniformly low levels, encompassing both active engagement and less visible forms of involvement. Occupational imbalance was primarily expressed as under-occupation, particularly in the leisure domain. These patterns underscore the importance of sustained access to varied and meaningful occupations for supporting recovery, occupational identity, and a sense of belonging. The findings further suggest that occupational balance may play an important role in both quality of life and recovery, highlighting the importance of a variety of everyday activities, satisfaction with occupations, and time allocation.

Importantly, the findings challenge age-based assumptions by demonstrating that there is no inherent age limit for change and recovery. Rather, occupational engagement and recovery remain dynamic and possible in later life but are shaped by access to supportive environments and opportunities to engage in activities beyond the home. Change is thus not static but contingent on the conditions within which everyday life unfolds. The results point at the same time towards issues of occupational injustice, where opportunities for engagement for those ageing with SMI are unevenly distributed across municipalities and at risk of being restricted through age-based service boundaries and a lack of individualised support.

Taken together, this thesis contributes to a more nuanced understanding of recovery in later life as a relational and context-dependent process, shaped by access to meaningful occupations and supportive environments and opportunities for connection and belonging across the transition into retirement age.

Clinical implications

Support for engagement in activities and social interaction should, from an occupational justice perspective, be based on individual needs rather than shaped by age-related limitations within existing service systems. Interpreting reduced engagement as a natural consequence of ageing may otherwise risk obscuring unmet needs, highlighting the importance of critically examining age-normative practices and ensuring equitable access to meaningful occupations and social participation regardless of age.

When services such as DCs function as safe social arenas where older mental health service users can engage in meaningful activities, experience a sense of belonging, and build and sustain social relationships with the support of staff, they appear to play an important role in enabling recovery in later life. This underscores the need to ensure continued access to these types of social arenas beyond age-related service boundaries.

Strengthening a recovery-oriented approach, including increased user involvement, may further enhance service provision by supporting more collaborative and person-centred practices. In this context, introducing various forms of user involvement may facilitate meaningful relationships and contribute to experiences of connection and belonging that extend beyond service-based environments. Such approaches may also support continuity and recovery over time.

There is, from a clinical and occupational therapy perspective, a need to support engagement that is both structured and flexible, particularly in under-occupied domains such as leisure. This includes facilitating routines, offering a variety of meaningful activities, and providing support without performance demands. Greater

attention should be paid to relational aspects of occupation, as experiences of connection and belonging appear central to sustaining engagement and recovery.

The use of assessments of occupational balance may further contribute by providing a more holistic understanding of individuals' everyday lives and complementing traditional outcome measures.

Implications for future research

Further research with larger samples is warranted to explore relationships between everyday occupations and related factors among people ageing with SMI. Findings from large-scale studies may be used to develop more targeted and effective support for this population.

There is a need for research examining how interventions that provide structure, routines, and engagement in meaningful occupations, particularly within home and leisure domains, where under-occupation appears most evident. Future studies could explore how structured and externally supported interventions in everyday contexts, especially in the leisure domain, may facilitate engagement and contribute to more balanced patterns of daily activity.

While the integration of user involvement in services is currently evolving in Swedish mental health, the potential role of this movement in supporting older mental health service users warrants further exploration.

Finally, further research is needed to explore the experiences of those ageing with SMI beyond service-based contexts, as individuals not engaged in or who have discontinued support from services remain under-researched and may face different challenges. Greater attention should also be given to underrepresented groups, such as older individuals with immigrant backgrounds.

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