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PO Box 117
221 00 Lund
+46 46-222 00 00

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MANUELA SCHMIDT

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Manuela Schmidt

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Abstract

The overall objective of the thesis was to describe who persons that frequently use psychiatric emergency services (PES) in Sweden are, to explore what needs they experience as well as how healthcare professionals working at PES view the needs of those persons and experience encounters with them.

This thesis includes both quantitative (I, II) and qualitative (II, III, IV) research designs and applies a broad range of data collection methods, such as use of register data (I), use of survey data (II), individual interviews and focus group interviews (III, IV). Data were analysed with statistical tests (I, II) and with qualitative content analysis (II, III, IV).

Study I is based on visits to PES during 2013–2015. A total of 27,282 persons made 67,031 visits. Of those 27,282 persons, 8.1% could be identified as frequent PES users, accounting for nearly two fifths of all visits. In Study II, 81 persons who frequently visited PES participated. The participants in Studies III and IV were healthcare professionals working at PES, such as assistant nurses, nurses with specialised education in psychiatry, and physicians. Nineteen healthcare professionals participated in individual interviews in both Study III and Study IV, and each of the studies was complemented with a focus group interview involving five and six professionals respectively.

The findings of this thesis were as follows: persons who frequently use PES in Sweden are a small, yet highly heterogeneous group who make a disproportionately high number of visits and differ significantly from other PES visitors; persons who frequently use PES and healthcare professionals at PES are in agreement about the complex and intertwined need patterns of the patients that originate from problems in everyday living, acute psychiatric suffering, and insufficient care possibilities, and thus were found to suffer from illness, unfavourable life circumstances and inadequate care; healthcare professionals at PES experienced the encounter as consisting of caring, professional, and humane processes where persons who frequently use PES were seen as fellow human beings and as unique, and were treated with as much respect, kindness, humility, confirmation, and empowerment as possible; and that in order to have caring encounters with persons who frequently use PES, the healthcare professionals also needed to nurture the relationship with oneself and with colleagues. Those results were interpreted by means of person-centredness and in light of a recovery-oriented care approach. Even though the latter has received more acknowledgement and acceptance within psychiatric care in the last decade, it needs to be developed and implemented further in the Swedish psychiatric care context.

Key words psychiatric emergency services, frequent use, needs, encounter, content analysis, person-centredness, Tidal Model

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‘Health is a human right and that right should apply equally to physical and mental health problems. Mental health services have historically been poorly funded and given a low priority, which means that the one in four of the population who will experience a mental health issue either have to wait far too long for help, treatment and support, or do not get any help at all. … This lack of mental health services is a form of discrimination that can result in violations of people’s basic human rights, and it must end. We all need to talk more about mental health, and governments must invest more in services and the nurses that make them run smoothly. Nurses act as patient advocates and play an essential role in preventing and eliminating … poor treatment of people with mental illness.’

Howard Catton, CEO
(International Council of Nurses (ICN), 2019)

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Acknowledgement

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Abbreviations and definitions

PES	Psychiatric emergency services (a psychiatric emergency department, open 24 hours a day, seven days a week). PES and acute intensive care units (also called acute psychiatric inpatient units) represent acute psychiatric care settings. It is acknowledged that the provision of acute psychiatric care services varies across countries.
Persons who PES	Five contacts or more within a period of 12 months frequently use
Need	Needs are understood as problems or a lack of health, well-being, access to care and services, or activities/interventions (Brewin, Wing, Mangen, Brugha, & MacCarthy, 1987).
Recovery	Recovery in psychiatric care is understood as a journey, process or attitude, in contrast to somatic care where it is more seen as an outcome, a destination, or cure (Deegan, 1997).
WHO	World Health Organization

List of Publications

This doctorate thesis is based on the following papers:

I: Schmidt, M., Ekstrand, J., & Bengtsson-Tops, A. (2018). Clinical profiles and temporal patterns of psychiatric emergency room visitors in Sweden. *Nordic Journal of Psychiatry, 72*(3), 197–204.

II: Schmidt, M., Ekstrand, J., & Bengtsson-Tops, A. (2018). Self-expressed and self-assessed needs in persons who frequently visit psychiatric emergency rooms in Sweden. *Issues in Mental Health Nursing, 39*(9), 738-745.

III: Schmidt, M., Garmy, P., Stjernswärd, S., & Janlöv, A.C. (2020). Professionals' perspective on needs of persons who frequently use psychiatric emergency services. *Issues in Mental Health Nursing. 41*(3), 182-193.

IV: Schmidt, M., Stjernswärd, S., Garmy, P., & Janlöv, A.C. (2020). Encounters with persons who frequently use psychiatric emergency services: Healthcare professionals' views. *International Journal of Environmental Research and Public Health,* 17, 1012, doi:10.3390/ijerph17031012 (Special Issue Mental Health Nursing)

Reprints are made with kind permission of the publishers. Paper I and an older submitted version of Paper II are also published in the licentiate thesis that was defended in June 2018 (Schmidt, 2018b) which was extended with Study III and Study IV. Several paragraphs from the licentiate thesis—mainly concerning the introduction, method, and ethical or methodological considerations for Studies I and II—were thus partly reused in this thesis. In particular, the *Introduction* chapter of the doctorate thesis corresponds to some extent with the same named chapter of the licentiate thesis, but, was further developed. The background subchapter *PES and the healthcare and social care services in Sweden* of the doctorate thesis corresponds to large extent with the background subchapter *Healthcare and social care services in Sweden* of the licentiate thesis. The *Method* chapter of the doctorate thesis corresponds 1) to some extent with the same named chapter of the licentiate thesis with regard to the subchapter *Design*, which however was further developed; 2) to large degree with the subchapter *Research context* Studies I and II; and 3) to large degree when describing the register data of Study I and the survey data of Study II, its participants and the analyses used. Finally, the chapter *Ethical considerations* and *Methodological considerations* of the licentiate thesis were reused, but were considerably developed.

Preface

> ”The emergency department is a safety net, I feel safe with the healthcare professionals, I like them, they are nice and they know what they are doing. I am greeted pleasantly and well treated. Getting a smile makes me feel better.” (Person with frequent PES visits, data collection manuscript II, 2016)

> “I don’t feel I’m getting any help [here]. [I’m] being unfairly treated by the doctors. I feel like an experiment” (Study II)

It is Monday morning. I am excited to start my observations at a PES. Nervously excited.

Excited because I am about to start my PhD studies. I am ready to dive into this project with open arms and with no hindrances as I have very limited pre-understanding both about persons with mental illness as well as PES as a setting. Having a background in business administration and not being a nurse myself, I am aware of both the advantages and disadvantages of being a novice in this field. So this is a very exciting and exotic endeavour, I thought. Studying something so far away from my reality and everyday life, not really knowing anyone who suffers from mental illness or uses PES, as far as I am aware.

And I am nervous. What will I see during my observations? Who will I meet? Probably people with intellectual disabilities, people with alcohol addiction, and people showing aggressive behaviour? I approach the site, I see glass doors and glass windows. I ring the bell and wait to be let in. It takes time. Glass door after glass door follow. All the doors are locked. I am greeted by the healthcare professionals and enter the small waiting room. And I can’t help but wonder, who goes through these doors? What does it feel like for them, what do they think when they come here? What state are they in? Why do they come and what do they need help with? How are they treated by the healthcare professionals? And just imagine, if you have to come here again and again, does it make any difference to how you are encountered? What do healthcare professionals think about those patients, actually?

During my observations at PES and during triage, I quickly realised that persons who (frequently) use PES are like anybody else, like you and me. And as time went by during my lengthy PhD studies, I came to realise that I do know people—close friends, acquaintances, colleagues, neighbours—that do use PES, frequently. There is nothing exotic or extraordinary about those people or those that I met at PES during my observations. They are as ordinary as can be, yet often they face immense challenges in their everyday life, lack coping mechanisms, or are tackling symptoms of a psychiatric illness such as depression, which are situations that we can all find ourselves in sooner or later. It humbled me; possibly scared me too about the future. And it definitely encouraged me to continue with and deepen this newfound passion of mine: mental health and mental illness.

My preconceptions were wrong, partly. I hardly met any people with intellectual disabilities, and as Study I shows, there are very few persons with intellectual disabilities visiting PES. Yes, I met people with alcohol addictions; in fact, alcohol related disorders are some of the most frequent illnesses among persons who frequently visit PES, as Study I shows. However, I met nowhere near as many as expected, probably because my observations were mainly scheduled during day time, not during night shifts, which—as Study I also shows—is the time when people with alcohol addiction are more likely to visit PES. There were only two occasions when I could observe harmful behaviour as a result of high distress and anxiety. In both cases, the actions were not directed towards other people, such as healthcare professionals, but were intended to cause self-harm.

This thesis focuses on persons who frequently use PES. To understand them, one needs to look beyond the obvious, pathological conditions. The point of departure to understand the problem of frequent use of PES should be to ask who the persons are who frequently use PES, and try to understand what kind of needs they have. As one quotation above shows, healthcare professionals working at PES and how they encounter persons who frequently use PES, play a central role for those persons. That is why the healthcare professionals' perspective is included in this thesis as well. The other quotation above reveals –which is equally important to consider and address—that many persons have negative experiences with PES, feel that they are not helped at all, and do not like how they are encountered by healthcare professionals.

It is expected that mental illness will continue to grow among all age groups. Thus sustainable solutions need to be found now for meeting the needs of persons with mental illness in general and persons who frequently use PES in particular to provide an efficient service resulting in increased patient satisfaction. As healthcare professionals are responsible and highly involved in those caring processes, how they encounter those persons is an important piece of the puzzle to consider. It is my hope that this thesis can contribute to adjusting or developing interventions in both psychiatric healthcare and social care services to improve the life situation, mental health and life quality of persons frequently visiting PES, by meeting their needs more efficiently and effectively.

Introduction

Many persons who frequently use PES struggle to express their needs, which in turn leads to difficulties in mastering their lives in general and in interacting with psychiatric healthcare and social care services in particular (Fleury, Grenier, Farand, & Ferland, 2019; Vandyk, Young, MacPhee, & Gillis, 2018). They not only have healthcare needs, but also social care needs. Like many persons suffering from mental illness, persons frequently visiting PES struggle with stigmatisation, discrimination, exposure to violence, and emotional suffering, and are at high risk of comorbidity and premature mortality (Keyes, 2002; Khalifeh et al., 2015; Liu et al., 2017; Rüsch, Angermeyer, & Corrigan, 2005; WHO, 2013). Although they have numerous contacts with psychiatric healthcare and social care services, they appear not to receive the help they need to meet their needs, but instead incorporate those contacts with PES into their otherwise limited social networks (Aagaard, Aagaard, & Buus, 2014; Nordström, Skärsäter, Björkman, & Wijk, 2009). Thus, healthcare professionals' attitudes and views on persons who frequently visit PES are crucial as they impact on the encounter with them. The encounters at PES are essential in identifying, assessing, prioritising and addressing the patients' needs. Yet healthcare professionals face numerous challenges when encountering persons who frequently visit acute care (Boomer & McCance, 2017).

Due to the growing number of persons suffering from mental illness in Sweden and worldwide (Public Health Agency of Sweden (Folkhälsomyndligheten), 2019; WHO, 2017) and their increased demands for interventions and healthcare providers such as psychiatric care, including PES, service supply has not yet adequately adjusted to this growing demand. Consequently, the gap between the need for treatment and its provision is wide (WHO, 2017).

To improve healthcare delivery as well as the life situation and life quality of persons who frequently use PES, three steps are considered in this thesis: first, related issues of defining and characterising these persons ought to be addressed so that they can consistently be identified; second, their needs ought to be identified. Since their visits are recurring over time, persons frequently visiting PES appear to have continuous unmet needs that prolong their suffering and drain healthcare services' resources. Third, and finally; as healthcare delivery takes place by means of interpersonal interactions during encounters, and since healthcare professionals at PES play such an essential role in the patients' lives (Aagaard et al., 2014; Malone, 1996), their perspective of the patients' needs should be explored as well as, including their experiences of those patients and their needs, and of the encounters with them. To guide this doctoral thesis, person-centredness is applied. Its point of departure lays in seeing the person behind the patient, and his or her needs, values and expectations and develop and maintain a relationship with the person when delivering and planning the care (WHO, 2015).

Background

Persons who frequently use PES

From an international perspective, the phenomenon of persons frequently using PES is well studied concerning those persons' diagnostic and sociodemographic profile, with a particular focus on North America and Europe. From a Nordic perspective, research is scarce, comprising one dated comparative study of Denmark and Finland (Saarento, Kastrup, & Hansson, 1998) and a few studies conducted in Denmark (Aagaard et al., 2014; Aagaard, Buus, Wernlund, Foldager, & Merinder, 2016; Buus, 2011) and Finland (Saarento, Hakko, & Joukamaa, 1998). A recent literature review found that no studies have explored persons who frequently use PES in Sweden (Schmidt, 2018a).

Previous studies on persons who frequently use PES have mainly applied a quantitative approach and have focused on investigating predictors for the frequent use of PES of this group. Those studies identified male gender, young age, single status, homelessness and unemployment as such predictors as well as economic impairment, social disability or lack of a reliable social network, and living alone (Schmidt, 2018a; Vandyk, Harrison, VanDenKerkhof, Graham, & Ross-White, 2013). In relation to those socioeconomic factors, the cause-and-effect relationship is often unclear, and it is questionable whether persons who frequently use PES are homeless, single, or socially disabled due to their mental illness or whether these factors can be seen as the main contributors to or causes of their mental illness (Gayer-Anderson & Morgan, 2013). Furthermore, persons are more likely to use PES often when they have unmet needs, do not receive or follow aftercare, are discharged prematurely and have poor compliance (Botha et al., 2010; Bruffaerts, Sabbe, & Demyttenaere, 2005; Schmidt, 2018a; Vandyk et al., 2013). Diagnostic predictors for frequent PES use are personality disorder, substance abuse disorder and schizophrenia (Kaltsidis, Bamvita, Grenier, & Fleury, 2020; Schmidt, 2018a; Vandyk et al., 2013). Yet another focus of those studies was to define quantitatively persons who frequently use PES, proposing definitions ranging from one or two visits per year to six or more visits (Schmidt, 2018a; Vandyk et al., 2013), making it difficult to compare or summarise results from this field of study. In line with the latest Nordic studies (Aagaard et al., 2014; Aagaard et al., 2016), empirically derived observations, and, the classification used by the PES that initiated this research, a definition of five contacts or more within a period of 12 months, was applied here.

The quantitative studies agree that use of PES (as well as use of general emergency departments by persons with mental illness) has increased rapidly over the last few decades worldwide, making it a global problem (Pines et al., 2011). One group contributing to this increase are persons who frequently use PES. Even though they comprise a relatively small group, they account for a disproportionally high number of total visits to PES and claim a considerable amount of PES' limited resources (Schmidt, 2018a; Vandyk et al., 2013). It is useful to know the characteristics of these persons because the considerable variation in the characteristics implies a rather heterogeneous profile. However, there is a lack of studies investigating the characteristics of persons who frequently use PES, the temporal patterns of their visits and hospitalisation in a Swedish context (I). This quantitative approach may however increase the risk of seeing the person as a patient with a diagnosis, discarding his or her subjective experiences, social context, feelings and thoughts. Thus it seems desirable to combine those quantitative studies using an explanatory design with qualitative studies using explorative designs to research what aspects besides demographics and diagnostics lead to frequent use of PES. This will help in understanding the persons' life circumstances and underlying needs that lead to frequent use of PES.

Previous studies on persons with mental health problems including persons who use PES have shown that they are a vulnerable group of individuals (WHO, 2010, 2013). They are subject to stigma and discrimination, and physical and sexual victimisation more often than the general population (WHO, 2010). Furthermore, they face disproportionate barriers concerning education and work life and restrictions in participating in public affairs (WHO, 2010). Those conditions can lead to emotional suffering, increased risk of disability, comorbidity and premature mortality (Keyes, 2002; Khalifeh et al., 2015; Liu et al., 2017; Rüsch et al., 2005; WHO, 2013). Persons with mental illness die on average 10-25 years earlier than the general population (Liu et al., 2017). Yet, a perspective shift can also claim that vulnerable persons are more at risk for increased mental illness since stigma, victimisation or exclusion from work life in themselves can lead to low self-esteem, low motivation and negative outlook on the future, depression, anxiety or substance abuse (WHO, 2010). This reciprocal development reinforces a negative spiral which may be difficult to escape.

Persons with mental illness who frequently use emergency care often view their visits as unavoidable, necessary and appropriate as they experience being in immediate need of acute care (Fleury, Grenier, et al., 2019; Vandyk et al., 2018; Wise-Harris et al., 2017) and feel left with no other option than emergency care (Clarke, Dusome, & Hughes, 2007; Nordstrom et al., 2019; Wise-Harris et al., 2017). In this thesis, a patient is understood as a person who seeks care due to health reasons (Dahlberg & Segesten, 2010) and who takes on the role of a patient temporarily when in contact with healthcare services. Persons who frequently use PES are understood as persons who are vulnerable, suffering and exposed to difficult life situations. Those are aspects of being a human being and apply to everyone (Kristensson Uggla, 2014; Rendtorff, 2002). In addition, just like any other person, persons who frequently use PES are also seen as capable, autonomous and social (Kristensson Uggla, 2014; McCance & McCormack, 2017b; Rendtorff, 2002). The terms ‘person’ and ‘patient’ are used interchangeably in this thesis.

Perspectives on needs

The patients’ needs are central in mental healthcare services (Barker, 2001). However, the term ‘needs’ is ambiguous and carries different meanings. In a psychiatric context, patients experience multiple and complex mental health needs as well as basic, health, social, psychological, service, and daily function needs (Phelan et al., 1995; Slade, Phelan, & Thornicroft, 1998). If provision of healthcare services is based on needs, consensus should be reached about what constitute needs, and when and how they should be addressed (Korkeila, 2000). There are different kinds or categorisations of needs (Bradshaw, 1972; Brewin et al., 1987; Maslow, 1970; Peplau, 1988, 1952; Stevens & Raferty, 2016), as well as different viewpoints on needs: self-assessed needs (identified by the patients themselves) and other assessed needs (identified by healthcare professionals or significant others) (Magi & Allander, 1981). Needs can also be assessed on an individual or population level (Stevens & Gillam, 1998). Thus, regardless of how needs are assessed, there will always be different views on them and no single truth exists (Priebe, Huxley, & Burns, 1999). In everyday life, a need is often understood as a strong desire, wish or want (Wiggins & Dermen, 1987). On a population level, the most common definition of a need is the ability to benefit from health care (Culyer, 1976; Stevens & Gabbay, 1991; Stevens & Raferty, 2016), which puts the focus on available and effective interventions and existing services. From this perspective, needs only exist under the premises of existing interventions (Culyer, 1976; Stevens & Raferty, 2016; Wing, Brewin, & Thornicroft, 2001). However, the most influential categorisation of needs remains Bradshaw’s sociological perspective (1972), which distinguishes between felt and expressed needs (self-assessed) as well as comparative and normative needs (other assessed). In the light of resource shortages and adding further complexity, the relationship among need, demand, service provision, and utilisation should be considered. “*Needs may not be expressed as demand, demand is not necessarily followed by provision or, if it is, utilisation; and there can be demand, provision and utilisation without real underlying need for the particular service used*” (Wing et al., 2001, p. 9). This may be of particular relevance when considering persons who frequently use healthcare services. A summary is shown in figure 1.

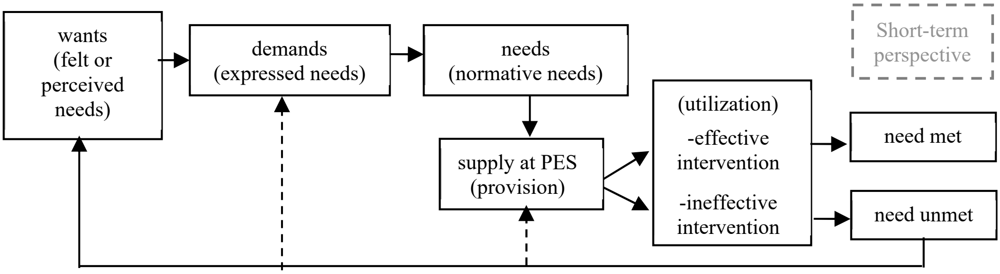


Figure 1: Demands-Needs-Supply, modified from Wright, Williams & Wilkinson (1998)

Within psychiatric care, and from an individual level, Brewin (2001) suggested three different interpretations of needs: (1) lack of health and well-being, where need is defined in terms of distress, symptoms, skills deficits, poor housing etc. leading to the failure to attain general goals of health and well-being; (2) lack of access to particular forms of institutionalised care, and inadequate level of service for the severity of the problem; and (3) lack of specific activities by mental healthcare professionals, including treatment-oriented and support-oriented activities. He and colleagues further identified needs that are unmeetable due to a current lack of effective treatment or the patient's rejection of proposed treatment (Bebbington, Marsden, & Brewin, 1997), also referred to as future needs, potential needs or no meetable needs (Wing et al., 2001). This stresses the notion of needs existing despite the lack of effective interventions. Thus, viewing needs in this thesis as a synonym for individual problems or lack of health, access or activities is in line with Brewin's ideas as well as with person-centredness. This perspective respects the subjective experiences of the patients and acknowledges that patients might suffer from 'problems in living', both *with others* and *with themselves* (Barker & Buchanan-Barker, 2005).

Within a psychiatric healthcare context, previous studies often use instruments for assessing needs quantitatively, e.g., the *Camberwell Assessment of Need* [*Short Appraisal Schedule]* (CAN[SAS]) (Ericson, 2013; Phelan et al., 1995; Wennström, Sörbom, & Wiesel, 2004). They are based on a quick assessment of 22 pre-defined need domains. With use of those instruments, the patients can self-assess their needs. Yet the ratings of the patient needs are often staff-based (e.g., Power, Dragović, & Rock, 2013; Ruggeri et al., 2004; Sirotich, Durbin, & Durbin, 2016), since patients in psychiatric care have been considered too ill to actively assess their own needs, which has meant the patients' perspective has been ignored (Arvidsson, 2001; Katschnig, 1997). However, using self-assessment of persons' needs may be more applicable when considering person-centredness that highlights patients' autonomy, as this thesis does. Thus, focusing on *felt* and *self-expressed* needs is deemed important to explore in this thesis due to its priority at the individual level (II).

Felt needs can either be expressed verbally (Bradshaw, 1972) or expressed in behaviour, as they give rise to tension that is converted into actions (Peplau, 1988, 1952). Healthcare professionals aid patients in providing interventions that will meet their present, i.e., short-term, needs (Peplau, 1988, 1952). Though it is believed that only patients can know their needs, they cannot always identify them, and instead only feel the need and the tension or anxiety they generate (Peplau, 1988, 1952). Since needs are value-laden, context-dependent, and not fixed, it can be desirable and beneficial to include different perceptions of two perspectives simultaneously (Korkeila, 2000; Warheit, Bell, & Schwab, 1977); that of the patients (II) and that of the healthcare professionals (III). Qualitative studies with an explorative design can complement the plethora of quantitative studies on measuring the needs of patients with mental illness.

The interpersonal encounter including trustful interactions between the patient and the healthcare professional is essential for the professionals in order to identify the needs of the patients; and for the patients to feel comfortable sharing their story and feelings (Barker & Buchanan-Barker, 2010; Molin, Graneheim, & Lindgren, 2016; Peplau, 1988, 1952). However, healthcare professionals within psychiatric care have reported not always understanding how patients' needs and concerns are relevant to their present well-being and recovery (Grant & Briscoe, 2002), and see persons with multiple and complex needs as difficult patients (Breeze & Repper, 1998). In fact, focusing on the complex needs of persons with mental illness in acute care settings seems challenging (Nordstrom et al., 2019) as most attention is often paid to crisis care and risk management (Rio, Fuller, Taylor, & Muir-Cochrane, 2019). Professionals working in acute psychiatric care settings can find themselves engaging in a trade-off of needs between the patients' individual needs, the safety of the environment, and the needs of a system with few resources, and they have to balance the competing needs of all stakeholders (Waldemar, Esbensen, Korsbek, Petersen, & Arnfred, 2019; Wyder et al., 2017). Not prioritising the patients, however, can lead to patients' avoiding or delaying communicating their needs (Shattell, 2004) and returning to the acute care settings frequently as their needs remain unmet (Vandyk 2013, Olsson 2001). They can also develop comorbid conditions as a result (Peplau, 1988, 1952). If healthcare professionals do not consider the patients' self-assessed needs as important, the possibility for recovery processes are low (Barker & Buchanan-Barker, 2010).

With regard to persons who frequently use PES, healthcare professionals in a quantitative study from 2002 rated 'difficulties accessing alternative services', 'substance abuse' and 'basic needs' as the most common reasons for persons to frequently visit PES (Arfken, Zeman, Yeager, Mischel, & Amirsadri, 2002). Qualitative studies on the needs of persons with mental illness in general and persons who frequently use PES in particular, are limited (Schmidt, 2018a). Needs that the patients express themselves in those few qualitative and mixed method studies focus on safety, comfort, and human interaction (Poremski et al., 2020; Vandyk et al., 2018), psychiatric diseases and lack of other services (Fleury, Grenier, et al., 2019).

Healthcare professionals at PES and their workplace conditions

The main task for healthcare professionals working at PES is to offer crisis evaluation, management and treatment (Brown, 2005). They assess and prioritise patients' mental health needs according to urgency and severity in order to initiate an immediate intervention and treatment (Buus, 2011). Often a triage system is used to guide this process, which helps to manage the growing imbalance between relatively scarce resources and the unlimited needs of the patients, based on fairness and the efficient use of resources (Brenner, Rydell, & Skoog, 2016; FitzGerald, Jelinek, Scott, & Gerdtz, 2010). Risk management and the evaluation of security and safety needs for patients, healthcare professionals and others is yet another ongoing and important task at PES (Allen, Forster, Zealberg, & Currier, 2002; Rio et al., 2019). In addition, telephone counselling is often provided at PES all around the clock (Brown, 2005). The experience of telephone encounters at PES has to the best of my knowledge not been investigated previously, but was included here in Studies III and IV.

Different kinds of professionals work at PES, with or without specialised education (Brenner et al., 2016). Their level of work experience may also vary greatly and PES often function as an important educational setting for physicians, nurses and students (Breslow, Erickson, & Cavanaugh, 2000). Pro-active healthcare professionals working in interdisciplinary teams are thus necessary to provide PES services of high quality (Breslow et al., 2000; Wright, McGlen, & Dykes, 2012).

Studies on the experiences of healthcare professionals working at PES are limited; however, there are many studies concerning healthcare professionals' experiences of caring for persons with mental illness in related or other care settings (such as general emergency departments or in psychiatric inpatient care). Studies show that healthcare professionals can feel pessimistic about persons who frequently visit acute psychiatric care settings (Cleary, Horsfall, O'Hara-Aarons, Jackson, & Hunt, 2012). In other studies, healthcare professionals described patients using PES frequently as difficult and hard to treat, a bother, or as not able to benefit from healthcare services (Blonigen et al., 2018; Buus, 2011; cf. Koekkoek, van Meijel, & Hutschemaekers, 2006; Schmidt, 2018a). A review revealed that healthcare professionals in general could view persons with mental illness as morally weak, lazy, malingerers and lacking self-control, and that healthcare professionals in acute care settings had blaming and hostile attitudes towards persons with mental illness (Ross & Goldner, 2009) and stigmatised frequent PES users (Blonigen et al., 2018). Those negative attitudes inevitably impact on the way healthcare professionals provide care and encounter persons who frequently use PES, and consequently can affect those patients' recovery processes negatively (Blonigen et al., 2018; Eriksson, 2014; Reed & Fitzgerald, 2005). Negative attitudes among healthcare professionals could be found for persons with mental illness in general (Hansson, Jormfeldt, Svedberg, & Svensson, 2013) and persons with borderline personality disorder, substance abuse disorder and schizophrenia in particular (Björkman, Angelman, & Jönsson, 2008; Dickens, Lamont, & Gray, 2016; Van Boekel, Brouwers, Van Weeghel, & Garretsen, 2013). Buus (2011) attempted to nuance the overall negative picture of healthcare professionals' views of frequent PES visitors somewhat by classifying them into good and difficult visitors. Healthcare professionals viewed frequent visitors as difficult when they were unable to deal with them efficiently and when they were unable to establish a mutual relationship with them (Buus, 2011). Furthermore, healthcare professionals working at PES could consider persons with frequent PES visits as making inappropriate demands or as having unreasonable needs for help. They may also experience them as manipulative and may think that certain groups should seek assistance elsewhere (Buus, 2011). With 'good' frequent visitors on the other hand, the healthcare professionals could act in a more straightforward manner; and good frequent visitors responded well to treatments and has 'appropriate' psychiatric diseases (Buus, 2011). Buus concluded that the classifications of good and difficult applied equally to infrequent visitors as well, thus shifting the focus somewhat away from frequent visitors being a problem to the problem of healthcare professionals' legitimacy, autonomy and authority in general (Buus, 2011). However, he remained within a categorisation frame of thinking that largely ignores person-centredness and the patients' individuality.

PES constitute intensive, demanding workplaces, unpredictable in its nature (Allen et al., 2002). High workload and increased utilisation rates make it challenging for healthcare professionals to provide quality care, and this can lead to high work stress among the professionals (Currid, 2009; Schmidt, 2018a). A literature review of nurses' experiences of delivering care in acute psychiatric care settings revealed that they viewed their role as very complex as they had to balance competing and conflicting perspectives, and when clinical care became too task-focused, they admitted providing unethical care (Wyder et al., 2017). The review also identified high workload, the number of administrative tasks, unsupportive organisational cultures, and insufficient time as the strongest barriers to providing recovery-oriented care, and teamwork, interdisciplinary staff, professional supervision and ability to self-care as facilitators (Wyder et al., 2017). Healthcare professionals working in acute psychiatric care settings could find themselves torn between humanistic ideals and the harsh reality of their daily work, hindering them from having close relationships with patients and instead providing superficial care

(Björkdahl, Palmstierna, & Hansebo, 2010; Hummelvoll & Severinsson, 2001; Shattell, Andes, & Thomas, 2008; cf. Zarea, Nikbakht-Nasrabadi, Abbaszadeh, & Mohammadpour, 2013). Healthcare professionals working at a psychiatric inpatient care setting in Turkey reported that high work load, staff shortages, lack of professional supervision, and poor work conditions could lead to unethical behaviours such as disrespect of patients' rights, stigmatisation, lack of proper communication, and bystander apathy (Eren, 2014). Yet another study from Iran showed that healthcare professionals working in an acute psychiatric care setting found that their work affected their mood and personal life negatively, that they suffered from stress, anxiety, and exhaustion, lacked job satisfaction and risked losing their professional identity (Zarea, Fereidooni-Moghadam, Baraz, & Tahery, 2018). Those results can be confirmed by healthcare professionals working at an acute psychiatric care setting in Sweden who reported that, even though they were aware of the impact they had on the patients, they found themselves brooding over the loss of their ethical, caring and professional values due to high expectations and high workload (Salzmann-Erikson, 2018). Even though the studies stemmed from varying acute care contexts and organisational structures (psychiatric care in Turkey, Iran, Sweden), they had similar results, which stresses the highly interpersonal nature of healthcare professionals' work in acute psychiatric care settings.

Consequently, powerlessness could emerge as an explanation for the healthcare professionals' view of caring for persons with mental illness in acute psychiatric care settings (Blonigen et al., 2018; Plant & White, 2013; Rose, Evans, Laker, & Wykes, 2015) and compassion fatigue could be developed (cf. Raab, Sogge, Parker, & Flament, 2015; cf. Turgoose & Maddox, 2017). Another outcome reported by healthcare professionals working in acute psychiatric care settings was moral distress that could lead to feelings of guilt, inadequacy, mental tiredness, emotional numbness and being fragmented (Jansen, Hem, Dambolt, & Hanssen, 2019). Even though the studies mentioned reported rather negative experiences and attitudes among psychiatric healthcare professionals, and despite the challenges of the workplace and work environment, the professionals did understand the importance of adopting a person-centred, recovery-oriented caring approach when working in acute psychiatric care settings. Healthcare professionals identified 'listening', 'empathy', and 'understanding the subjective experience of the patients' as important interpersonal skills in an acute psychiatric healthcare setting (Cleary, Horsfall, et al., 2012) and essential for establishing meaningful and caring interactions with the patients. Several studies could include mixed results, with some patients also reporting positive experiences on care in psychiatric acute care settings (Johansson, Skärsäter, & Danielson, 2009; Molin et al., 2016; Schmidt & Uman, 2020; Shattell, Starr, & Thomas, 2007; Ådnøy Eriksen, Arman, Davidson, Sundfør, & Karlsson, 2014) stressing that just one person could make a difference in the whole emergency department experience, and it could range from either traumatic to empowering (Clarke et al., 2007). Yet in sum, even though healthcare professionals often reported struggling to provide care and to develop interpersonal encounters for persons in psychiatric care settings due to workplace requirements and competing demands, they also saw the importance of taking responsibility and engaging with the patients, being moral, present and respectful, and connecting (Gabrielsson, Sävenstedt, & Olsson, 2016), and expressed a desire to deliver high quality care (Ejneborn Looi, Gabrielsson, Sävenstedt, & Zingmark, 2014). However, lack of support or time could at times force them to promote their own survival by refuting their responsibility (Gabrielsson et al., 2016), adopting a staff-focused approach, and prioritising staff's needs at the expense of the patients' needs (Ejneborn Looi et al., 2014). This line of reasoning corresponds with the recent discussions concerning compassion fatigue and burnout among healthcare professionals in general and the potential harm to *self* due to their (in)ability to care for suffering persons, dissatisfaction with working conditions and organisational culture, and feelings of inadequacy, resulting in apathy and disinterest in work and relationships (Todaro-Franceschi, 2019).

Experiences of healthcare encounters at PES

The encounter—also referred to as a caring encounter or care relation—is the foundation of psychiatric healthcare (Cleary, Hunt, Horsfall, & Deacon, 2012; Peplau, 1988, 1952) and is viewed as the core of caring where the care processes unfold (Björck & Sandman, 2007; Eriksson, 2014). Despite its apparent essential role in healthcare, the deeper meaning of the encounter is often not clarified (Björck & Sandman, 2007; Holopainen, Kasén, & Nyström, 2014). The quality of the encounter and its interactions between the healthcare professionals and the patients have been shown to have a profound impact on healthcare outcomes, how patients experience the healthcare services, and patient satisfaction with care (De Leeuw, van Meijel, Grypdonck, & Kroon, 2012; King, Linette, Donohue-Smith, & Wolf, 2019; Snellman, Gustafsson, & Gustafsson, 2012). In addition, each encounter between the patient and the healthcare professional is characterised by power imbalance, asymmetry and differences in expectations (Delmar, 2012; Holopainen, Nyström, & Kasén, 2019; Snellman et al., 2012). Thus, it is important for healthcare professionals to be aware of how they encounter the patients.

Patients' perspective

Persons using PES can at times experience barriers to engaging in the encounter. They may experience difficulties in identifying their needs and difficulties in communication, expressing their thoughts and feelings and relating to people (Peplau, 1988, 1952). They also might not enter each encounter at PES voluntarily. Reviews taking the perspective of persons suffering from mental illness, reported rather varied yet predominantly negative portrayals of their experiences of the encounter and interactions with healthcare professionals in acute care settings (Bolsinger, Jaeger, Hoff, & Theodoridou, 2020; Schmidt & Uman, 2020). On the one hand, in some studies, some patients experienced interactions and the encounter with healthcare professionals as positive, they felt listened to, consoled, and safe, and the healthcare professionals were experienced as friendly and attentive (Schmidt & Uman, 2020). One study in particular highlighted the peaceful non-verbal and verbal communication of the healthcare professionals and the way they addressed the patients' needs for distance and closeness as particularly helpful during the encounter (Sebergsen, Norberg, & Talseth, 2016). On the other hand, persons suffering from mental illness often experienced healthcare professionals in acute care as stressed, and understood that they had a high workload, and had to prioritise administrative tasks, and that this affected the availability of the professionals and the quality of the care and the encounters (Bolsinger et al., 2020; Schmidt & Uman, 2020). Healthcare professionals in acute care settings were often experienced as dismissive, uninterested, disrespectful and uncaring during the encounter which made the person with mental health problems feel dismissed, disliked and unworthy of attention. Furthermore, they could be experienced as unemotional, disengaged and uncommitted (Schmidt & Uman, 2020). Those negative findings are supported by an observational study in mental health inpatient settings in Denmark (Waldemar et al., 2019). The study found that healthcare professionals' interactions with patients were artificial, and that patients were treated like children (Waldemar et al., 2019). The professionals remained superior experts in charge of decisions, and their approach made it almost impossible to detect any recovery-oriented interactions (Waldemar et al., 2019). A study conducted in a psychiatric inpatient unit in Sweden showed that patients often felt invisible and ignored (Molin et al., 2016). Healthcare professionals were often experienced by the patients as passive, disengaged, "too professional" and unable to master their own feelings (Molin et al., 2016). With that being said, some patients could also at times experience trustful interactions with the healthcare professionals when they were honest about feelings, shared humour, and fostered an open dialogue (Molin et al., 2016).

Finally, the patient boards in each municipality as well as the Health and Social Care Inspectorate (IVO) in Sweden receive an increased number of patient complaints each year expressing dissatisfaction with the care they received. The boards and IVO report that many of those complaints concern the encounter with healthcare professionals (Health and Social Care Inspectorate (IVO), 2018). Those unsatisfactory encounters concern, e.g., not being listened to, being ignored, and being talked to in an unpleasant way (Health and Social Care Inspectorate (IVO), 2017).

Healthcare professionals' perspective

Within the latest decade, the need for recovery-oriented care within psychiatric care is promoted and called for (Barker & Buchanan-Barker, 2010; Dawson, River, McCloughen, & Buus, 2019; Gabrielsson & Ejneborn Looi, 2018; Ådnøy Eriksen et al., 2014). To facilitate those recovery processes requires an interpersonal, person-centred approach to care and the encounter between the patient and the healthcare professionals (Gabrielsson, Sävenstedt, & Zingmark, 2015; Goulter, Kavanagh, & Gardner, 2015). However, creating and sustaining caring encounters can be difficult in acute psychiatric care settings, since they are a unique and complex context (Bolsinger et al., 2020; Schmidt, 2018a; Schmidt & Uman, 2020; Vandyk et al., 2018).

At PES, triage and fast assessment of patients' needs and safety and PES' security in light of its resources is of the utmost importance, yet so is the need to empathetically connect during the encounter (Lee & Hills, 2005). Encounters in acute care settings are often described as short, shallow and instrumental, setting aside the uniqueness of the patient and his or her needs (Nyström, Dahlberg, & Carlsson, 2003; Waldemar et al., 2019; Wiman & Wikblad, 2004). However, short encounters in acute care can have caring elements despite the urgent situation (Holopainen, Kasén, & Nyström, 2015) and lack of time can be seen as an excuse when not having the courage to be open to the patients' suffering and truly be present (Holopainen et al., 2014). Yet it is a fact that time is repeatedly reported as important by both patients and healthcare professionals. For the patients, it is crucial that the healthcare professionals take time and do not rush (Rose et al., 2015; Shattell et al., 2007). On the other hand, healthcare professionals expressed the need for enough time to build relationships with the patients and have meaningful interactions (Gabrielsson et al., 2016; McAllister & McCrae, 2017; Rose et al., 2015). A review study showed that healthcare professionals in psychiatric care spent as much as 4% to 6% of their time on one-to-one interactions and therapeutic interactions (Goulter et al., 2015; Sharac et al., 2010) and lacked therapeutic engagement (Rio et al., 2019), thereby reducing the possibility for caring and meaningful encounters. However, a study by McAllister and McCrae (2017) showed that healthcare professionals in psychiatric care in the UK spent 20.9% of their time therapeutically engaged. Healthcare professionals were also found to interact in a committed manner, regardless of the length of the interaction, and patients were generally found to be satisfied with the interactions (McAllister & McCrae, 2017). In a Swedish psychiatric care context, healthcare professionals engaged in direct care with the patient for 11% of their time, with most time spent in performing medication related tasks and tasks indirectly related to patients yet without the patients being present (Glantz, Örmon, & Sandström, 2019). Yet another review of the literature reporting the perspective of healthcare professionals working in acute psychiatric care settings, showed that it remained a challenge for them to find a balance between having caring interactions and coping with the high workload and administrative tasks (Wyder et al., 2017). Those findings were confirmed in a recent study by healthcare professionals working in an acute psychiatric care setting in Sweden (Salzmann-Erikson, 2018).

Instead of focusing on the negative connotations that persons who frequently use PES trigger, when referring to them as boarding patients, frequent flyers, revolving door patients, or using negatively loaded terms such as recidivism, overcrowding and malingering, there is also an opportunity in the repetitive nature of the contacts as they imply a new opportunity to establish caring encounters with them leading to enduring change in small actions (Lee & Hills, 2005). Each new contact at PES is an opportunity to provide the patients with positive experiences that can impact their future interactions with other healthcare professionals in other healthcare settings. Furthermore, even though studies report short and shallow encounters in acute care, the relationship patients and healthcare professionals have is often based on many contacts over a long period of time when referring to persons who frequently use PES, and thus might not be fully comparable with first encounters between strangers.

PES and the healthcare and social care services in Sweden

According to the *Swedish Association of Local Authorities and Regions,* there are 54 PES in Sweden. How they are organised and operate can differ within Sweden (Brenner et al., 2016). They are nowadays usually hospital-based and operate 24 hours a day, serving either smaller or larger urban areas. However, mobile teams have started to become available too, e.g. in Stockholm (Lindström, Sturesson, & Carlborg, 2020; Region Stockholm, 2020). Yet provision of those services may differ from that in other countries, where psychiatric emergency care can be administered by ambulance or well implemented mobile assessment teams (Brown, 2005; Oliveira et al., 2020), be covered by general emergency departments which in some cases are or are not accompanied by psychiatric staff (Clarke et al., 2007; Plant & White, 2013), or are run by general and psychiatric emergency departments of integral nature (Carstensen et al., 2017).

The first-line care for persons suffering from mental illness in Sweden is usually primary care (Skårderud, Haugsgjerd, & Stänicke, 2010), including both the treatment and rehabilitation of those with mild and moderate symptoms, while specialised open psychiatric care treats more severe forms of mental illness. However, persons suffering from mental illness often use PES as a primary care source (Eppling, 2008), when in fact they represent a medical specialty. Furthermore, for many who lack socioeconomic resources or access to care, PES also represent a safety net (Nicks & Manthey, 2012; Young et al., 2005), refuge, and part of their social network (Aagaard et al., 2014). Although persons who visit PES have several points of contact with psychiatric healthcare and social care services (Aagaard et al., 2014; Nordström et al., 2009), PES are a preferred place to go, not least due to their availability 24 hours a day, seven days a week (Schmidt, 2018a; Vandyk et al., 2013).

Healthcare and social care services in Sweden are based on a socialised welfare system that addresses both somatic and mental illness and is primarily financed by taxes, yet requires the patient to pay a small fee per consultation. The provision of psychiatric healthcare and social care services is regulated by law and policies, and is based on the principle that everyone is of equal value and has equal rights, and that the autonomy and integrity of the patients must be respected (SFS, 2001, 2017). Furthermore, the responsibility for psychiatric healthcare and social care services is shared between national government, municipalities ($N = 290$), and county councils ($N = 21$) as a result of the implementation of the Mental Health Care Reform in 1995, which imposed a new care structure on psychiatric care (SOU, 1992; Stefansson & Hansson, 2001). The objective of the reform was to improve the conditions in society and the quality of life for persons with mental illness (Government Bill, 1994). While the national government is responsible for promoting research, auditing processes, and providing subventions and incentives within specific areas, the municipalities are obliged to provide social care services such as housing, social support, and activities for persons with psychiatric disabilities. This legislation emphasises participation, countering discrimination, and self-determination and is embedded in the Social Services Act (SOL) (SFS, 2001) and the Act Concerning Support and Service to Persons with Certain Functional Impairments (LSS) (SFS, 1993). However, the design of goals and priorities can differ among municipalities as well as county councils because they self-govern their own budgets, have different priorities, have different economic preconditions and are steered by different political parties, which can result in great variation in or lack of support functions provided by the municipalities to persons suffering from mental illness or psychiatric disabilities. Health and medical care is provided by the county councils. This includes primary healthcare, specialised psychiatric care, emergency care, and in- and out-patient care, and is regulated by the Health and Medical Services Act (HSL) (SFS, 2017). Meanwhile, it can be a challenge to provide good continuous healthcare and social care services and to collaborate across the boundaries of organisations applying different perspectives and various legislations (Brenner et al., 2016; Janlöv, Ainalem, Andersson, & Berg, 2016), yet collaboration between all parts of the system is stipulated by those laws. Those patients who need recurring healthcare contact expressed dissatisfaction with different care providers and lack of collaboration and planning between them (Health and Social Care Inspectorate (IVO), 2017, 2018).

Acute psychiatric care and person-centredness

This thesis belongs to the field of health science, and more specifically, nursing. At PES however, different kinds of healthcare professionals work multi-professionally and in teams (Brenner et al., 2016; Currier & Allen, 2003), including nurses with or without different specialisations, assistant nurses with or without different specialisations and with different educations, intern and resident physicians as well as medical secretaries, and on-call physicians, among others. Acknowledging the patient in the centre as well as *all* healthcare professions, caring science is considered as profession-neutral, and offers a more inclusive and broader perspective than nursing science (Dahlberg & Segesten, 2010; Eriksson, 2014).

WHO calls for a fundamental paradigm shift in how healthcare services are delivered, which implies a move away from the traditional biomedical model with the patient being a passive recipient of care to a more humanistic model rooted in universal principles of human rights, participation and empowerment (WHO, 2015). Thus, person-centredness has been a central concern within healthcare in the last decades, including the field of psychiatric care (Barker, 2001; McCormack & McCance, 2017a). Person-centredness includes promoting care *of* the person, *for* the person, *by* the person and *with* the person (McCormack, van Dulmen, Eide, Skovdahl, & Eide, 2017; Mezzich, Botbol, Christodoulou, Cloninger, & Salloum, 2016). Thus, it stresses caring relationships, and holistic and collaborative care (McCormack & McCance, 2017a) and puts the person and his or her needs in the centre. Person-centred care also comprises one of the core competences within Swedish healthcare (Leksell & Lepp, 2019; Svensk Sjuksköterskeförening. Svenska Läkaresällskapet och Dietisternas Riksförbund, 2019) and is applied within Swedish healthcare regulations when emphasising equal rights, autonomy, and integrity of the patients as well as respecting their needs and establishing good relationships (SFS, 2017).

One view on person-centredness is offered by McCormack and McCance who define it as "*an approach to practice through the foundation of fostering healthful relationships between all care providers, service users and others significant to them in their lives. It is underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development*" (McCormack & McCance, 2017a, p. 3). They developed the Person-centred Practice Framework that can be applied in any healthcare context including acute and psychiatric care by any healthcare profession (Boomer & McCance, 2017; Davidson, Bellamy, Flanagan, Guy, & O'Connell, 2017; Gabrielsson et al., 2015).

One person-centred theory within the field of psychiatry is the Tidal Model. It was originally developed for acute psychiatric care and is based on an interdisciplinary approach (Barker & Buchanan-Barker, 2005, 2010). It is described as a "*deeply collaborative, person-centred, narrative-based theory*" (Barker & Buchanan-

Barker, 2005, p. 213). The Tidal Model also serves as a recovery model, as the person is believed to have the capacity to change, i.e., to possess resources on his or her own for recovery (Barker & Buchanan-Barker, 2010). In line with person-centredness, it aims at putting the person back on a life course, ‘getting going again’, and living a meaningful life in the community (Barker & Buchanan-Barker, 2010), retaining and keeping control over the life situation (Borg & Karlsson, 2017). It implies that the healthcare professionals help the patients to identify, describe, and begin to address the issues, problems, or difficulties that lead to the current situation, and thus they can begin to rejoin the flow of life (Barker & Buchanan-Barker, 2010). Person-centred care and recovery-oriented care have a close relationship, influencing one another (Gabrielsson et al., 2015; Hummelvoll, Karlsson, & Borg, 2015). Based on the Tidal Model, the aim of acute psychiatric care is to provide a ‘safe haven’ (Barker & Buchanan-Barker, 2010) and the aim of the healthcare professional is to establish the conditions necessary for the promotion of growth and development, i.e., focusing on the virtues of care (Barker & Buchanan-Barker, 2005). The concept of care is metaphorically understood as a wrapper: it provides the means of holding together a complex set of human processes (Barker & Buchanan-Barker, 2005). During the encounter, the healthcare professional and the patient form a temporary act of unison, characterised by equal status, conversation and collaboration (Barker & Buchanan-Barker, 2005).

The ideas and philosophical underpinnings behind McCormack’s framework and the Tidal Model are alike, promoting collaboration, recovery and autonomy. Both also acknowledge the diversity of professions involved in care and emphasise the importance of care contexts; Barker and Buchanan-Barker (2005) calling it a care continuum, and McCormack calling it *person-centred cultures* including *care processes* (micro level), *care environment* (meso level) and *macro context* (McCance & McCormack, 2017a; McCormack et al., 2015). Both the Tidal Model and the Person-centred Practice Framework are recognised as mid-range nursing theories (Brookes, 2018; Buchanan-Barker & Barker, 2019; J. Cutcliffe, McKenna, & Hrykas, 2009; McCance & McCormack, 2017b).

Rationale

Persons who frequently use PES can be viewed from different perspectives. From an economic, managerial and organisational perspective, they are one of the major contributors to the strain on emergency resources. From an objective need perspective, it can be argued that since the frequent nature of their use of PES cannot be met with any effective interventions, frequent visitors may not even have a real need to begin with. They are often described as a problem and as problematic, yet it is the PES' task to meet the person's emergent needs for safety and security and his/her physical and mental health needs.

Persons who frequently use PES may have a completely different view from those in charge and their voice has not been represented in research for a long time. This thesis takes the individual perspective of persons who frequently use PES, complemented by the healthcare professionals' perspective. They experience their visits as necessary, unavoidable and appropriate. Their journey often starts with their living situation, in everyday life. From a subjective need perspective, they suffer from multiple and chronic psychiatric conditions, struggle in life and have complex long-term needs, which should be the point of departure, not the question of how to reduce or prevent readmissions or reuse. Furthermore, their needs at PES may not be met due to problems in the service supply that does not or cannot adequately and efficiently address those needs. Healthcare professionals are an important part of the patients' otherwise often limited social network. Their views may contribute valuable knowledge about persons who frequently use PES and can add a puzzle bit to better understand them. How they encounter persons who frequently use PES is essential for their recovery and satisfaction with the care service. However, healthcare professionals' work situations and needs also matter and should not be ignored.

It is expected that mental illness will continue to grow (Public Health Agency of Sweden (Folkhälsomyndligheten), 2019; WHO, 2017). Utilisation rates of PES are soaring and with that the workload of PES, which may make it difficult for healthcare professionals to provide professional and caring encounters and quality services. They have an intensive, stressful and challenging workplace which forces them at times to balance contradictory perspectives and leaves them torn between their humanistic ideals and the harsh reality. This thesis considers person-centredness to emphasise the patient as a person, with his or her lived experiences, values and needs.

Aim

The overall objective of the thesis was to describe who persons that frequently use psychiatric emergency services (PES) in Sweden are, to explore what needs they experience as well as how healthcare professionals working at PES view the needs of those persons and experience encounters with them.

Specific aims

I:	(1) To describe persons visiting PES and (2) to compare persons who frequently and infrequently visit PES in terms of group size, age, gender, PES location (inside versus outside the home municipality), diagnosis (ICD 10), temporal patterns of visits, and hospital admissions.
II:	To investigate self-reported needs for care, support and treatment among persons who frequently visit PES.
III:	To explore how healthcare professionals experience persons who frequently use PES in terms of their needs.
IV:	To explore healthcare professionals' experiences of encounters with persons who frequently use PES.

Method

Epistemological assumptions

Paradigms, or worldviews, are general perspectives on the complexities of the world and comprise ontological (the study of being, i.e., what exists for people), epistemological (the study of knowledge, i.e., how people create knowledge and what is possible to know), and methodological (how best to obtain the evidence) considerations (Polit & Beck, 2016). Within health science, two paradigms dominate: positivism, which is mainly used in quantitative studies, claiming that an objective reality exists and that the researcher is independent from those being researched, thus knowledge derived is value-free and universal; and constructivism which is often used in qualitative studies claiming that multiple realities exist and that the researcher interacts with those being researched, thus knowledge derived is value-laden and contextually unique (Polit & Beck, 2016). However, a third paradigm, pragmatism, has emerged focusing on mixed methods research. Thus, the proposed worldview in this thesis is pragmatism, which opens the door to multiple methods, viewpoints, and assumptions, as well as multiple forms of data collection techniques, analysis, and procedures (Creswell, 2014) emphasising the need for methodological pluralism rather than separatism. By combining the methods and exploiting their specific strengths, more insight can be gained, facilitating a broader, yet deeper and nuanced understanding of the phenomena under investigation. The ontology and epistemology of pragmatism implies that it is not necessary to commit to any one system of philosophy and reality and allows the researcher to draw from both qualitative and quantitative assumptions in the research (Creswell, 2014). Truth is what works for the moment (Creswell, 2014). Pragmatism stresses free choice in designing studies in order to fit the specific purpose of the research. This implies that the objective of the study is more important than the specific methods used to address it (Polit & Beck, 2016). It also goes hand in hand with the practice relevance of this thesis. Studies I and II were initiated by healthcare professionals within an acute psychiatric care unit that also participated in the data collection (II), and in all studies healthcare professionals participated in the choice of research questions (I, II, III, IV).

Design

This thesis incorporates method triangulation, and includes both quantitative (I, II) and qualitative (II, III, IV) research designs. In addition, it combines the perspective of the patients and that of the healthcare professionals. An overview of the methods and designs used is given in Table 1. By applying method triangulation, both advantages and disadvantages could be acknowledged and balanced in each design. Not only were both qualitative and quantitative designs used, the included studies also applied a broad range of data collection methods, such as register data (I), survey data (II), individual interviews and focus group interviews (III, IV). Finally, data were analysed with statistical tests (I, II) and with qualitative content analysis (II, III, IV). The qualitative analysis method proposed by Graneheim and Lundman (2004) has been shown to be particularly useful since it allows for multiple ways and levels of analysis and has been applied differently in each study; focusing on the manifest content using a descriptive approach (II), the latent content using a more hermeneutic approach (IV), or a combination of both (III) (Graneheim, Lindgren, & Lundman, 2017).

Table 1. Overview of the thesis

Studies	Study I	Study II	Study III	Study IV
Design	Cross-sectional, descriptive, and quantitative	Cross-sectional, descriptive, and both qualitative and quantitative	Explorative and qualitative	Explorative and qualitative
Sample	All persons visiting PES in one county in southern Sweden (*N* = 27,282)	Persons who frequently visit (5 + visits) a PES in Sweden (*N* = 81)	Healthcare professionals (N=19)	Healthcare professionals (N=19)
Data collection	Register study of archival data	A – Qualitative open-ended questions B - CANSAS B - AUDIT B - DUDIT C - brief ISSI D - Interpersonal violence	Individual interviews, Focus group	Individual interviews, Focus group
Data collection period	June 2016	Dec 2016-Maj 2017	Oct, Nov 2018, Jan 2019	Oct, Nov 2018, Maj 2019
Analysis	Descriptive statistics, Chi-square tests	Descriptive statistics, Chi-square tests, Spearman correlations, Mann-Whitney U test, Qualitative content analysis	Qualitative content analysis	Qualitative content analysis

Research context

PES is the context of this thesis. Two studies (I, II) included in this thesis were conducted in one county in southern Sweden while the others (III, IV) were conducted in another county in southern Sweden. The counties combined had roughly 1.6 million inhabitants (Statistics Sweden, 2019), representing 15.3% of Sweden's population and consisting of both urban and rural areas.

Studies I and II

In Study I, all PES (*N* = 4) in a county in southern Sweden were included. This county covers nearly 1.4 million inhabitants living in four larger cities and rural areas, representing 13.3% of Sweden's total population (Statistics Sweden, 2019). The PES were hospital-based. In Study II, data were collected in one of the four PES that were included in Study I, whose triage staff were involved in the data collection. This PES served a rural/urban catchment area of around 200,000 inhabitants (Statistics Sweden, 2019). It had open access 24 hours a day, seven days a week, and was connected to a psychiatric intensive care unit with several beds for short-term stays.

Studies III and IV

In Studies III and IV, data were collected in another county in southern Sweden. Healthcare professionals and researchers collaborated in the choice of the research questions, as was the case in Studies I and II. The PES was located in a larger town and also served a rural/urban catchment area of around 200,000 inhabitants (Statistics Sweden, 2019). It had open access 24 hours a day, seven days a week and was connected to a psychiatric intensive care unit with several beds for short-term stays.

Both study contexts used different triage systems. While all PES involved in Study I and II applied the RETTS-psy triage system (Swedish Council on Health Technology Assessment (SBU), 2010) which was carried out by triage staff to assess and prioritise the urgency and severity of the illness, the PES involved in Studies III and IV applied a narrative triage approach carried out by the intern physicians. Emergency telephone counselling was also handled differently in the settings. While the PES in Study II applied an ad-hoc approach with incoming calls answered directly by whoever was available to pick up first, which sometimes resulted in unanswered calls, the PES in Studies III and IV secured one fulltime position of a psychiatric nurse exclusively for telephone service 24h/7 days a week to return calls to persons who had left a message on their phone service. This way, triage service was not disturbed by telephone ringing.

In Sweden, as in the other Nordic countries, the Classification of Mental and Behavioural Disorders, version 10 (ICD-10) is mainly used (WHO, 1992). It is a diagnostic manual that provides a common language for reporting and monitoring psychiatric diseases, which allows for comparison and standardisation, and provides a biomedical perspective. In this thesis, it is acknowledged that mental illness includes severe psychiatric problems with clinical diagnoses, i.e., diagnostic categories, as well as minor or moderate mental conditions falling short of diagnostic criteria, though negatively affecting the person's everyday life (Bremberg & Dalman, 2015; Public Health Agency of Sweden (Folkhälsomyndigheten), 2016). Psychiatric diagnoses and the term *disease* stress a purely pathologic, biomedical perspective (Arlebrink, 2012; Dahlberg & Segesten, 2010). Though applied in order to map the field (I), the aim of this thesis is to look beyond those manuals and consider the whole person and his or her experiences (II, III, IV) which is why mental *illness* is the preferred term in this thesis.

Data collection

Register data

Study I was a large-scale register study; register data were drawn retrospectively for the years 2013–2015 from the support database for care recipients from the county's central management division in June 2016. The applied inclusion criteria (i.e., providing 24-hour service, a triage system, open referral system, telephone helplines, and beds for acute short-term stays in a specialised inpatient psychiatric intensive care unit) identified four PES in the chosen county. A dependency centre was excluded since it did not fulfil all the inclusion criteria.

The variables collected were age, gender, PES location inside versus outside the home municipality, diagnosis (ICD 10), temporal patterns of visits, and hospital admissions. One diagnosis was registered per visit in the register. Temporal patterns included day of the month (1–31), day of the week (Monday–Sunday), and time of day (morning shift 07:00–14:59, afternoon shift 15:00–22:59, and night shift 23:00–06:59).

Survey

For Study II, the data comprised an interviewer-administered questionnaire with open-ended questions and validated instruments. Data were collected from December 2015 to May 2016 by triage staff by means of face-to-face interviews using a structured interview manual, developed in collaboration with researchers, service user organisations, and PES professionals. Triage staff interviewed patients who visited PES five or more times within a year. The decision to collect data by triage staff was motivated by the fact that the research project was initiated by the management and staff of this PES and because resources could be supplied to allow for this participatory approach. Furthermore, from a person-centred perspective, it was deemed valuable to let healthcare professionals spend additional time with the patients since patients view them as part of their integrated social network and feel comfortable with them (Aagaard et al., 2014). The data collection approach also helped protect the integrity of the patients and made them feel more comfortable with the interview situation. All triage staff received one day of training in how to perform an interview according to the interview manual. One triage nurse was given the main responsibility for the data collection; in total, 16 triage staff were involved in the data collection. Each interview lasted around 30–45 minutes and was interviewer-administered, i.e., all answers were written down by the interviewer with the agreement of the participants.

The first part of the interview manual covered background characteristics such as gender, age, and home municipality. In the next part **(A)**, four qualitative open-ended questions about self-expressed needs were asked concerning the motives for the patients' visits and what kind of help they received at the PES. Open-ended questions were used to give the participants the opportunity to freely discuss their problems relating to the PES, their everyday life, or their health. Since needs assessment tools consist of pre-defined need domains, it was felt important to investigate whether other problem areas could be identified by using open-ended questions. The answers were written down by the interviewer, mainly verbatim or sometimes in paragraph form. In the third part of the interview manual, instruments commonly used for assessing needs in persons with mental health problems were used. This part collected quantitative data and included **(B)** the *Camberwell Assessment of Need Short Appraisal Schedule* (CANSAS). To capture a more comprehensive and detailed picture of needs concerning alcohol/drug abuse and the social network, the *Alcohol Use Disorders Identification Test* (AUDIT), *Drug Use Disorders Identification Test* (DUDIT) and **(C)** part of the *Interview Schedule for Social Interaction* (ISSI) were used as well.

Since CANSAS does not cover needs related to interpersonal violence, which previous studies have noted that persons with mental health problems are often subjected to (Bengtsson-Tops & Ehliasson, 2012; Howard et al., 2010; Oram, Trevillion, Feder, & Howard, 2013), four dichotomous questions **(D)** concerning *interpersonal violence* covering experiences of threats, physical violence, and sexual abuse within the last year were added ("Within the last year, have you been exposed to (1) verbal threats of physical abuse; (2) verbal threats to be killed; (3) physical violence, and (4) sexual abuse").

CANSAS

CANSAS (Ericson, 2013; Phelan et al., 1995) is an instrument for assessing persons' needs within a psychiatric context. It consists of 22 pre-defined domains of needs, each represented by one item, experienced within the last month: accommodation, food, household skills, self-care, daytime activities, physical health, psychotic symptoms, information about condition and treatment, psychological distress, safety to self, safety to others, alcohol, drugs, company, intimate relationships, sexual expression, child care, basic education, telephone, public transport, money, and social benefits. CANSAS provides the ability to add additional domains that fit the context of the study, so the domain 'dental care' was added (Bengtsson-Tops & Hansson, 1999).

In the first section of the instrument, which was used in this study, the prevalence and severity of the needs experienced by persons who frequently visit PES were self-assessed using a three-point-scale: 0 = no need, 1 = met need, and 2 = unmet need. A rating of 9 = not known was used when the patient did not know or did not want to answer questions within specific domains. The instrument produces three scores: *total needs*, *total met needs*, and *total unmet needs*. CANSAS is a validated instrument (e.g. Phelan et al., 1995) and has been used in different psychiatric care contexts (e.g., Kulhara et al., 2010; Zahid & Ohaeri, 2013).

AUDIT and *DUDIT*

The Swedish versions of the AUDIT (Babor, Higgins-Biddle, Saunders, & Monteiro, 2001; Bergman & Källmén, 2002) and the DUDIT (Berman, Bergman, Palmstierna, & Schlyter, 2003) were used for the visitors' self-assessment of frequencies and amounts of intake of alcohol and drugs. The scales consist of 10 and 11 questions, respectively, and result in scores of 0–40 and 0–44. AUDIT scores of 8 in men and 6 in women indicate hazardous and harmful alcohol use or alcohol dependency (Källmén, Wennberg, Berman, & Bergman, 2007). For DUDIT, scores of 6 in men and 2 in women were used (Berman, Bergman, Palmstierna, & Schlyter, 2005). Both AUDIT and DUDIT are widely used screening instruments that have good psychometric standards in various psychiatric care contexts (Hildebrand, 2015; Lundin, Hallgren, Balliu, & Forsell, 2015).

ISSI

Parts of the ISSI (Eklund, Bengtsson-Tops, & Lindstedt, 2007; Undén & Orth-Gomér, 1989) from the sub-scale 'Availability of social interaction' were used to investigate the social networks of persons who frequently visited PES. Answers categorically ranking six options ranging from 'No-one' to 'More than 15 people' were provided.

Interviews

Studies III and IV used both individual interviews and focus group interviews as data collection methods.

Individual interviews

The purpose of qualitative data collection methods like individual interviews is to understand and describe social phenomena as experienced by the subjects themselves and in their natural context (Polit & Beck, 2016). The researcher lets the subject describe their experiences, perceptions, feelings and actions in detail to capture differences and varieties of the phenomena (Kvale & Brinkmann, 2009). The individual interviews were conducted in October and November 2018 by MS. Inclusion criteria for participation were 1) to be an assistant nurse, registered nurse or physician, 2) having been in contact with persons who frequently use PES, and 3) to have been employed for at least six months at the PES prior to the interview. However, point 3 was revised to include intern physicians since they have extensive contact with the patients but are employed at PES for three months only for educational purposes. Prospective participants were informed about the study during workplace meetings by MS, a video recorded by MS, and an information email that contained information about the study aim, data collection methods, and the right to withdraw. A semi-structured interview guide was used to make sure a certain set of topics was covered (Polit & Beck, 2016). The guide consisted of two sections of open-ended questions covering the healthcare professionals' perspective of the patients' needs (including question such as "Can you freely tell me about your experiences with persons who frequently use PES?", "What problems do they have?" and "How do you address their problems at PES?") and their experiences of the encounter with the patients (including questions such as "How do you encounter persons who frequently use PES (visit or call in)?", "Can you describe examples of an encounter that you felt satisfied with/experienced as challenging?" and "How do you communicate with persons who frequently use PES?"). The participants were encouraged to talk freely about the chosen topics, and to tell stories about their experiences in their own words. The interviews lasted on average 51 minutes (range, 27-86 min) and took place at the participants' workplace during work time. Two pilot interviews were performed by MS and ACJ and were included in the analysis. All interviews were audio-recorded and transcribed verbatim.

Focus group interviews

The individual interviews were complemented by focus group interviews. In a focus group interview a number of individuals, often five or more, discuss a topic with the purpose of gathering information (Krueger & Casey, 2015). The discussion is guided by a moderator and observer, using an interview guide (Polit & Beck, 2016). Focus group interviews capitalise on communication between the participants, and these group interactions offer a direct indication of similarities and differences among the participants' experiences, opinions, and feelings (Morgan, 1996). Focus group interviews take advantage of those group dynamics and they are an important part of the data collection. Thus focus group interviews are different from the sum of individual interviews (Morgan, 1996; Schoenberg, Shenk, & Kart, 2007). The focus groups were conducted by MS as moderator and ACJ as observer and took place at the participants' workplace during work time. An interview guide was used, created based on the preliminary results from the individual interviews. The focus group interviews lasted 100 and 90 minutes respectively.

By using within-method triangulation such as individual and focus group interviews (Thurmond, 2001), a clearer and more comprehensive picture of the phenomenon of interest can be provided. It also strengthens the trustworthiness of the study and improves the authenticity of the results (Holloway & Wheeler, 2015; Polit & Beck, 2016). While the individual interviews contributed to the in-depth data collection, the focus group interviews added variety and breadth to the data. Using focus groups interviews also gave us an opportunity to report back preliminary results from the individual interviews to the participants and thus allowed for validation of those results. It also gave the opportunity to explore differences of experiences among professions in another way and helped in exploring more deeply the contradictory experiences that were narrated during the individual interviews.

Participants

In Study I, prospective participants, i.e., persons who visited PES five or more times in one year, were informed about the study through an advertisement in three local newspapers. The advertisement included information about the right to decline participation, which none did. A total of 27,282 persons participated in Study I based on their visits made to PES during the 2013–2015 period, resulting in 67,031 visits. There was a relatively even gender distribution (50.9% women, 49.1% men) and the mean age of the participants was 42.6 years (SD ± 17.8).

In Study II, prospective participants, i.e., persons who visited PES five or more times in one year, were informed about the study by means of posters at the chosen PES. The patients were invited to participate by triage staff. A total of 177 persons who fulfilled the inclusion criteria visited PES during the data collection period, of whom 47 were excluded. Of those 130 persons who were eligible to participate, 81 participated in Study II. Persons suffering from acute psychosis or severe aggression were excluded, as were persons coming with police assistance or who were intoxicated (*n* = 47). An additional 11 persons declined participation and 38 persons were not asked to participate due to the high workload of the staff. Participants were persons frequently visiting the PES; on average they made 12.63 PES visits. Of the participants, 56.8% (*n* = 46) were men and the mean age was 39.74 years (SD ± 15.6).

In Studies III and IV, all prospective participants who were healthcare professionals received information about the planned studies during workplace meetings from MS, by means of a video recorded by MS, and an information email containing information about the study's aim, data collection methods and the right to withdraw. Sixty-two healthcare professionals fulfilled the inclusion criteria, and 21 were purposefully selected (Holloway & Wheeler, 2015) based on profession, work experience, age and gender. Of those 21 healthcare professionals who were asked to participate, two withdrew due to workload. Thus, the final sample for the individual interviews consisted of 19 participants.

The focus groups in Studies III and IV consisted of healthcare professionals that previously had participated in an individual interview. For Study III, one focus group interview was conducted in January 2019 consisting of five participants. For Study IV, one focus group interview was conducted in May 2019, consisting of seven participants.

Analysis

Statistics

All statistical analyses were performed using SPSS software, version 23.0© (I, II).

In Study I, descriptive statistics (i.e., frequencies, percentages, and means) were used to present the participants' background information (e.g., sociodemographic characteristics) as well as outcomes (e.g., diagnosis frequency). Furthermore, Chi-square tests in combination with Bonferroni correction (Field, 2017) were used for comparing differences between categorical variables for persons with one to four visits or five and more visits with regard to age groups, most common diagnoses, temporal patterns of visits, and temporal patterns of hospital admissions.

In Study II, descriptive statistics (i.e., frequencies, percentages, means, standard deviations, and median) were used to present the participants' background information. In CANSAS, ratings of 9 were recoded to 0. The sum of rating 1 in the different need domains comprised *total met needs* per person. Likewise, the sum of rating 2 comprised *total unmet needs* per person. The sum of met and unmet needs formed the total needs score. Chi-square tests in combination with Bonferroni correction (Field, 2017) were used to test for differences in proportions between categorical variables. Spearman rank correlations were used to test for associations between continuous variables and variables with a natural rank order. A drop-out analysis was performed comparing participants with the total number of excluded patients, those not asked to participate, and those who declined. This analysis used a Chi-square test with regard to gender and a Mann-Whitney U test with regard to age (II).

P values of .05 or less were considered to be statistically significant (I, II). Confidence intervals had a 95% confidence level (Field, 2017).

Qualitative content analysis

In Studies II, III, and IV, qualitative content analysis was performed. Content analyses are used to analyse written or verbal communication in a systematic way (Krippendorff, 2013). The qualitative content analysis used in the studies is based on Graneheim and Lundman (2004). Their recommendations have been shown to be a useful choice of analysis within nursing and health science as it emphasises the analysis of experiences, perceptions and attitudes. Graneheim et al.'s analysis focuses on subject and context as well as similarities within and differences between parts of the text (Graneheim et al., 2017) and can comprise the manifest and latent content or a combination of both. As any text can have multiple meanings, there is always a certain degree of interpretation when analysing them (Graneheim & Lundman, 2004). Furthermore, an interpretation can have varying levels of depth and abstraction. All analysis was carried out inductively, that is, the themes emerged from the data, and thus were text-driven (Krippendorff, 2013).

When analysing the four open-ended qualitative questions of part A of the interview manual in Study II, a content analysis of the manifest content of the text was performed due to the limited level of richness and the amount of the collected data. This started with repeatedly reading the text to obtain a sense of the whole. Verbatim text was formed into meaning units which were then condensed. The content was then sorted into clusters, also called content areas (Graneheim & Lundman, 2004). Thereafter, the data were labelled into categories and subcategories that are the core features of qualitative content analysis (Graneheim & Lundman, 2004). This process was circular and continued until agreement was reached between the authors on the manifest content of the data.

In Study III, an analysis of both the manifest and latent content of the text was performed. The analysis followed a systematic and stepwise process as described by Graneheim and Lundman (2004). The analysis process in Study III included two stages consisting of several steps. Stage 1 included 1) reading the individual interview texts to obtain a sense of the whole, 2) identifying the units of analysis and bringing them together in one document, 3) and dividing the text into meaning units and condensing them. Condensing the text implied shortening it while keeping its core meaning (Graneheim & Lundman, 2004). The process continued with 4) coding the condensed meaning units, and finally 5) sorting the codes into subcategories and categories. After stage one, the preliminary analysis of the individual interviews was completed. Thereafter the focus group interview was conducted and stage two of the analysis started. The analysis steps 2 to 5 in stage 1 were repeated with the focus group text. It largely validated the categories and advanced the analytical process by exploring and clarifying the preliminary results of the individual interviews. After analysing all the texts from all interviews, some categories and subcategories were merged and/or renamed. Four categories were formed with each consisting of four subcategories. Categories comprise the descriptive level of content and thus represent the manifest content of the text. Finally, an overall theme emerged representing the latent meaning of the texts which was derived by interpretation and abstraction (Graneheim et al., 2017).

In Study IV, an analysis of the latent content of the text was performed. The analysis followed a similar analysis design as described in Study III and followed two stages: stage one including the individual interview texts and stage two including the focus group text. Both stages followed the same stepwise procedure: the text was divided into meaning units related to the aim of the study. Then –in contrast to Study III— the meaning units were condensed and interpreted directly instead of coded. Those interpreted meaning units were thereafter formed into sub-themes and themes. The analysis resulted in 10 sub-themes and two themes. Due to the richness of the data, it was possible to begin interpretation and formulating sub-themes and themes directly after interpreting the meaning units (Graneheim et al., 2017).

In both Studies III and IV, the analysis was circular and involved moving back and forth between the parts and the whole of the text and between the analysis steps (Graneheim & Lundman, 2004). Furthermore, the interactions of the focus groups showed consensus between the participants. In both Studies III and IV, all authors were involved at different stages of the analysis process. MS, ACJ and PG discussed and reflected upon the categories, subcategories and themes individually and together until a consensus was reached. Thereafter SS was involved in the analysis process to introduce a new pair of eyes to the analysis process, which restarted the discussion. The analysis was final when consensus among all involved authors was reached.

Central to any type of research and analysis process is the researcher's awareness of his or her pre-understanding, which can influence how a text or results are understood or interpreted. Pre-understanding implies everything from preconceived meanings, common prejudices and emotional attachment related to the studied phenomenon, to preferred methods, theories or models used in the research (Dahlberg, Dahlberg, & Nyström, 2008). The concept of pre-understanding partly overlaps with the concept of reflexivity, which consists of two parts: 1) the researcher's self-reflection about own biases, preconceptions, preferences, or fears, and 2) the researchers' awareness of themselves as part of the data they are collecting, and being part of the setting and the context of the study (Polit & Beck, 2016). Both concepts require researchers to adopt a continuously open-minded and conscious approach to the part they play in their own research, and to reflect on their own previous experiences and behaviour and how this could affect the data

(Dahlberg et al., 2008; Polit & Beck, 2016). When I entered this PhD project, I tried to be aware of prejudices that could affect my research process. My pre-understanding concerning mental illness in general and persons who frequently use PES in particular was limited. I tried to evaluate and re-evaluate constantly during the PhD studies as my pre-understanding changed from study to study. I did so by self-reflection or by reflecting on my supervisors' feedback on my material. Doctoral seminars discussing my and others' work also helped me to constantly question my prejudices and reflect on my own research process. During PES observations, I tried to keep an open mind and was aware of my posture and facial expression and when conversing with the healthcare professionals, I tried to learn about and to understand the situation from the patients' and/or healthcare professionals' perspective. I was also reflective when conducting individual interviews and focus group interviews since, as a researcher, I became a co-creator of the data. When choosing the data collection and analysis methods, I was mainly driven to find methods best suited to meeting the aim of the respective study, i.e., I let my pragmatic approach steer the choices rather than choosing methods I was already familiar with.

Ethical considerations

Reflecting on ethical considerations is an ongoing process that starts during planning and does not end after publication of a study *per se*. This thesis allows to revisit each study, invites re-evaluation and own questioning of choices one once made. As persons who frequently use PES represent a vulnerable group of society, the most pressing ethical dilemma I faced during my PhD studies was the question of to what degree, how and if at all it would be considered ethically acceptable to involve those patients, and not least, to what degree *I myself* would consider it ethically acceptable. Study I was approved by the county deputy medical director (I), and all studies conducted in this thesis were approved by the Regional Ethical Review Board (Dnr. 2015/645, Dnr. 2016/181, Dnr. 2018/549) adhering to all necessary requirements. However, such approval does not nullify one's own ethical concerns. It was important for me to include the voice of persons who frequently use PES, yet by no means should their participation in research add to their already complex life situation. As they are seen as capable and autonomous individuals in this thesis (including making their own decisions about research participation), they were included in Study I by use of register data, and participated actively in Study II. Careful decisions concerning planning and study design were taken to accommodate this process to the best of my ability and knowledge, with the principle of beneficence and non-maleficence in mind. As for Studies III and IV, I opted to give voice to healthcare professionals as they represent a valued and important source for those patients. The four principles that lie at the core of moral reasoning in healthcare, i.e., respect for autonomy, non-maleficence, beneficence, and justice (Beauchamp & Childress, 2013), were considered in all studies to protect participants, gain the trust of the participants and the involved organisations, and demonstrate integrity.

Respect for autonomy

The principle of autonomy is concerned with the participants' right to make their own decisions based on knowledge and understanding of all the risks and benefits of the study. It is the basis of the principle of informed consent and voluntariness. In Study I, prospective participants were informed about the study through an advertisement in three local newspapers. The advertisement included information about the right to decline participation. Furthermore, the prospective participants were informed about the data to be included in the study and about the contact persons from both the research group and the involved clinical organisation. Despite this being a standard procedure in register studies, the appropriateness of this procedure could be questioned and to what extent persons who used PES in the given time period were reached by those advertisements in the newspapers. After time for reflection, one could have considered—in addition to the advertisements—informing prospective participants by using information sheets at all PES in the chosen county, as well as at primary care centres and social services, via case managers etc. and considerably extending the period for responding to increase the possibility of reaching more of those prospective participants.

In Study II, prospective participants were informed about the study by means of posters at the chosen PES. The patients were invited to participate by triage staff after they had received triage assessment. The patients were informed about the research purpose as well as their right to decline participation. They received the letter of consent in written form, and it was read aloud for the participants and signed before the interview started. Based on this principle, triage staff excluded persons who may not have fulfilled this principle, e.g., persons with acute psychosis, severe aggression, or temporary intoxication, as those conditions could have affected their capacity to make competent, reasonable decisions at that time.

In Studies III and IV, all prospective participants who were healthcare professionals repeatedly received information about the planned studies. I attended workplace meetings, recorded a video to be sent via email, and wrote an information email containing information about the study's aim, data collection methods and the right to withdraw. The letter of consent was discussed before each interview, emphasising that participation was voluntary, and it was signed by all participants before the interviews started.

Beneficence and non-maleficence

These principles refer to the value of research, doing good, and to the risks of harming the participants or others in society. In Studies I and II, data were collected in an anonymous manner for the researchers, and results were presented at the group level in Study I. In Study II, triage staff were chosen to conduct the interviews, to make the participants feel comfortable and to protect their integrity. An additional reason for involving triage staff was to engage them in their work and involve them in research. However, the participants may also have felt some degree of dependency on the triage staff due to the high possibility of previously having met one another and doing so in the future as well as due to the care concerning the current visit. Therefore, the patients were only asked to participate after the triage process. Of 130 eligible persons, 92 were invited to participate, with 11 declining. However, it was believed that the chance of being more comfortable during the interview with a known and familiar healthcare professional outweighed the possible risk of dependency. Certain questions in the interview manual used in Study II may have caused psychological discomfort, e.g., questions about physical or sexual abuse. However, contact information for support groups was provided by the interviewer if abuse had occurred and if the participant wanted it. In the case of self-harm (i.e., suicidal or other self-destructive behavioural tendencies) or harm of others, the involved physician would have been notified (which participants were informed of in the letter of consent). The involved triage staff received training from a senior researcher in how interview-based questionnaires were to be used in Study II. They also received education in research ethics. The answers to the four qualitative open-ended questions were written down by the interviewer (mainly verbatim or sometimes in paragraph form) instead of being audio-recorded, to make the participant feel more comfortable. Part A of the interview manual intentionally contained a limited number of open-ended questions with no distressing content, so as not to cause discomfort for the participants. Questions were formulated to be easy to understand, and since the manual was interviewer-administered, all questions were read to the participants. This strengthened the interaction with the participants and helped engage them in meaningful dialogue and discussion, which they seemed to appreciate during the sometimes long waiting times. Also the possibility to be listened to by a healthcare professional was appreciated and gave an opportunity to interact one-on-one.

In Studies III and IV, participants were informed that the collected data would be treated confidentially and that only the authors of the study would be able to access it. Identities were not revealed in the interview transcripts and chosen citations. Whether potential harm could be caused in the form of workplace tensions by conducting multi-professional focus group interviews was considered. As the participants knew each other, there could have been a risk for future problems when working together if the participants had strong disagreements on the phenomena discussed or related issues such as work ethics, work values, leadership, experienced hierarchies or emotions. However, open dialogue between colleagues and venting opinions is a common activity at the workplace and thus what happened in the focus group interviews did not differ from that. Additionally, since the participants were acquainted and familiar with each other, a shyness bias could be limited and the risk of not wanting to reveal too divergent opinions from the group was minimal since the participants were already used to and dependent on a straightforward and open communication style at the workplace.

The research may be considered beneficial with regard to clinical/practical relevance. Since the idea of all studies originated from the studied PES, i.e., its management and staff, the present results may contribute new knowledge that could improve not only awareness of this patient group among healthcare providers but, most importantly, improve the care this group receives in PES and elsewhere, and potentially meet their needs more efficiently.

Justice

This principle refers to the participants' right to be treated fairly during the recruitment process. In Study II, several patients were not invited to participate due to the high workload at the PES, which implies that this principle may not have been fully followed. Excluding persons due to the autonomy principle (e.g., persons who could not give oral and written consent to participate or who suffered from acute psychosis, severe aggression, or temporary intoxication that could affect their capacity to make competent, reasonable decisions at that time) results in not being able to include their perspective, which might affect the transferability of the results of the study. However, when choosing to work with organisations, jointly collecting data with them, researchers have to accept the existing work conditions and contexts.

In total, 62 persons were eligible to participate in Studies III and IV and had the opportunity to be individually interviewed. However, after 19 individual interviews, the researchers agreed that the data was rich enough to conclude with the individual interviews. The participants for the focus group interviews were chosen primarily based on pragmatic reasons, i.e., their availability due to their alignment in work schedules. Even though not all prospective participants were asked to participate in the focus group interviews, the researchers agreed that conducting focus groups at the organisation represented a challenge. Thus, only one focus group for Studies III and Study IV was conducted, and care was taken that it did not interfere more than necessary with the organisation's primary task, which was taking care of the patients.

Results

Who are persons who frequently use PES?

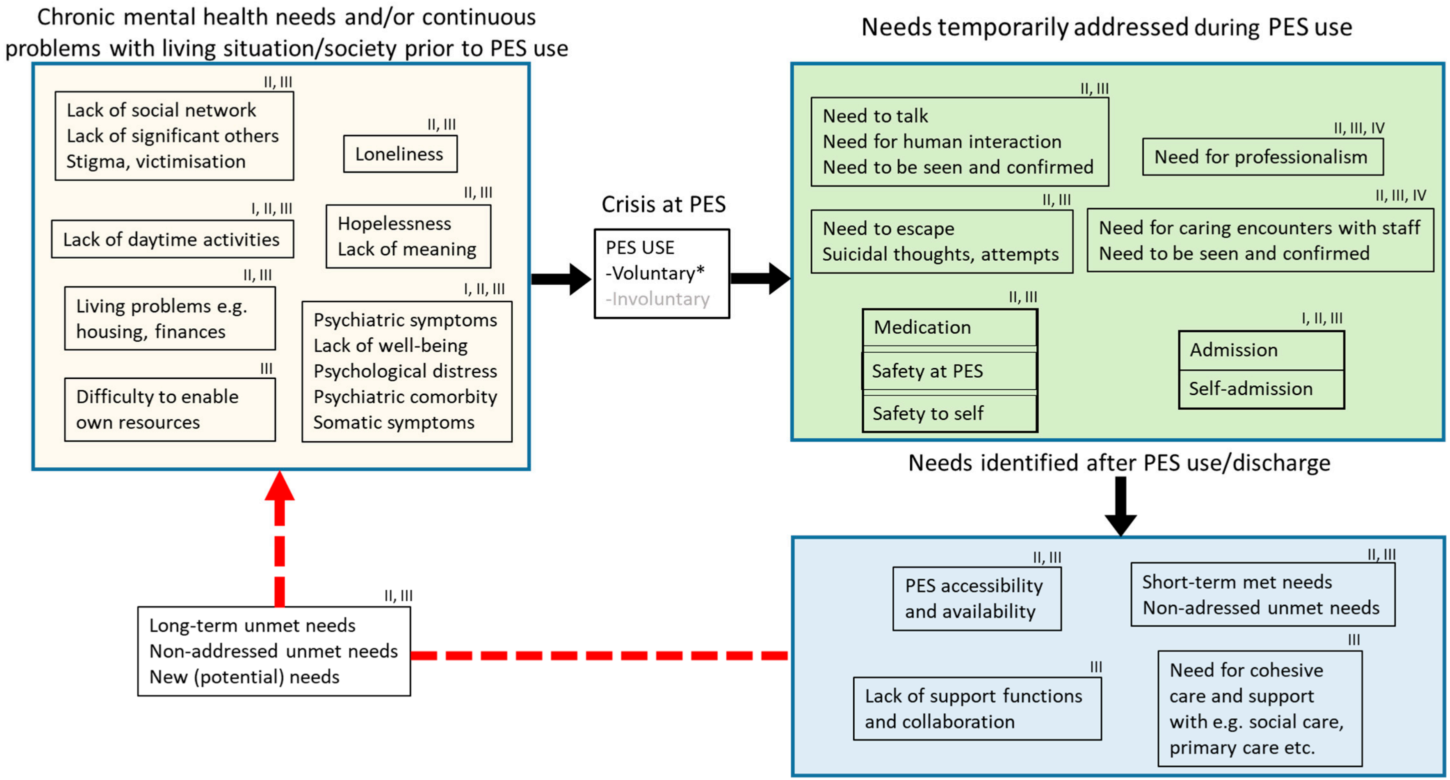
One of the important findings of this thesis is that persons who frequently use PES in Sweden were a small group (8.1% of all visitors) who are responsible for two fifths of the total visits made to PES (I). They differed in terms of gender, age groups, diagnostic profile, hospital admissions, temporal utilisation patterns, and how far they lived away from PES, compared to other PES visitors (I). Despite often being described as young (Chaput & Lebel, 2007; Ledoux & Minner, 2006), they were shown here to be middle aged (I) suffering from a broad spectrum of psychiatric diagnoses (I, II, III), having often not only one but several psychiatric diagnoses (I, II, III). In Study I, 51.4% of persons who frequently visited PES received three or more psychiatric diagnoses within a period of three years (I). They often had comorbid somatic conditions (II, III). Persons who frequently use PES suffered mainly from anxiety (I, II, III), substance abuse (I, II, III), personality disorders with self-harm (I, III), schizophrenia (I) and psychological distress (II). Thus, persons who frequently use PES comprised a heterogeneous group in terms of their diagnostic profile (I, III) though anxiety was particularly emphasised by both patients and healthcare professionals (I, II, III). Furthermore, many of them had few social interactions, lacked close relationships and were lonely (II, III), lacked daytime activities (II, III) and had been exposed to verbal (36.7%), physical (21.5%) or sexual violence (11.4%) (II). In Study II, nearly 40% of the persons with frequent PES visits had no friend or relative to visit and around 30% had no friend or relative that they could talk to openly (II). Nearly 60% said they lacked intimate relationships, 60% lacked company and 40% lacked sexual relationships (CANSAS, II). Many patients had numerous contacts with other health and social care services (II, III) yet kept using PES due to dissatisfaction, lack of quality, or shortage or lack of those services (II, III). The qualitative content analysis in Study II and III showed that they felt in despair, helpless, unwell, had lost hope and had a negative outlook on the future (II, III) which is in line with the high amount of self-harm, suicidal thoughts and threats being expressed (II, III). In sum, persons who frequently use PES were shown to suffer to a high extent; from illness, unfavourable life circumstances and inadequate care (I, II, III). Furthermore, healthcare professionals found that persons who frequently use PES were common visitors to PES, and were a large and exceptionally heterogeneous group who were unwell, help-seeking, and lacked self-esteem (III).

What needs do persons have who frequently use PES?

Persons who frequently use PES assessed themselves (II) as having multiple needs in many life domains, including physical and psychiatric health needs, and financial, emotional and social needs. Physical needs referred to the patients' self-assessed physical problems, dental problems, high blood pressure, diabetes etc. Psychiatric health needs included mainly psychological distress, psychotic symptoms, suicidal ideation or attempt and self-harm, anxiety and panic attacks, substance abuse, severe stress but also sleeping problems or everyday problems that became obvious when trying to handle the current life situation. Emotional and social needs mainly referred to lacking company and a social network, lacking close and significant relationships and being sexually inactive. The lack of daytime activities (which was reported by nearly 70% in CANSAS) amplified the problems with finances, loneliness or finding meaning in life. The number of total needs (9.52) as well as unmet needs (6.63) was high. The patients' PES visits increased the more unmet needs they reported through self-assessment ($p <$,05). Furthermore, persons who frequently use PES longed to be relieved from their suffering as soon as possible when at PES, either with the help of medication, by hospitalisation or by talking to someone. Other needs expressed by the patients included the need to feel secure, including physical safety. Healthcare professionals who are not stressed and professional as well as the fact that PES was available day and night helped to create a feeling of security. The need for caring encounters was yet another strong need expressed by the patients. Conversely, persons who frequently use PES assessed themselves as not posing a risk to others, which thus represented one of the lowest need domains.

Healthcare professionals could also identify a variety of needs among the patients (III) covering the patients' living situation and health conditions prior to, during and after PES use. This is shown in the overarching theme ***"To suffer from illness, unfavourable life circumstances, and inadequate care stresses the need for sustainable support"***, which consists of four categories: the *need to relieve loneliness,* the *need to relieve hopelessness*, the *need to relieve psychiatric symptoms*, and the *need for cohesive care and support*. The healthcare professionals understood the patients' high degree of suffering from illness and the need to find relief from it. The conditions of the patients could range from milder symptoms such as sleeping problems to acute and severe healthcare needs; however, the healthcare professionals stressed that the patients' subjective experience of their own health conditions was the point of departure, not the professionals' perception of the patients' conditions. They also viewed persons who frequently use PES as having problems with loneliness. They were seen as lonely on several dimensions including a deeper, inner loneliness, the lack of significant others as many lived alone and had little or no contact with family, and finally the lack of a social network and friends. The healthcare professionals saw societal changes as a contributor to patients' loneliness, vulnerability and alienation. They also saw that the patients had numerous problems with their living situations. The saw them as struggling with everyday life, and as being dissatisfied with housing, finances and daytime activities. They described persons who frequently use PES as having low self-esteem and lacking inner strength, as hopeless, wanting to escape their troublesome lives, and needing someone to take care of them, which was a need directed towards PES. The professionals also identified the patients' need for safety, need to be seen and confirmed, and their need for caring encounters. They tried to meet those needs by being empathetic and taking the patients seriously, and by trying to foster hope and empowerment. Conversely, *uncaring* encounters could lead to an increase of PES use according to the professionals. Finally, the healthcare professionals described the patients' need for cohesive care and support that included a long-term perspective, something that PES cannot provide. The professionals were aware that the patients often had numerous other support and healthcare contacts, but that they used PES frequently because they were let down by those services. The professionals strongly agreed that those services were inadequate and lacking in quality, quantity and availability.

Figure 2 represents a combination of the patients' self-assessed needs, i.e., their demands (II), and the healthcare professionals' perspectives of the patients' needs, i.e., normative needs and how they were met at PES (III, IV). The coloured boxes can be seen as representations of the patients' problems prior to, during and after PES use. Prior to PES use, the patients described being lonely, and also lacked daytime activities. All the needs the patients self-assessed, were also seen by the healthcare professionals. Those needs within a box could also be interrelated with each other, e.g., the lack of daytime activities could lead to loneliness, and loneliness could reinforce the lack of well-being or psychiatric symptoms. The green box represents the needs that were identified and addressed during PES use. Loneliness and the need for human interaction e.g., could be addressed by caring encounters at PES. Thus the need for caring encounters could be a means but also a need in itself. Professionalism and competence were important for both patients and healthcare professionals. The results show, that after PES use, certain needs were not or could not fully be addressed at PES. The red dashed lines represent the frequent nature of the use.



*including phone calls

Figure 2. Combined perspectives of needs as identified by patients and healthcare professionals

Besides the strong agreement between both views and their emphasis on being in the here and now, the healthcare professionals' perspective was somewhat broader by also acknowledging the lack of a long-term approach, lack of collaboration between and lack of other services. Yet another aspect brought up only by healthcare professionals was the patients' inability to mobilise inner strength. Patients—besides identifying multiple needs in many life domains—remained in the *here and now* and had a strong focus on needs related to their acute suffering from mental illness. Finally, though not the focus of the thesis, healthcare professionals' voices reporting on their own situation should be highlighted, which were sometimes described as hopeless and limited despite the overall meaningful aspects of their work and encounters with the patients at PES.

How do healthcare professionals at PES experience the encounter with persons who frequently use PES?

Caring encounters have been identified by both professionals and patients as a central need for persons who frequently use PES (II, III). For patients (II) such encounters meant being cared for and understood as well as feeling welcomed, and being treated well in terms of kindness, humanity, and fairness. Healthcare professionals were expected not to be stressed, and to take the patients seriously. However, many participants also had negative experiences with the encounter (II). Healthcare professionals (III) understood caring encounters with the patients as meeting them in an empathetic and humane way. They also experienced that *uncaring* encounters could lead to frequent use of PES and that the patients would not feel that they were being taken seriously. Thus, both perspectives were largely in concordance.

Study IV showed that healthcare professionals experienced encounters with persons who frequently use PES as situations in which they aimed to treat everyone equally, with ethical consideration, and in line with human values, and as situations where they had a non-judgemental, open attitude towards the patients. Moreover, the encounters were individual and characterised by respect, kindness, humility, confirmation and empowerment. Each encounter was seen as the first, i.e., the healthcare professionals tried to reset before each encounter not to let previous difficult encounters with the patient affect the current or future encounters.

The latent meaning of the content was presented in two themes (IV):

Nurturing the encounter with oneself and colleagues for continuous, professional improvement

Healthcare professionals described how, with experience, they became so familiar with any possible scenario concerning the encounter that they could allow themselves to act intuitively and naturally with the patients. They also emphasised that this was a learning process that could not be learnt from books. Professional behaviour was mentioned repeatedly and was of great importance to the healthcare professionals during the encounters. Therefore, they tried to discuss their emotions, and at times feelings of powerlessness or frustration, with other colleagues and kept their emotions in check during the encounter with the patients. The support from colleagues and management, along with the effective interdisciplinary teamwork and clinical supervision enhanced mutual learning processes, and created a good working climate and workplace satisfaction. These positive factors functioned as prerequisites for having caring encounters with patients. Not only was the relationship with colleagues shown to be important, but also the relationship with oneself was deemed essential in order to have a caring encounter with patients. The healthcare professionals showed a high amount of self-insight and self-compassion, could admit to mistakes during encounters, acknowledged their limitations, and saw themselves as ‘just’ human. Furthermore, they understood the importance of being true to themselves in the encounters in order for them to be authentic, while also retaining a professional work role. The encounters demanded high level of critical thinking, including self-criticism, and those reflecting and re-evaluation processes were constantly ongoing and could at times lead to mental tiredness among the professionals.

Striving for a meaningful connection with the patient

The healthcare professionals learnt to become a chameleon during the encounter with the patients, constantly adjusting intuitively to the patients and their needs. They tuned in with the patients based on an initial assessment of the current situation, considering not only the person and his or her needs, but also useful knowledge from previous encounters, current prejudices, level of tiredness, and situational aspects such as the current situation in the waiting room or the time of the day. Then the professionals allowed themselves to *feel* the right responses and trusted their senses, which were safely embedded in those previous experiences. Hope, laughter, and physical contact were important and powerful tools in the encounter that were used by all profession groups for making a connection and for strengthening the relationship, but humour and physical closeness were highly situation- and person-dependent. The latter was only used when knowing the patient well and for a long time. Thus, encounters with persons who frequently use PES differed from encounters with unknown patients, not only in terms of physical contact but also because the professionals could be more free, informal and flexible with the patients based on the knowledge gained though previous encounters. This helped with seeing the patients as fellow human beings, who also had human needs, such as being confirmed as a person. The professionals used small gestures such as using the patient's name or sitting next to the patient, and were welcoming, inviting, and supporting the person and his or her decision to contact PES, a decision of which the patient might be ashamed, despite frequent previous use of PES. Conversation was important but so was silence. To engage in a conversation, the professionals stressed the importance of being present, not stressed, and taking time. However, the time aspect was not seen as a general prerequisite for a good encounter. Connections between patients and professionals could also be established quickly or could last only a few moments if there was mutual trust. Conversing was seen as an art that need to be mastered and that included a broad set of interpersonal skills. Conversation required a sense of mutuality, sensibility, responsiveness, and reciprocal skills, and it was compared to a two-person dance. Yet telephone encounters, i.e., the faceless encounters, were described as more difficult than face-to-face conversations because the professionals lacked clues such as facial expressions or body language. Knowing the patients thus was helpful in those situations. Also, the professionals thought encounters that started out as difficult had the potential of becoming meaningful for the patients. Yet they could also accept being unable to connect with the patients. Those encounters were not bad encounters *per se* but simply 'just' encounters, that were also characterised by respect, humility and kindness.

Discussion

General discussion of the results

The overall objective of the thesis was to describe who persons that frequently use PES in Sweden are, to explore what needs they experience, as well as how healthcare professionals working at PES view the needs of those persons and experience encounters with them. In a Swedish context, this is the first thesis that has focused on persons who frequently use PES, and their needs. The results of the thesis show that persons who frequently use PES are a small group of people that are responsible for a disproportionately high number of visits to PES (I). Those results are in line with previous research (Boyer et al., 2011; Chaput & Lebel, 2007; Ledoux & Minner, 2006; Poremski et al., 2017; Schmoll, Boyer, Henry, & Belzeaux, 2015). Though a small group, healthcare professionals experienced this group as large and very common (III). They could have comprehensive problems in various life domains, and complex intertwined need patterns (II, III) that kept them from living their lives on equal terms as the rest of society. The high proportion of self-assessed unmet health and social needs combined with their need to reduce acute suffering may reflect a difficult life situation from which they wanted to be relieved (II, III). Yet they did not only suffer from illness and unfavourable life situations, but also from inadequate care, which stresses the need to find more sustainable care and support possibilities (III). Through caring encounters, which has been identified by both patients and professionals as an important need in itself for the patients (II, III), the professionals have the opportunity to address some other needs, e.g., such as the need of providing a glimpse of hope, the need of being confirmed as a person, or having humane and meaningful connection (III, IV). Compared to the rather negative picture of frequent PES visitors and healthcare professionals' often negative attitudes and difficulties with balancing competing interests and managing time described in the background chapter of the thesis, the results showed that healthcare professionals saw the patients as fellow human beings. Persons who frequently use PES were not viewed as difficult patients; instead their visits and calls were welcomed by the professionals. Yet the healthcare professionals acknowledged the difficult life situations that the patients were in and wished for more appropriate long-term support and more preventive interventions outside of PES. Below, the results are discussed and compared with other relevant literature and health-related concepts from health science as well as person-centredness in order to allow for a better understanding of persons who frequently use PES and their needs.

A suffering that threatens the person' existence

Persons who frequently use PES have been found to suffer to a high extent from illness, unfavourable life circumstances and inadequate care. The present findings are in line with Eriksson's (2006) categorisation of suffering from illness, suffering from care, and suffering from life. Eriksson (2006) compared suffering to a form of dying in that the absence of confirmation of one's worth as a human being leads to a world beyond relationships that is characterised by hopelessness, sorrow, guilt, humiliation, and loneliness. In this thesis, it was found that persons who frequently use PES suffered in many ways but particularly from a high degree of hopelessness and loneliness. Stratton (1992) further distinguished between acute and chronic suffering, with the former relating to illness and the latter to the patient's situation as a whole. Both forms of suffering and their resulting needs were identified by both patients and professionals in this thesis. Although the professionals stressed that their task was to offer only short-term ease of acute symptoms at the PES, they could see beyond illness-related needs and also acknowledge the patients' unmet long-term needs originating from aspects of their life situation. These results further correspond to the four modes of suffering identified by Cutcliffe et al. (2015): social suffering (as in the category *need to relieve loneliness*, III), existential suffering (as in the category *need to relieve hopelessness*, III), disease suffering (as in the category *need to relieve psychiatric symptoms*, III), and care and treatment suffering (as in the category *need for cohesive care and support*, III). The existential dimension of the patients' suffering was often described by the professionals in terms of the patients' existential loneliness, their need for meaning in life, their need to escape, and suicidal ideation, and by the patients in terms of suicidal ideation and attempts, and their need for physical and emotional safety.

Persons who frequently use PES self-assessed their unmet needs concerning their own safety, the latter representing a dominant concern for them. This need included a feeling of security, implying that not only the internal, emotional security (such as providing feelings of trust, support from professionals at PES) but also external, physical safety (such as reducing suicidal attempts or self-harm at PES, and the care provided by the professionals) is of importance in a crisis situation. According to the Tidal Model's conceptualisation of personhood's 'Domain of Self' (Barker & Buchanan-Barker, 2005), questions about one's own existence are touched upon in those crisis situations. Questioning one's own existence jeopardises success in gaining self-esteem and self-efficacy or in strengthening one's sense of self. In addition, the results showed that persons who frequently use PES are subject to abuse, in verbal, physical or sexual terms, which further poses additional threats to their sense of self, self-esteem, and self-efficacy as well as their existence in general.

According to Edwards (2001) and McCormack and McCance (2017b), a person's existence is constituted by the relationship between oneself and the body, and the relationship between the body and the world. Together, these two relationships form a seamless whole. According to the results of the thesis and previous studies (Cleary, Hunt, et al., 2012; Ådnøy Eriksen, Sundfør, Karlsson, Råholm, & Arman, 2012), both relationships, hence one's existence, are jeopardised among persons who frequently use PES, enhancing their suffering on an existential level.

This thesis also confirms that persons who frequently use PES feel profoundly lonely on internal, emotional and social dimension. Other studies on loneliness of persons with mental illness arrived at similar results (Lindgren, Sundbaum, Eriksson, & Graneheim, 2014; Nilsson, Nåden, & Lindström, 2008; Poremski et al., 2017; Wang, Mann, Lloyd-Evans, Ma, & Johnson, 2018). Loneliness among persons with mental illness is significantly higher compared to the general population (Badcock et al., 2015; Holvast et al., 2015; Victor & Yang, 2012). Eriksson (2006) argues that the deepest form of suffering is loneliness and thus not being seen. Loneliness combined with feelings of worthlessness, hopelessness, and helplessness yet again could be seen as a threat to the person's existence and can result in existential vulnerability. Existential vulnerability occurs when limit situations are experienced. Limit situations are common for all persons when one's sense of wholeness and unity of 'being in the world' crashes (Fuchs, 2013), e.g. when facing death or a fight, being at the mercy of chance, or when suffering (Jaspers, 1971/1995). Those situations are inevitable and touch upon existential questions (Arlebrink, 2012), like crisis situations at PES. Persons with mental illness are particularly prone to existential vulnerability and can experience seemingly insignificant events as limit situations since the threshold that separates everyday experience from limit situations has shifted (Fuchs, 2013). Experienced limit situations can lead to paralysis and foundational 'ontological' uncertainty and confusion, blocking the ability to take responsibility and act (Fuchs, 2013). This could be compared to the healthcare professionals' experiences of the patients' lacking inner strength and will. They could sometimes experience persons who frequently use PES as wanting to be taken care of and fixed, and passive, which might be a result of paralysis as explained by Fuchs. Yet another explanation for the patients being experienced as inactive or paralysed could be the fact that many persons with mental illness can also suffer from certain types of traumas, often interpersonal ones, such as physical or sexual assaults (Mauritz, Goossens, Draijer, & Van Achterberg, 2013; Spitzer, Vogel, Barnow, Freyberger, & Grabe, 2007), which this thesis was able to confirm. Those traumas and subsequent development of posttraumatic stress disorder (PTSD) often remain overlooked and undiagnosed in persons with mental illness (Mauritz et al., 2013; Spitzer et al., 2007). A consequence of those traumas and extreme stress is either an overstimulation, i.e., a state of too much arousal (hyperarousal), known as fight or flight response, characterised by anxiety, difficulty sleeping, problems managing emotions, and panic attacks; or a state of too little arousal (hypoarousal), also known as freeze response, characterised by dissociation, passivity, immobilisation, emptiness and emotional numbness, helplessness and hopelessness (Ogden, 2010; Siegel, 2012). This may imply a need for more awareness among healthcare professionals concerning diagnosing trauma and PTSD as well as a need to provide trauma and PTSP-related interventions. However, this line of reasoning is not further considered here as it is beyond the scope of this thesis and may require additional research.

Persons experiencing a crisis due to mental problems often report a loss of their 'sense of self', referred to in the Tidal Model as *piracy* (Barker & Buchanan-Barker, 2005) leading to a high risk of not feeling whole as a person, a condition also described as a damaged or defected self, 'crisis of the self', threat to selfhood (Barker & Buchanan-Barker, 2005) or 'spoiled identity' (Goffman, 1963/1986). Thus healthcare professionals working in psychiatric acute care need to be prepared to acknowledge and address the existential dimensions of frequent visitors' needs. Dahlberg et al. focus primarily on the need to address a person's existential loneliness within psychiatric care contexts (Dahlberg, Segesten, Nyström, Suserud, & Fagerberg, 2003) while in psychiatric acute care, Barker and Buchanan-Barker (2005) emphasise particularly the need to provide a sophisticated form of life saving when in crisis, i.e., a psychiatric rescue, which focuses on the need for physical and emotional security. The latter need was highly prevalent among the patients in this thesis. Thereafter, recovery and reclamation processes are important to restore or reconstruct the notion of the self. Caring encounters are tools to address and meet the needs necessary for achieving this. In particular, trust, respect, non-judgement, confirmation and feelings of connectedness appear to be helpful, as shown in this thesis and other research within psychiatric care (Barker & Buchanan-Barker, 2010; Ådnøy Eriksen, Arman, Davidson, Sundfør, & Karlsson, 2013).

Recovery. One step forward, two steps back

For persons to move away from those existential states of suffering, hope-supporting and interpersonal relationships are needed. These are being formed with healthcare professionals through caring encounters (Wyder et al., 2017; Ådnøy Eriksen et al., 2014). The professionals participating in this thesis, regardless of their profession, were aware of the value of supporting and empowering the patients by believing in them and providing them with some glimpse of hope. Provision of hope during periods of illness and vulnerability, by nurses and psychiatric nurses in particular (Hammer, Mogensen, & Hall, 2009), has consistently been identified as crucial in previous literature. Hope-inspiring interventions and their therapeutic value have been shown to be essential to the experience of illness and well-being, recovery, and the ability to live meaningful lives (Eriksson, 2006; Moore, 2005; Nekolaichuk, Jevne, & Maguire, 1999). However, it is primary the nursing profession that is reported to focus on hope-supporting and interpersonal relationships. As this thesis shows, those activities can include all professions working at PES. A study including mental health professionals confirmed that inducing hope, and recognising and confirming mental health patients as fellow human beings increases their self-respect, self-worth, and sense of self (Ådnøy Eriksen et al., 2013).

The voices calling for a recovery-oriented care approach within psychiatric care have become stronger within the last decade, resulting in increased acknowledgement and acceptance of the approach (Barker & Buchanan-Barker, 2010; Dawson et al., 2019; Gabrielsson & Ejneborn Looi, 2018; Ådnøy Eriksen et al., 2014). To facilitate those recovery processes, an interpersonal, person-centred approach to care and the encounter between the patient and the healthcare professionals is required (Gabrielsson et al., 2015; Goulter et al., 2015; Hummelvoll et al., 2015; Seed & Torkelson, 2012). Creating and sustaining encounters in acute psychiatric care settings can be challenging as they constitute a unique and complex context (Bolsinger et al., 2020; Schmidt, 2018a; Schmidt & Uman, 2020; Vandyk et al., 2018). However, the results of this thesis show that healthcare professionals genuinely strived for a meaningful connection during the encounter with persons who frequently use PES, and contributed both caring and humane as well as professional elements to the encounter. Healthcare professionals emphasised the importance of a non-judgemental, open-minded, respectful, kind and humble attitude, of treating everyone equally and being personal and authentic during the encounter. The encounter was experienced as highly individual and was adjusted to the patients' healthcare and human needs, highlighting seeing and confirming the fellow human being. Those kinds of encounters are of particular significance when enhancing recovery processes (Gabrielsson et al., 2015; Ådnøy Eriksen et al., 2014). The thesis' findings are in line with Halldorsdottir (2008) who describes caring encounters as caring and connecting processes that develop a professional intimacy characterised by respect and compassion while maintaining a professional distance. Findings from that field of psychiatric care quite often contradict the present findings of the thesis, with healthcare professionals mainly reporting struggling with the conflicting interests and needs of all involved stakeholders, and with clashes between their humanistic ideals and harsh reality, often resulting in superficial, unethical and unprofessional care instead of close relationships with patients (Eren, 2014; Salzmann-Erikson, 2018; Waldemar et al., 2019; Wyder et al., 2017; Zarea et al., 2013), and with negative experiences often dominating over positive experiences among the patients (Schmidt & Uman, 2020). Even though the healthcare professionals that participated in this thesis could occasionally mention having an administrative workload—an recurring problem identified in previous studies (Schmidt & Uman, 2020; Wyder et al., 2017), they thrived in their positive work environment, reported high work satisfaction and support from all colleagues, and were rather stress-free in their encounter with the patients, something that was not only valued by the patients included in this thesis but also mentioned by other patients in previous studies as important (Schmidt & Uman, 2020). Lack of time—

another frequently mentioned problem reported by many other studies as a hindrance to caring encounters (Schmidt & Uman, 2020)—was not identified as a particular problem by the healthcare professionals in this thesis.

Recovery in the Tidal Model aims at putting the person back on a life course 'getting going again' and regaining a meaningful life in the community (Barker & Buchanan-Barker, 2010), retaining and keeping control over the life situation (Borg & Karlsson, 2017) and being in charge of this process (Ådnøy Eriksen et al., 2014). It is not cure-driven and viewed as a destination as in somatic care. Instead it is understood as a personal journey that is unique (Barker & Buchanan-Barker, 2010; Deegan, 1997). This seems important to keep in mind when encountering and caring for persons who frequently use PES. Several healthcare professionals in this thesis sometimes expressed disappointment at not seeing any improvement in the patients' situations despite years of engagement. Besides societal explanations and (self)stigmatisation, the healthcare professionals blamed the lack of recovery processes on the lack of continuity of care within the healthcare system and the related lack of collaboration between the different involved support and health services. Such lack of support in navigating social services such as benefits, housing or employment leads to social vulnerability (Newman, O'Reilly, Lee, & Kennedy, 2015). To support recovery processes, Barker and Buchanan-Barker developed in the Tidal Model a care continuum which spans hospital care and community-based services. Instead of separating these two traditional ways of caring, the continuum represents an integrative care version that puts the person's need for care at the centre, not the care setting in which it is delivered. In this way critical care (with a short-term focus on acute care), transitional care (providing a smooth passage) and developmental care (with a long-term focus on the community) can be seamlessly offered, providing the patient with a continuity of care and a long-term perspective (Barker & Buchanan-Barker, 2005, 2010). This approach failed from the perspective of healthcare professionals working at PES, as this thesis shows. However, the lack of adequate local services and social support, the lack of collaboration between service providers, and a fragmented care system has also been mentioned repeatedly in other studies (Bolsinger et al., 2020; Fleury, Fortin, et al., 2019; Poremski et al., 2020; Priebe, 2015; Schmidt, 2018a). In a Swedish context, inter-professional collaboration across organisational boundaries within the psychiatric care context has been shown to be particularly challenging. This is mainly due to the legal division of responsibilities between the county councils (which are obliged to offer healthcare services) and municipalities (which are obliged to offer social care services). The evaluation of an improvement program with the purpose of improving collaboration across county council and municipality organisations in Sweden confirmed that—despite the somewhat increased understanding of each other and the awareness of the importance of improvement and person-centredness compared to the current task orientation style—resistance remained among colleagues and leadership, who got stuck in the 'us versus them' mode and in organisation boundaries (Janlöv et al., 2016). Thus, organisational problems in the two systems remained, threatening the patients' recovery processes and requiring a more comprehensive organisation change to counter this fragmentation that hindered continuity in the chain of care and service for persons with mental illness (Janlöv et al., 2016).

Consequently, the Tidal Model's conceptualisation of personhood's 'Domain of Others' (Barker & Buchanan-Barker, 2005) which is concerned with aftercare, transitional or developmental care, i.e., the person's need for support and services in areas of everyday living, is in jeopardy. As a result of this, caring encounters at PES risk becoming frozen snapshots that—despite being meaningful for the moment and despite patients finding comfort from being recognised and confirmed as a person by known healthcare professionals—cannot facilitate recovery processes in the long term. However, recovery and continuity of care, defined as long-term continuity (change in known staff), longitudinal continuity (breaks in care), and contextual continuity (social services being responsible for the living situation) among others, are naturally connected in mental healthcare (Burns et al., 2009). Continuity of care is thus lacking for persons who frequently use PES. This is confirmed not only by this thesis but also by other studies (Blonigen et al., 2018; Fleury, Grenier, et al., 2019; Poremski et al., 2017; Vandyk et al., 2013). Though recovery is understood in a psychiatric context and it is acknowledged that growth and development occur through small, often barely visible changes (Barker & Buchanan-Barker, 2005), those short-term recovery processes that are awakened and enhanced through caring encounters at PES may not be efficiently supported or built on outside of PES. Thus there may be a move one step forward and two steps back, which risks making PES a vacuum rather than a part of a care continuum in a Swedish psychiatric care context. These results are supported by a literature study that claims that a recovery-oriented care approach in psychiatric care is still absent, which reinforces feelings of loneliness and isolation among the patients (Newman et al., 2015).

Social psychiatry and the importance of relationships

Another finding of the thesis is that both patients and healthcare professionals identified many of the patients' needs and origins of suffering in the patients' social and everyday lives. Persons who use PES frequently described themselves as lonely and were seen by professionals as excluded from society and exposed to (self)stigmatisation and victimisation. Furthermore, they lacked daytime activities and were dissatisfied with their housing and financial situation and with the limited availability and quality of the support and healthcare services, resulting in long-term challenges in everyday life. Those findings can be confirmed by previous studies of persons with mental illness (Fleury, Grenier, et al., 2019; Poremski et al., 2017; Rio et al., 2019; Schmidt, 2018a; Ådnøy Eriksen et al., 2012), which paid attention to the high amount of social needs (Phelan et al., 1995; Slade et al., 1998). One study described how social workers at the emergency department played a crucial role for persons with mental illness and who made frequent visits by better connecting them to the community-based services (Blonigen et al., 2018). Those findings may support a social-psychiatric approach, implying that more attention should be paid to people's social contexts (Priebe, Burns, & Craig, 2013), i.e., not only to the individual's immediate social context, but also to the political responses to societal structures at the local, national, and international levels (Mann et al., 2017; Priebe, 2015). By considering all aspects of individuals and their everyday lives, including the social perspective, a more person-centred caring approach is possible that may lead to more empowerment of patients and may better meet their long-term needs, thus providing more sustainable support and a better chance of recovery. Person-centred frameworks have acknowledged the importance of the wider picture of context and have thus incorporated a macro level perspective on person-centredness (Barker & Buchanan-Barker, 2005; McCance & McCormack, 2017a; WHO, 2015) including health and social care policies, strategic work and leadership perspectives, the role of the country, its government and financial resources, integrated health services and networks, and also acknowledge the importance of other related services such as education and housing. This may somewhat correspond with Catton's appeal stated on page seven, urging the government to take responsibility by playing an active part in addressing mental illness.

"A social paradigm requires research to study what happens between people rather than what is wrong with an individual wholly detached from a social context" (Priebe et al., 2013, p. 320). From this point of departure, encounters between persons who frequently use PES and healthcare professionals naturally can also be viewed from a social perspective because the encounter is not only a professional but also a social construct in itself (Barker & Buchanan-Barker, 2005) forming a relationship. And even though recovery is understood as a personal and individual journey, it can be argued that this implies a risk of considering the person out of social context, putting the burden of recovery solely on the person, instead of stressing that this journey also is a social process that may depend on being recognised and acknowledged in relationships with other people (Price-Robertson, Obradovic, & Morgan, 2017; Topor, Borg, Di Girolamo, & Davidson, 2011; Ådnøy Eriksen et al., 2014), such as e.g. during a caring encounter. As all persons, including persons who frequently use PES, are viewed as relational in this thesis, relationships are important for recovery and crucial for the sense of self as this is restored and developed in recognition of the other, and in being recognised by the other (Sebergsen et al., 2016; Ådnøy Eriksen et al., 2014). Healthcare professionals included in this thesis recognised the patients as fellow human beings and met them with respect and an open-minded attitude and emphasised the importance of understanding the subjective experience of the patients. The latter was also identified by healthcare professionals as important in another study (Cleary, Horsfall, et al., 2012). Meaningful connections that could be established by small gestures during the encounter included shared laughter, eye contact, a touch, sitting

down next to the patient or using the patient's name. These are also called micro-affirmations (Topor, Bøe, & Larsen, 2018). Through those connections between patients and healthcare professionals not only can the power asymmetry be balanced out and the patients' suffering be confirmed but it also helps the patients to restore their sense of self and in their recovery process, sending a message of shared humanity and hope (Topor et al., 2018). Through caring encounters, the patients were seen and confirmed as fellow human beings, but also the needs for talking and interaction, to fit in, and to be understood were temporarily addressed at PES; needs that otherwise could have been addressed in social life, in everyday life. Those micro-affirmations can be compared to Barker's need for ordinary interactions that have re-emerged as a complement to developing a number of therapeutic and communication skills: *"…the power of 'ordinary' relationships* [and interactions]*…might—in actuality—be extraordinary*" (Barker & Buchanan-Barker, 2005, p. 35), which stresses the equal importance of healthcare professionals being both human (ordinary) and professional (Barker, Jackson, & Stevenson, 1999). The need for ordinary interactions and their importance for recovery was confirmed by other studies stating that nothing is too small to engage in or react to in psychiatric care (Cleary, Hunt, et al., 2012; Molin et al., 2016). The results of this thesis showed an overly recovery-oriented approach by professionals when encountering persons who frequently use PES. This approach is based on mutuality and understanding the patients' subjective experience of their needs. The healthcare professionals in this thesis had caring encounters that consisted of caring, professional and humane processes; they valued and respected persons (including themselves, colleagues, and patients) which is in line with person-centredness and its underpinning values of mutual respect and understanding, and the right for self-determination (McCormack & McCance, 2017a). Having known the patients for longer periods—as is normal with frequent visitors or callers—helped the healthcare professionals to make a connection and to confirm the patient as a person. They did this by, e.g., being physically close when needed, or sharing a laugh or common interests during the encounter, which was made possible based on the knowledge gathered from previous encounters. Thus, recovery-oriented care and person-centredness are tightly connected and intertwined, not only as shown in Barker's Tidal Model (Barker, 2001) but also in other psychiatric care research (Gabrielsson et al., 2015).

The healthcare professional—a person as well…with needs

An additional finding of the thesis was that, despite the focus on the patients and their needs, it became apparent that all included professionals expressed needs of their own and sometimes felt hopeless. They were aware of the patients' needs, yet could often not address them, and they emphasised that the patients needed healthcare and support services earlier and elsewhere in the caring process and more interventions of a preventive nature. The latter indicated that the patients' and professionals' needs may be somewhat intertwined, particularly in the area of *needs* *for cohesive care and services*. Addressing the patients' needs in this area would ultimately address certain work-related problems of the professionals as well (e.g. time stress or administrative workload, which are frequently mentioned in the literature), which may lead to greater patient and staff satisfaction.

The healthcare professionals in this thesis described not showing certain emotions and feelings during the encounters with the patients in order to keep a professional approach, to avoid burdening the patients, and to keep the focus on the subjective experiences of the patients. A review of patients with mental illness confirmed that they experienced healthcare professionals who showed emotions, in particular negative emotions, as non-helpful (Ljungberg, Denhov, & Topor, 2016). Yet another study within Swedish psychiatric care found that patients experienced that the professionals could not master their feelings, which had negative consequences for the patients, resulting in the patients paying close attention to how the professionals acted (Molin et al., 2016). Instead of showing their feelings and emotions to the patients, the healthcare professionals in this thesis found support from their colleagues and expressed occasional feelings such as powerlessness, dejection, resignation, hopelessness or disappointment and were careful to avoid showing fear or irritation during the encounter. Barker and Buchanan-Barker (2005) acknowledge that healthcare professionals also need to keep themselves in balance so as not to risk their own emotional and spiritual safety, and sees this as a learning process. The thin line between emotional involvement and professional caring was described as challenging in other studies, and there was the risk of providing care without any emotional attachment at all and with too much distance from the patients in order to keep one's personal boundaries and not be invaded and overpowered by other persons' feelings and opinions (Ejneborn Looi et al., 2014; Halldorsdottir, 2008; Hem & Heggen, 2003; Waldemar et al., 2019; Ådnøy Eriksen et al., 2013).

The organisational culture, learning environment, and the care environment itself have been identified as the biggest challenges for applying person-centredness in acute care (McCormack, Dewing, & McCance, 2011). However, the healthcare professionals in this thesis experienced the learning environment and the care environment as positive, which was a prerequisite for ensuring person-centredness in the encounters with the patients but also for being self-compassionate. All the professionals expressed a great interest in learning more about psychiatric conditions, medicine and somatic care and about learning from each other, and were engaged in their work and with the patients. Furthermore, the healthcare professionals experienced their care environment as enriching and satisfying, having supportive colleagues and managers and a positive work climate with access to clinical supervision. Good teamwork, interdisciplinary staff, and professional supervision have been reported to facilitate recovery-oriented care in psychiatric acute care settings in another study (Wyder et al., 2017). Even though the professionals could at times find their work emotionally and mentally tiresome, the person-centred care environment enabled them to cope with their work at PES. Those results can be understood as indicating compassion satisfaction, derived from healthcare professionals' work and their contentment with the workplace (Stamm, 2010; Todaro-Franceschi, 2019). It also allowed them to be 'just' human, implying that mistakes could occur during encounters. They could accept their own limitations and tried to learn from them, and they could be honest and self-critical and backed each other up. In this way the colleagues recognised and acknowledged their humanity with each other. Person-centred services empowering patients in their recovery processes are more likely to be facilitated when person-centred cultures are provided (McCormack et al., 2010), which this thesis strongly confirms. Those cultures are formed by the care environment, which comprises professional relationships, supportive organisational systems, and leadership, and a common set of values among the different professions (McCormack et al., 2010; Wolf, Ekman, & Dellenborg, 2012). To enable person-centred processes in encounters between healthcare professionals and patients, the same person-centred values, attitudes, and processes need to permeate the workplace's physical, organisational and social structures (Wolf et al., 2012). Thus, it is important to not only consider patient recovery but also to offer healthcare professionals a supportive care environment, and to provide them with sufficient recovery opportunities at work and clinical supervision, and to prevent compassion fatigue, e.g. by use of mindfulness and self-compassion interventions (Raab et al., 2015). The latter two chapters of the discussion section may somewhat support the notion of moving away from person-centred care which focuses on meeting the individual's needs, to concentrating instead on relationship-centred care, focusing on interactions among all parties involved, accounting for everyone's needs in order to provide good care (Nolan, Davies, Brown, Keady, & Nolan, 2004).

Methodological considerations

This thesis uses quantitative research designs (I, II) and qualitative research designs (II, III, IV). The use of different methods is recommended when deeper knowledge of a phenomenon is sought (Polit & Beck, 2016). To investigate persons who frequently use PES, register data (I), interviewer-administered questionnaires (II), individual interviews (III, IV) and focus group interviews (III, IV) were used and analysed statistically (I, II) and by means of qualitative content analysis (II, III, IV). However, the methods and instruments chosen for these studies have both strengths and weaknesses that affect the studies' results, influencing their generalizability and quality (Olsson & Sörensen, 2011). To ensure the quality of the quantitative research included in this thesis, reliability and validity were mainly used as quality indicators (Polit & Beck, 2016). To ensure the quality of the qualitative studies, Lincoln and Guba's criteria of trustworthiness (Graneheim et al., 2017; Guba & Lincoln, 1994;

Lincoln & Guba, 1985): credibility, dependability, confirmability, transferability and authenticity were used.

Reliability: Studies I and II

Reliability concerns the accuracy and consistency of information obtained in the study, i.e., the methods used for measurement of variables (Polit & Beck, 2016), in this case, whether persons who frequently use PES in Study I were properly identified or not. In defining the frequent visitors, Study I relied on an extensive literature review of the number of visits. Furthermore, the definition of frequent visitors in relationship to the number of visits further built on clinical observations. By choosing a cross-sectional design in Study I, the visitors were defined as persons who frequently or infrequently visit PES, based solely on their visits from 2013 to 2015. This entailed a risk of wrongly defining persons based on those visits only. For example, a person making four visits in January 2013 might be classified as a person infrequently visiting PES, even though previous visits may have occurred in 2012 (which was unavailable information), posing a threat to the reliability of the study.

Given that the reliability and validity aspects are closely intertwined due to the nature of data collected by the means of established instruments in Study II, further discussion concerning Study II is undertaken under the section *construct validity* later in the text.

Internal validity: Studies I and II

Internal validity is concerned with the validity of the conclusions (Polit & Beck, 2016). Study I used national register for research, an approach which is well established in Sweden and is considered a standard method, permitting outstanding quality of results (Swedish National Data Service (SND), 2017). However, it posed certain challenges for the study design. The variables chosen in Study I were limited by the register, which is used purely for administrative purposes. Since the register contains only one diagnosis per visit, investigation into possible comorbidity was limited. Excluding a regional dependency centre located within the studied county affected the prevalence of substance abuse diagnoses; this affected the internal validity and therefore should be considered when interpreting the results of this study.

In Study II, most questionnaires refer to time periods of the last month (i.e., CANSAS) or the last year (i.e., AUDIT, DUDIT, interpersonal violence), which may pose a risk of recall bias, i.e., the correct answer may have been forgotten or was hard for participants to recall. Recruitment for Study II proved to be a challenge and it was not possible to include all eligible patients. The staff workload at the studied PES was high, which led to a generous extension of the data collection period. Despite the extension, several persons who frequently visited the PES were not invited to participate (*n* = 38). An additional number of eligible patients (*n* = 47) were excluded due to their condition, although they represented the target group, which could in turn raise questions about the participants' and the study's representativeness. Yet a drop-out analysis identified no differences with regard to age and gender when comparing who was included and who was excluded, and thus the risk for selection bias was low. Despite the number of participants who were not invited to participate, the response rate was considered high, which strengthens the internal validity/credibility of the study.

External validity: Studies I and II

External validity is concerned with the generalisability of the results (Polit & Beck, 2016). Due to the high proportion of participation in Study I, external validity can be considered high. How far the results may be generalisable to other groups within healthcare or to other regions inside or outside Sweden, however, may be questioned. This is because the provision of care and services differs in each municipality in Sweden. The number of PES visits may be influenced by the availability of other facilities, by PES services being delivered differently (e.g., by psychiatric emergency ambulance or mobile assessment), or by the extent to which processes involve case managers or assertive community treatments (i.e., ACT and flexible ACT).

Regarding the data collection of Study II, the possibility that the participants might have known the triage staff, i.e., the interviewers, was high, creating a risk of dependency and thus affecting the validity/credibility as well as the objectivity/confirmability of the study. However, that the interviewer and interviewee knew each other might also have increased familiarity and hence interviewee openness in revealing sensitive information, which could have been important for the participants, particularly in this study. Although participants self-assessed for AUDIT, DUDIT, and ISSI, they might not necessarily have viewed their alcohol use, drug use, or lack of interaction as a problem. Therefore, some level of interpretation with regard to these instruments may have been added by the researchers. Given that the data were collected in one PES, the external validity/transferability of the results of Study II should be viewed with caution and considered in light of the applied context.

Construct validity: Study II

Construct validity is concerned with the accuracy of measuring the phenomenon under study (Polit & Beck, 2016). The instruments chosen in Study II were *CANSAS*, *AUDIT* and *DUDIT* and parts of *ISSI*. Those are validated instruments that have good psychometric standards and that have been used in various psychiatric care contexts, which strengthens the construct validity of the study. However, even well validated instruments lose construct validity over time, which is why they should be used with caution and consideration, and the interpretation of the results should be carried out in light of this consideration.

Trustworthiness: Studies III and IV

Credibility, which is the most important factor of trustworthiness, refers to the confidence in the truth of the data and interpretations of it (Lincoln & Guba, 1985). In Studies III and IV (as well as concerning Study II), familiarity with the included organisation prior to data collection was established by me being part of the healthcare professionals' workplace and routines in PES, and having participatory observations that could establish a mutual relationship of trust and showed engagement, which may have improved credibility (Lincoln & Guba, 1985; Shenton, 2004). Furthermore, another measure addressing credibility was the use of within-method triangulation, (referring to the choice of data collection methods and their sequence) starting with individual interviews, followed by a focus group interview. This choice of design made it possible to confirm and deepen discussions across professions as well as clarify and discuss conflicting experiences. It also allowed for the member checks by reporting back and thus verifying preliminary results from the individual interviews to the focus groups (Polit & Beck, 2016; Shenton, 2004).

Credibility cannot be established in the absence of dependability (Lincoln & Guba, 1985). Dependability refers to the stability of data over time and different conditions, assessing to what extent a study can be replicated (Lincoln & Guba, 1985). To address dependability in Studies III and IV, four authors were involved in the analysis process until consensus was reached. All the authors had various pre-understandings and interpretative ranges (Graneheim et al., 2017), which the authors tried to be aware of and open about. Furthermore, to strengthen dependability, the same semi-structured interview guide was used during the individual interviews, covering the same questions. Naturally, dependability was also strengthened by providing a thorough description of the research design (Shenton, 2004), and this was attempted in both studies.

Confirmability refers to objectivity and the attempt to capture the participants' voices without the researchers' bias or motivations getting in the way (Lincoln & Guba, 1985). Triangulation promoted confirmability (Shenton, 2004), in this case, within-method triangulation and investigator triangulation, i.e., the involvement of four researchers in the analysis process (Polit & Beck, 2016; Shenton, 2004). The Consolidated criteria for Reporting Qualitative research (COREQ) (Tong, Sainsbury, & Craig, 2007) were followed to address confirmability. However, confirmability, i.e., the objectivity of the data, may also be considered in light of potential biases with regard to the participants. There is a risk that the participants responded with a ‘wish to please’ attitude. Yet as the results show, the participants had a high level of self-critical and self-reflecting abilities. With regard to the focus groups, the participants showed they were used to open and critical communication with each other. Therefore, the risk for ‘wish to please’ responses estimated to be rather low in Studies III and IV. The same applies in terms of self-serving biases among the participants. Though it cannot be fully ruled out, the participants were both self-critical as well as critical with regard to the patients and the management, and thus may gain no benefit from positioning themselves or others in a better light.

Transferability refers to the degree of applicability of the findings to other contexts or groups (Lincoln & Guba, 1985). The transferability of qualitative findings is usually problematic due to the small number of participants and specific contexts of the studies (Shenton, 2004). To enable the reader to judge this criterion, the participants’ demographics and professions were described as well as the context of Studies III and IV in the method sections (Shenton, 2004). Additionally, a thick description of the phenomenon under study is given in the background sections to provide the reader with a proper understanding of it (Graneheim et al., 2017; Shenton, 2004).

Finally, authenticity represents the criterion of fairness, ontological, educational, catalytic, and tactical authenticity (Guba & Lincoln, 1994; Lincoln & Guba, 1985; Shannon & Hambacher, 2014). Authenticity (in terms of fairness) was demonstrated by assessing several viewpoints: that of persons who frequently use PES and of healthcare professionals working at PES. It was attempted to represent those different viewpoints in a fair manner by use of reflexivity and critical thinking as well as member checks during the focus group interviews. It was further facilitated by providing examples of the abstraction and interpretation processes (Graneheim et al., 2017). The use of quotations is a further attempt to convey the participants’ experiences and feelings in a fair manner and enable the reader to better understand them (Polit & Beck, 2016). Authenticity (in terms of ontology and education) may have been difficult to demonstrate because the healthcare professionals already showed high awareness of the complexity of their social environment as well as for the patients (Shannon & Hambacher, 2014). Generating a dialogue between the healthcare professionals and the patients was not part of the thesis, however may have been interesting and would have increased authenticity. Finally, catalytic and tactical authenticity may have been difficult to assess as well. To what degree the studies have stimulated action and potential change at the PES (Shannon & Hambacher, 2014) is not known at this point as disseminating results from this thesis is still ongoing.

Conclusions and clinical implications

The main conclusions of this thesis are

- Persons who frequently use PES in Sweden are a small, yet highly heterogeneous group who make a disproportionately high number of visits and differ significantly from other PES visitors.
- Persons who frequently use PES and healthcare professionals at PES are in agreement about the complex and intertwined need patterns of the patients. Those needs originate from problems with everyday living, acute psychiatric suffering, and insufficient care possibilities, and thus the patients are found *to suffer from illness, unfavourable life circumstances, and inadequate care, which stresses the need for sustainable support*.
- That healthcare professionals at PES experience the encounter as consisting of caring, professional, and humane processes where persons who frequently use PES are seen as fellow human beings, who are unique, and who are treated with as much respect, kindness, humility, confirmation, and empowerment possible.
- In order to have caring encounters with persons who frequently use PES, the healthcare professionals also need to nurture the relationship with themselves and with colleagues.

Even though the recovery-oriented care approach has received more acknowledgement and acceptance within psychiatric care in the last decade, there is a need to develop and implement this care approach further in the Swedish psychiatric care context. Healthcare professionals need to be provided with the right prerequisites and resources in order to be able to provide such a recovery-oriented care approach that is based on the principles of person-centredness. A positive care environment at PES does not only facilitate workplace satisfaction and compassion satisfaction for healthcare professionals at PES but also, in consequence, improves the quality of caring encounters and patient satisfaction. This implies that staffing of PES should be sufficient, which in turn impacts positively on healthcare professionals' management of their time and workload, making it possible to encounter the patients in a stress-free, competent, humble and non-judgemental way. This facilitates meaningful connections for the patients and enables the healthcare professionals to address the patients' short-term needs well. So far, the long-term perspective of the patients' needs has been largely neglected, meaning that more consideration should be given to how best to provide continuity of care to persons who frequently use PES after discharge. Instead of ignoring the social and societal pressures that persons who frequently use PES experience, social support services and psychiatric emergency care should be better integrated.

Future research

In order for healthcare professionals to have caring encounters with persons who frequently use PES, they need to nurture not only the relationship with themselves—and be self-insightful, self-critical and self-compassionate—but also the relationship with colleagues. To further this research area, it could be helpful to investigate healthcare professionals' needs in the workplace, including their experiences of leadership, management, and interdisciplinary teamwork in relation to person-centredness. The implementation and evaluation of mindfulness and self-compassion interventions in a PES context could also be of practical relevance. Another stream of possible research could be to investigate more deeply into the faceless encounter, i.e., the experiences of telephone counselling at PES, as this was singled out by healthcare professionals in this thesis as particularly challenging. Finally, it is desirable to address how health and social care services could find opportunities to collaborate more efficiently to move towards a care continuum, working across boundaries involving psychiatric inpatient and outpatient care, primary care, case managers, social care services and dependency centres, as well as patients. This could be done by applying a participatory action research approach putting the patient at the centre. In-depth interviews with PES users could be a logical starting point to develop, implement, and evaluate such a care continuum.

Svensk sammanfattning

Syftet med denna avhandling var att beskriva vilka de personer är, som upprepade gånger uppsöker psykiatrisk akutmottagning (PA) i Sverige, vilka behov de upplever sig ha, samt hur den vårdpersonal som arbetar på psykiatrisk akutmottagning, ser på dessa personers behov och hur de erfar mötena med dem. Personer som upprepade gånger uppsöker psykiatrisk akutmottagning definierades som personer med fem kontakter eller mer inom en period av 12 månader.

Avhandlingen innehåller både kvantitativa (I, II) och kvalitativa (II, III, IV) forskningsdesigns och tillämpar ett brett spektrum av metoder för datainsamling, såsom registerdata (I), enkäter (II), individuella intervjuer och fokusgruppintervjuer (III, IV). Data analyserades med statistiska test (I, II) och med kvalitativ innehållsanalys (II, III, IV).

Totalt deltog 27,282 personer i studie I baserat på deras besök till PA under perioden 2013–2015, vilket resulterade i 67,031 besök. Av dessa 27,282 personer kunde 8.1% identifieras som personer med upprepade besök, som svarade för nästan två femte delar av alla besök. I studie II deltog 81 personer som upprepade gånger uppsöker psykiatrisk akutmottagning. Deltagarna för studie III och IV var vårdpersonal som arbetade vid PA, såsom undersköterskor, sjuksköterskor med specialiserad utbildning i psykiatri och läkare. Nitton anställda deltog i individuella intervjuer i både studie III och studie IV, och varje studie kompletterades med en fokusgruppintervju bestående av 5 respektive 6 anställda.

Resultaten visar att personer som upprepade gånger uppsöker psykiatrisk akutmottagning i Sverige bildar en liten, men mycket heterogen grupp som gör oproportionerligt många besök och skiljer sig signifikant från andra besökare; att personer med upprepade besök och vårdpersonal på psykiatrisk akutmottagning har en samstämmig bild över de komplexa och sammanflätade behovsmönstren hos patienterna, vilket har sitt ursprung i problem i vardagen, akut psykiatriskt lidande och otillräckliga vårdmöjligheter, och således visade sig drabbas av sjukdom, ogynnsamma livssituationer och otillräcklig vård; att vårdpersonalen upplevde mötet som en vårdande, professionell och humana process, där patienterna sågs som medmänniskor och som unika och behandlas med så mycket respekt, vänlighet, ödmjukhet, bekräftelse och empowerment som möjligt: och att för att upprätthålla vårdande relationer med personer med upprepade besök måste vårdpersonalen också ta hand om relationen med sig själva och relationen med kollegorna. Dessa resultat tolkades med hjälp av personcentrering och mot bakgrund av en recovery-orienterad strategi. Även om det sistnämnda har fått växande acceptans inom psykiatrisk vård det senaste decenniet, finns ett starkt behov av att vidareutveckla och implementera recovery-ansatsen och person-centrering i den svenska psykiatriska vårdkontexten.

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Paper I

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ORIGINAL ARTICLE

Clinical profiles and temporal patterns of psychiatric emergency room visitors in Sweden

Manuela Schmidt[a,b], Joakim Ekstrand[c] and Anita Bengtsson Tops[a]

[a]Faculty of Health Science, Kristianstad University, Kristianstad, Sweden; [b]Department of Health Sciences, Lund University, Lund, Sweden; [c]Faculty of Business, Kristianstad University, Kristianstad, Sweden

ABSTRACT

Aims: To describe persons visiting the psychiatric emergency room (PER) in Sweden and to compare persons who frequently (PFV) and infrequently (PIFV) visit PERs in terms of group size, age, gender, PER location inside versus outside the home municipality, diagnosis (ICD 10), temporal patterns of visits and hospital admissions.

Methods: This register study included all visits to PERs in one Swedish county over 3 years, 2013—2015 ($N = 67{,}031$ visits). The study employed descriptive statistics as well as Chi-square tests combined with Bonferroni correction to compare PFV with PIFV.

Results: Of the total of 27,282 visitors, 2201 (8.1%) were identified as PFV (five or more visits within 12 months) and they accounted for 38.1% of the total visits. The study found differences between PFV and PIFV in gender, diagnostic profile, hospital admissions and temporal patterns. Differences were also detected with regard to distance between PERs and home municipalities. However, no age-related differences were found between the two groups.

Conclusions: PFV and PIFV have different clinical profiles and temporal patterns. These results may be important when planning, developing and evaluating interventions targeting the needs of each group, which is in accordance with a person-centred approach. Such an approach might eventually result in fewer visits to PERs.

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Background

In recent decades, psychiatric care and services have changed significantly due to deinstitutionalization [1—5] and various psychiatric care reforms [6—8], leading to a shift from hospital- to community-based psychiatric care. Within the Nordic and international contexts, this shift, as well as a reduction in the number of beds in psychiatric hospital-based care, has resulted in the increased use of psychiatric emergency rooms (PERs) [9—11]. Consequently, PERs have not only become the main entry point into the mental health care system and a source of primary care [12], but also become one of the main sources of treatment, especially for persons with enduring mental health conditions [13]. Furthermore, for many who lack access to care or socioeconomic resources, PERs also represent a safety net [14,15], when in fact psychiatric emergency services represent a medical specialty that ought to concentrate on providing specialized, high-quality frontline care in acute care situations [16].

Previous studies have shown that PERs are increasingly used by persons with nonurgent needs [17—19], and it has been questioned whether persons visiting PERs represent 'true emergencies' [20,21]. These results give reason to reflect on whether the quality and availability of care for persons suffering from acute psychiatric crises are being compromised [22], putting further pressure on PERs to function as gatekeepers for persons seeking psychiatric care [9,23—25].

The mismatch between the complexity of the patients' service needs and the resources available at PERs has led to recent trends, such as high hospital admission and re-admission. Previous studies have also noted that some persons frequently visit PERs [16,26], often referring to concepts such as the 'revolving door' phenomenon [27,28] or recidivism [29,30]. Though these persons constitute a relatively small group, they account for a disproportionately high number of total PER visits, consuming a considerable amount of PERs' already limited resources [26,31—35]. Persons who frequently visit PERs have been described as single [36,37], unmarried [37,38], homeless [34,36,39], unemployed [34,37,38] and young [31,35,36,38]. They also often suffer from a personality disorder [34,37,40,41], schizophrenia [31,32,37,42] and/or substance abuse [35,40,42].

A person-centred perspective has shown to better meet the afflicted person's needs, strengthen their autonomy and participation, as well as increase flexibility of care [43]. Yet, in order to apply such an approach, one should better understand the nature of the persons' needs. Accordingly, examination of clinical profiles and temporal patterns regarding persons that visit PERs ought to be a prioritized starting point for research. This study is further motivated by the

CONTACT Manuela Schmidt ✉ Manuela.schmidt@hkr.se Faculty of Health Science, Kristianstad University, Kristianstad, Sweden

emergence and adoption of a person-centered care discourse, acknowledged and implemented both in Europe and elsewhere in health care services in general [43,44] and in psychiatry in particular [45,46], which also is relevant given nowadays constrained allocation of resources in the psychiatric care system [47,48]. In a Swedish context, no studies have examined persons that visit PERs, or considered the nature of the temporal patterns or clinical profiles. A descriptive mapping design is of particular interest, given that local settings may vary in terms of clinical practices, patients, policies and guidelines [49]. The results of such a mapping study of one Swedish county could serve as a basis for planning, developing and organizing person-centered care in PER.

Aims

The aims of the study were to (1) describe persons visiting Swedish psychiatric emergency rooms (PERs) and (2) to compare persons who frequently (PFV) and infrequently (PIFV) visit PERs in terms of group size, age, gender, PER location inside versus outside the home municipality, diagnosis (ICD 10), temporal patterns of visits and hospital admissions.

PFV are defined as persons aged 18 years or older who visit PERs five or more times during a 12-month period. PIFV are defined as persons 18 years or older who visit PERs fewer than five times during a 12-month period. This study is part of a collaboration project that involves municipalities and hospitals from the studied region. Thus, the definition of PFV is based partly on the experience of professionals involved in the project, and who work within the studied context, that is, clinically based, and partly on previous research [9].

Methods

This register study has a retrospective design and incorporates data on all visits to PERs in one county of Sweden from 2013 to 2015.

Setting

Health care in Sweden is based on a socialized welfare system, financed mainly by taxes, and PERs are obliged to uphold a number of various laws and policies [50—53]. The *Health and Medical Services Act* [50] requires the prioritization of patients most in need and advocates patient participation. Furthermore, national guidelines have instituted the ethical principles of ‘human dignity’, ‘need and solidarity’ and ‘cost-effectiveness’ [54]. An overall policy for Swedish emergency rooms is to use the Rapid Emergency Triage and Treatment System (RETTS) [55] which was adjusted for use in PERs (RETTS-psy) and is carried out by psychiatric nurses, that is, triage nurses.

The southern Swedish county studied here covers a catchment area including a total of 1,288,868 inhabitants [56], representing 13.2% of Sweden’s population. The county consists of both urban and rural areas.

The county has four hospital-based PERs that met the inclusion criteria, (i.e. provide 24-h service, use the same triage system, have an open referral system, have telephone helplines, and provide beds for acute short-term stays in specialized inpatient psychiatric care units). Within the county, there is a specialized region-based PER that serves only persons with dependency disorders; however, since it did not provide 24-h service or use the triage system, it was excluded from the study.

Data collection

Anonymized register data for 2013—2015 were drawn in June 2016 from the county’s central patient administrative register, that is, Patient Administrative Support in Scania (PASIS) used in psychiatric care in the county. The variables collected were age, gender, clinically based diagnosis made by PER psychiatrists (ICD 10), PER location inside versus outside the home municipality, visit date and time and whether or not the visits were followed by hospital admissions.

Ethical approval for this study was obtained from both the Regional Ethical Review Board in Lund, Sweden (Dnr. 2015/645, Dnr. 2016/181) and the county’s deputy medical director.

Analysis

The data obtained were arranged into two datasets: one was in the chronological order of the visits (‘*dataset of visits*’) to reveal the temporal patterns, allow investigation of hospital admissions and diagnoses. One diagnosis per visit was available in the original register and was used in this dataset. The other dataset was arranged according to the visitors (‘*dataset of visitors*’) to reveal their sociodemographic characteristics.

The diagnosis codes were condensed into the main codes of ICD 10. However, to provide a more detailed description of PER’ visitors, some codes were kept at a detailed level due to their high frequency among the visitors (e.g. F10 (Alcohol-related disorders) and F19 (Other psychoactive substance-related disorders)).

The participants were arranged into four subgroups by age: 18—30, 31—50, 51—65 and 65 + years. This was done in order to portray a thorough picture of persons visiting PERs in terms of gender differences, whether PERs were located inside or outside home municipality, diagnosis and hospital admissions.

The temporal variable ‘day of the month’ was divided into three subgroups: days 1—10, 11—20, and 21—31. ‘Time of day’ was divided into three subgroups based on the shift schedule (i.e. morning, afternoon and night) of the PER staff.

The data were processed with SPSS software, version 23 [57]. Descriptive statistics were used for analysis as well as non-parametric Chi-square tests [58,59] in combination with the Bonferroni correction, to compare the differences between categorical variables for PFV and PIFV. Differences were considered significant at p values of .05 or less. Furthermore, confidence intervals were calculated to estimate the size of differences in proportions and to identify significant differences within groups.

Results

It was found that 27,282 persons visited the county's four PERs in 2013—2015 making 67,031 visits in total. The total number of PFV was $n = 2201$, representing 8.1% of the total number of visitors. In sum, PFV made $n = 25{,}695$ visits, accounting for 38.3% of the total number of PER visits. The total number of PIFV was $n = 25{,}081$ (91.9%) and they made $n = 41{,}336$ visits, accounting for 61.7% of the total number of visits. The mean (±SD) number of visits per PFV, 2013—2015, was 11.7 (±14.4) with a median (range) of 8 (5—372) versus a mean (±SD) of 1.65 (±1.1) and median (range) of 1 (1—9) per PIFV.

More thoroughly investigating the visits made by PFV revealed that 31.7% ($n = 698$) made 5 or 6 visits, 22.0% ($n = 486$) made 7 or 8 visits, 24.3% ($n = 533$) 9—13 visits and 22.0% ($n = 484$) 14—372 visits.

Sociodemographic characteristics

Sociodemographic data were obtained from the *dataset of visitors*. The mean (±SD) age of all visitors was 42.6 (±17.8) and no significant age difference was found between PFV (42.4, ±15.8) and PIFV 42.6 (±18.0). However, according to Table 1, presenting the number of PFV and PIFV divided into age subgroups, significant differences between PFV and PIFV were found (p=.000). The proportion of visitors aged 31—65 years was higher among PFV than PIFV (61.1% vs. 54.1%), while the proportion of PIFV was higher among visitors aged 18—30 years (32.9% vs. 29.1% of PFV) and above 65 years (13.0% vs. 9.8% of PFV).

Table 1. The number of PFV and PIFV by age group, 2013—2015.

	PFV ($n = 2201$)		PIFV ($n = 25{,}063$)[a]		95% CI of the difference in proportions		p
					Lower	Upper	
Age groups	n	%	n	%			**.000**
18—30	640	29.1	8250	32.9	−5.82	−1.85	
31—50	885	40.2	9072	36.2	1.88	6.15	
51—65	461	20.9	4489	17.9	1.27	4.80	
65+	215	9.8	3252	13.0	−4.52	−1.90	

[a] 18 observations were excluded due to missing value (i.e. age).

Regarding all visitors to PERs, there was a relatively even distribution between women ($n = 13{,}895$, 50.9%) and men ($n = 13{,}387$, 49.1%). Subdividing the visitors into PFV and PIFV, as shown in Table 2, revealed gender differences ($p = .001$) between the two groups. The proportion of men was higher among PFV, whereas the proportion of women was higher among PIFV. When comparing different age groups of PFV and PIFV, gender differences were found only in the 31—50-year age group ($p = .033$) consisting of a higher proportion of men among PFV and a higher proportion of women among PIFV.

Table 2 also shows the differences between PFV and PIFV regarding whether the visited PERs were located inside or outside the home municipality, both for the groups as a whole and for the age subgroups. Significant differences were found between PFV and PIFV regarding whether PERs were located inside or outside the visitors' home municipality ($p = .000$). The proportion of persons living in a municipality with a PER was higher among PFV, whereas the proportion of visitors living in a municipality that did not have a PER was higher among PIFV. However, comparing PFV and PIFV by age group revealed that the above result applied only to those aged 51—65 years ($p = .001$) and 65 + years ($p = .041$).

Diagnoses

Data on diagnoses were obtained from the *dataset of visits*. Table 3 presents all diagnoses for all visits made during the investigated time period, subdivided into PFV and PIFV. Overall, the most common diagnoses were F41 (other anxiety disorders) (16.6%) and F32 (major depressive disorder) (11.9%). Comparing diagnoses between PFV and PIFV revealed significant differences in nearly all diagnoses ($p = .000$). Among PIFV, F41 (other anxiety disorders), F32 (major depressive disorder) and F43 (reaction to severe stress and adjustment disorders) were the most common diagnoses, whereas among PFV, F41 (other anxiety disorders), F10 (alcohol-related disorders) and F2 (schizophrenia, schizotypal,

Table 2. Gender and PER in home municipality (h.m.) of PFV and PIFV within different age groups, 2013—2015.

	PFV		PIFV				PFV		PIFV		
	n	%	n	%	p		n	%	n	%	p
Total[a]	2201	8.1	25,063	91.9	**.001**	Total[b]	2114	8.4	23,086	91.6	**.000**
Male	1155	8.6	12,219	91.4		PER in h.m.	1265	8.9	12,897	91.1	
Female	1046	7.5	12,844	92.5		No PER in h.m.	849	7.7	10,189	92.3	
18—30	640	7.2	8250	92.8	.146	18-30	594	7.5	7306	92.5	.443
Male	320	7.6	3879	92.4		PER in h.m.	351	7.7	4199	92.3	
Female	320	6.8	4371	93.2		No PER in h.m.	243	7.3	3107	92.7	
31—50	885	8.9	9072	91,1	**.033**	31-50	853	9.3	8336	90.7	.209
Male	474	9.5	4518	90.5		PER in h.m.	504	9.6	4739	90.4	
Female	411	8.3	4554	91.7		No PER in h.m.	349	8.8	3597	91.2	
51—65	461	9.3	4489	90.7	.144	51-65	454	9.6	4274	90.4	**.001**
Male	264	9.9	2411	90.1		PER in h.m.	284	10.9	2313	89.1	
Female	197	8.7	2078	91.3		No PER in h.m.	170	8.0	1961	92.0	
65+	215	6.2	3252	93.8	.621	65+	213	6.3	3170	93.7	**.041**
Male	97	6.4	1411	93.6		PER in h.m.	126	7.1	1646	92.9	
Female	118	6.0	1841	94.0		No PER in h.m.	97	5.4	1524	94.6	

[a] $N = 27{,}264$; 18 observations were excluded due to missing value (i.e. age).
[b] $N = 25{,}200$; 2082 observations were excluded because the h.m. was outside the county or values were missing.

Table 3. Diagnoses for all visits of PFV and PIFV, 2013—2015 ($N = 67{,}031$).

	PFV ($n = 25{,}695$)		PIFV ($n = 41{,}336$)		CI 95% of the difference in proportions	
Diagnoses	*n*	%	*n*	%	Lower	Upper
F0- Mental disorders due to known physiological conditions	278	1.1	566	1.4	**−0.46**	**−0.12**
F1 other - Mental and behavioral disorders due to psychoactive substance use	493	1.9	659	1.6	**0.12**	**0.53**
F10 - Alcohol-related disorders	3206	12.5	3250	7.9	**4.13**	**5.09**
F11 - Opioid-related disorders	1252	4.9	675	1.6	**2.95**	**3.53**
F19 - Other psychoactive substance-related disorders	1422	5.5	1277	3.0	**2.12**	**2.77**
F2 - Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	2999	11.7	3538	8.6	**2.64**	**3.59**
F3 other - Mood (affective) disorders	1782	6.9	3393	8.2	**−1.68**	**−0.87**
F32 - Major depressive disorder, single episode	1717	6.7	6279	15.2	**−8.97**	**−8.05**
F4 other - Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders	292	1.1	474	1.1	−0.18	0.16
F41 - Other anxiety disorders	3292	12.8	7808	18.9	**−6.63**	**−5.52**
F43 - Reaction to severe stress, and adjustment disorders	1375	5.4	5173	12.5	**−7.58**	**−6.74**
F5 - Behavioral syndromes associated with physiological disturbances and physical factors	146	0.6	380	0.9	**−0.48**	**−0.22**
F6 - Disorders of adult personality and behavior	2797	10.9	987	2.4	**8.09**	**8.91**
F7 - Intellectual disabilities	615	2.4	212	0.5	**1.68**	**2.08**
F8 - Pervasive and specific developmental disorders	466	1.8	347	0.8	**0.79**	**1.16**
F9- Behavioral and emotional disorders with onset usually occurring in childhood and adolescence	535	2.1	728	1.8	**0.11**	**0.54**
F99 - Unspecified mental disorder	334	1.3	986	2.4	**−1.29**	**−0.88**
Z - Factors influencing health status and contact	1684	6.6	3116	7.5	**−1.38**	**−0.59**
Other diagnoses including A—Y/unknown	1010	3.9	1538	3.7	−0.09	0.51

Table 4. Most common diagnoses for all visits as well as PFV and PIFV, by age group, 2013—2015 ($N = 66{,}989$).

	Overall most common diagnoses				Most common diagnoses[a]				
	1st		2nd		PFV ($n = 25{,}695$)		PIFV ($n = 41{,}294$)		*p*
Age groups		%		%		%		%	**.000**
18—30	F41	19.6	F32	13.2	F6	17.6	F41	22.7	
31—50	F41	15.0	F43	11.5	F2	12.6	F41	17.7	
51—65	F10	22.0	F2	14.0	F10	26.0	F10	19.0	
65+	F41	19.1	F32	15.0	F41	22.9	F41	17.6	

[a] 42 observations were excluded due to missing value (i.e. age).

delusional and other nonmood psychotic disorders) were most common.

As shown in Table 4, when investigating into age groups more thoroughly, F41 (other anxiety disorders) was the most common diagnosis for persons for all age groups with the exception of persons aged 51—65 years who were more likely to be diagnosed with F10 (alcohol-related disorders). There were significant differences in diagnoses between the age groups of PFV and PIFV ($p = .000$).

When connecting all diagnoses from all visits to each person, we found that among PFV, $n = 448$ (20.4%) received the same diagnoses throughout the three investigated years, $n = 621$ (28.2%) received two diagnoses, $n = 542$ (24.6%) three, $n = 311$ (14.1%) four and $n = 279$ (12.7%) received five to ten different diagnoses.

Among PIFV, $n = 20{,}097$ (80.1%) received the same diagnoses throughout the three investigated years and the remaining $n = 4984$ (19.9%) received two to five different diagnoses. PFV had an average of 2.79 diagnoses versus 1.25 among PIFV.

Among men, the most common diagnosis was F10 (alcohol-related disorders) (14.5%), followed by F41 (other anxiety disorders) (13.4%), whereas women were most often diagnosed with F41 (other anxiety disorders) (19.7%), followed by F32 (major depressive disorder) (13.0%). There were significant differences in almost all diagnoses between male and female PFV ($p = .000$) and male and female PIFV ($p = .000$).

Temporal patterns of visits

Data on temporal patterns were obtained from the *dataset of visits*. Table 5 presents the temporal patterns of the visits made by PFV and PIFV, subdivided by day during the month, day of the week, and time of day. Overall, visits to PER were equally distributed over the month. As the table shows, when comparing PIFV and PFV regarding which day of the month the visits occurred, no significant differences were found.

Regarding the distribution of visits during the week, more visits occurred at the beginning of the week, with the number declining toward the end of the week. Comparing visits made by PFV and PIFV on weekdays, significant differences ($p = .000$) were found between all days, with the exception of Wednesday. When grouping weekdays and weekends, it showed that PIFV made significantly fewer visits ($p = .000$) than PFV did on weekends (21.2% vs. 26.5%), being more likely to visit PER during the week. In contrast, PFV visited PER in a more day-independent manner, i.e. on both weekdays and weekends.

Regarding time of the day, the proportions of visits made by both groups were highest during the morning shift, somewhat lower during the afternoon shift and much lower during the night shift. When comparing PFV and PIFV, significant differences were found ($p = .000$) with the exception of the morning shift. The proportion of visits made by

Table 5. Temporal patterns of PFV and PIFV visits, 2013—2015 (*N* = 67,031).

	Visits made by PFV (*n* = 25,695)		Visits made by PIFV (*n* = 41,336)		CI 95% of the difference in proportions		
	n	%	*n*	%	Lower	Upper	*p*
Day of the month							.347
1—10	8774	34.1	13,889	33.6	−0.19	1.28	
11—20	8398	32.7	13,624	33.0	−1.01	0.46	
21—31	8523	33.2	13,823	33.4	−0.10	0.46	
Day of week							**.000**
Monday	4059	15.9	6943	16.8	**−1.57**	**−0.43**	
Tuesday	3735	14.5	6720	16.3	**−2.28**	**−1.16**	
Wednesday	3941	15.3	6402	15.5	−0.71	0.41	
Thursday	3545	13.8	6469	15.6	**−2.40**	**−1.31**	
Friday	3598	14.0	6029	14.6	**−1.13**	**−0.04**	
Saturday	3392	13.2	4256	10.3	**2.40**	**3.41**	
Sunday	3425	13.3	4517	10.9	**1.89**	**2.91**	
Time of day							**.000**
07:00—14:59, morning shift	12,121	47.2	19,646	47.6	−1.13	0.42	
15:00—22:59, afternoon shift	9865	38.4	16,759	40.5	**−2.91**	**−1.39**	
23:00—06:59, night shift	3709	14.4	4931	11.9	**1.97**	**3.04**	

PIFV was higher during the afternoon shift while more visits were made by PFV during the night shift.

Finally, when investigating which diagnoses were more dominant during different work shifts, significant differences were found ($p = .000$). For example, most visits by persons suffering from F10 (alcohol-related disorders), F2 (schizophrenia, schizotypal, delusional and other non-mood psychotic disorders) and F6 (disorders of adult personality and behavior) were made during the night shift, whereas persons suffering from F3 other (mood (affective) disorders), F32 (major depressive disorder), or F41 (other anxiety disorders) were more likely to visit during the morning or day shift. Significant differences were found between both groups ($p = .000$), in that the diagnostic patterns per shift differed significantly between PFV and PIFV.

Hospital admissions

Hospital admission data were obtained from the *dataset of visits,* and it was found that nearly one-third of all visits resulted in hospital admissions (30.5%, $n = 20{,}465$). Comparing hospital admissions among PFV and PIFV, significant differences ($p = .000$) were found with a higher proportion of hospital admissions among PIFV than PFV (31.6% vs. 28.9%).

Regarding age of persons being hospitalized, most admissions occurred among those age 31-50 years (36.9%). Furthermore, the most frequent diagnoses among persons admitted to hospital were F2 (Schizophrenia, schizotypal, delusional and other nonmood psychotic disorders) (17.7%), followed by F32 (major depressive disorder) (12.7%) and F10 (alcohol-related disorders) (11.7%). When subdividing PFV and PIFV into age groups, significant differences in hospital admissions were found in all age groups ($p = .000$). In those aged 18—30 years, the proportion of PFV admitted to hospital was higher than that of PIFV (40.5% vs. 32.4%); the reverse was the case in the other age groups.

Overall, there were no gender differences in hospital admissions. However, when comparing the gender of PFV and PIFV with regard to hospital admissions, significant gender differences were found among men ($p = .000$), that is, significantly less male PFV were hospitalized than PIFV (27.7% vs. 32.3%). No such differences were found among female PFV and PIFV.

Temporal patterns of hospital admissions

Regarding the temporal patterns of the hospital admissions, admissions were evenly distributed throughout the month, with 30.3%, 30.7% and 30.5% of admissions occurring on days 1—10, 11—20 and 21—31, respectively. However, there were significant differences ($p = .000$) in admissions between the days of the week. Admissions were more likely to occur early in the week, particularly on Mondays (16.0%) and Tuesdays (15.9%) but dropped on the weekends. When grouping weekdays and weekends, significantly fewer hospital admissions ($p = .000$) occurred on weekends (28.8% vs. 31.0%). When comparing PFV with PIFV with regard to weekdays versus weekend admissions, significant differences were found among PFV ($p = .000$), that is, the proportion of hospital admissions of PFV was smaller on weekends than weekdays (25.6% vs. 30.1%). No such differences were found among PIFV.

Concerning the time of the day of all hospital admission, significant differences ($p = .000$) were found, with 26.0% of admission were made during morning shift and 33.2% and 39.2% during the day and night shifts, respectively. Comparing PFV with PIFV regarding the work shift during which admissions occurred, significant differences ($p = .000$) were found, with significantly more PIFV than PFV being admitted during each shift.

Discussion

The study aimed to describe persons visiting Swedish PERs as well as compare PFV and PIFV.

The mean age of all PER visitors, that is, 42.6 years, was slightly above the mean age of all inhabitants of Sweden [60]. Furthermore, the most common diagnoses were F41 (Other anxiety disorders) and F32 (Major depressive disorders). Women were more likely to be diagnosed with F41 (Other anxiety disorders), whereas for men F10 (alcohol-related disorders) was the most frequent diagnosis. More visits were made on Mondays than any other day and during morning shift. Furthermore, the results indicate that roughly one-third of all visits resulted in hospital admissions, which were more likely to occur on Mondays during night shift. It was further found that -although fewest visits to PER occurred during night shift rather than the other shifts — most hospital admissions occurred at this time. Those persons diagnosed with F2 (schizophrenia, schizotypal, delusional, and other nonmood psychotic disorders) and F10 (alcohol-related disorders) were more likely to visit PER at night, and these are among the diagnoses most often leading to hospitalization, which may explain the high number of nighttime hospitalization.

The results concerning all PER visitors could be of clinical relevance for planning and organizing PER services, for example, facilitating the adjustments of staff schedules to fit the temporal patterns of visits and admissions or the development of interventions to meet the particular needs of persons with anxiety, depression or stress. Specifically, for example, human resources at PER could be planned so that Monday morning shifts, when a disproportionate number of the visits occur, as well as night shifts, when hospitalization mostly takes place, are sufficiently staffed to meet the needs of visitors. This way, a higher flexibility of care might be provided, based on patients' needs, being an important goal of person-centered care. Past studies exploring the relationship between alignment of human resource management and temporal patterns in clinical context, have shown to have positive patient outcomes such as reduction in waiting time [61,62].

With regard to PFV and PIFV, it was found that PFV formed a relatively small group representing 8.1% of all visitors, yet, it accounted for nearly two fifths of PER visits. These results are in line with those of previous research indicating that a rather small group of persons account for a disproportionately high number of PER visits [31,34,35,42]. Furthermore, no age differences between PFV and PIFV were found; both groups' average age was around 43 years. Concerning PFV, this finding diverges from previous international studies describing them as relatively young, i.e. in their end-twenties and up to mid-thirties [31,35,36]. Yet, the finding is in line with another Nordic study by Aagaard et al. [9], in which most PER visitors were reportedly in their forties.

Only in those aged 31—50 years were gender differences found between PFV and PIFV indicating that PFV consisted of more men than women. By combining sociodemographic characteristics, that is, adding additional layers of for example age groups when scrutinizing the differences between PFV and PIFV, this study contributes with new insights by providing a more nuanced picture of PFV and PIFV. In contrast to studies exploring gender and age separately in relation to patient groups [9,35,63], by combining these two demographic characteristics, this study can explore the interrelations between them.

Few previous studies have examined the temporal patterns of PER visitors; they have focused either on the time interval between visits [32] or visits before and after the Christmas season [64]. Two studies are notable in the context of this study: a study by Arfken et al. [65] demonstrating that PFV visits were significantly associated with Mondays and the first and last weeks of the months, whereas PIFV visits were significantly associated with Sundays and the first and last weeks of the months; and a study by Chaput and Lebel [31] showing no differences between persons visiting PERs frequently and rarely in terms of the day of the week of their visits. These results could only partly be confirmed by the present study, which found that visits by both groups were evenly distributed throughout the month and that more visits by both PFV and PIFV were made on Mondays than other weekdays. Yet, while PFV visited PERs in a more day-independent manner, i.e. on both weekdays and weekends, PIFV visited more often on weekdays and in the daytime. It may be somewhat surprising that PIFV choose to visit PERs in the daytime, when other health care and welfare services are available. This result may indicate the acute nature of PIFV' suffering.

Suffering from mental health problems in general and visiting PERs in particular have proven to be stigmatizing for the person in need [66—68]. By applying the present results in psychiatric emergency services in Sweden, for example in designing staff education, organizing and allocating available resources better, and developing tailored interventions for PFV and PIFV, PERs may be able to adjust their services and provide care more in line with a person-centered approach [44,69].

Conclusions

The results of the study indicate several differences between PFV and PIFV in terms of diagnostic patterns, temporal patterns and hospital admissions; differences that emerge in greater detail when another sociodemographic layer (e.g. age distribution) is added to the analysis. Given the study's findings on differences between PFV and PIFV, and in line with a person-centered approach, it is suggested that PFV and PIFV may require different triage processes at PERs, which could provide more flexibility of care and tailored interventions to fit each group's needs.

Limitations

The study is not without its limitations which should be addressed. First, only one county of Sweden was the source of data used here; however, this county is home to 13.2% of Sweden's population and includes both urban and rural areas. Second, excluding the regional dependency center affected the prevalence of substance abuse diagnoses, which has to be considered when interpreting the results of this study. Third, the variables considered here were limited by the register (the register used is purely administrative and is not kept for research purposes), in particular the register contains only one diagnosis per visit and thus complicates investigation into possible co-morbidity. Finally, by choosing a cross-sectional design, the visitors are defined as PFV and

PIFV based solely on their visits from 2013 to 2015. However, a strength of the study was that the register used ensured completeness because it covered all PER visits in the chosen county and can be considered a highly reliable regional register; moreover, there was no attrition.

Disclosure statement

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Paper II

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Self-Reported Needs for Care, Support and Treatment of Persons Who Frequently Visit Psychiatric Emergency Rooms in Sweden

Manuela Schmidt, PhD student[a,b], Joakim Ekstrand, PhD[c], and Anita Bengtsson Tops, RN, PhD[a]

[a]Faculty of Health Science, Kristianstad University, Kristianstad, Sweden; [b]Department of Health Sciences, Lund University, Lund, Sweden; [c]Faculty of Business, Kristianstad University, Kristianstad, Sweden

ABSTRACT
Aim: To investigate self-reported needs for care, support and treatment among persons who frequently visit psychiatric emergency rooms (PERs).
Design: A cross-sectional design. Qualitative and quantitative data were collected using an interview-based manual. Qualitative data were analysed using content analysis, whereas quantitative data were analysed using descriptive, non-parametric statistical tests.
Results: Persons who frequently visit PERs self-reported unmet needs for care, support and treatment in life domains such as health, socialisation, daytime activities, and emotional and financial security.
Conclusion: To meet the needs of persons who frequently visit PERs, close cooperation between concerned welfare actors should be implemented.

Introduction

Persons who frequently visit psychiatric emergency rooms (PERs) are a relatively small and heterogeneous group accounting for a disproportionately large number of visits (Chaput & Lebel, 2007; Pasic, Russo, & Roy-Byrne, 2005) and using a high proportion of allocated resources (Ledoux & Minner, 2006; Pasic et al., 2005). However, most studies in this research area cover associations between frequent use of PERs and the sociodemographic and clinical characteristics of the patients.

Adopting a psychiatric, person-centred perspective, emphasising a holistic approach including recovery and empowerment, it has been argued that patients' self-reported needs for care, support and treatment should play a pivotal role when planning, organising, and providing psychiatric and mental healthcare (Barker, 1999). In the present study, self-reported needs for care, support and treatment among persons who frequently visit PERs are in focus.

Background

It is a well-known phenomenon that there are persons who frequently visit PERs (Schmidt, 2018; cf. Vandyk, Harrison, VanDenKerkhof, Graham, & Ross-White, 2013). Clinical predictors for frequent use of PERs have been found to be personality disorder (Bruffaerts, Sabbe, & Demyttenaere, 2005), schizophrenia (Aagaard, Aagaard, & Buus, 2014; Chaput & Lebel, 2007), substance use disorder (Aagaard et al., 2014; Ledoux & Minner, 2006), and/or anxiety disorder (Ellison, Blum, & Barsky, 1989; Schmidt, Ekstrand, & Bengtsson Tops, 2018). These are all results that may indicate health needs, and needs for accurate medical treatment. Interestingly, prior psychiatric hospitalisation has been shown to be another clinical predicting factor for frequent visits to PERs (Aagaard et al., 2014; Arfken, Zeman, Yeager, Mischel, & Amirsadri, 2002; Pasic et al., 2005). Also, social predictors such as male gender, being single/unmarried, unemployed, homeless, living alone or in sheltered housing (Aagaard et al., 2014; Boyer et al., 2011; Ledoux & Minner, 2006; Pasic et al., 2005; Saarento, Hakko, & Joukamaa, 1998; Sullivan, Bulik, Forman, & Mezzich, 1993) as well as having shortcomings in social interactions (Ledoux & Minner, 2006) and weak social support (Pasic et al., 2005) have been pointed out in previous research. Intriguingly, Aagaard et al. (2014) found—after having interviewed 15 persons who frequently visited PERs—that they viewed staff at PERs as an integrated and valued part of their social network. The same study also found that persons who frequently visit PERs had numerous contacts with other professional healthcare providers (Aagaard et al., 2014).

Yet another reason for the high frequency of PER visits may be the long-term effects of the deinstitutionalisation (Dencker & Gottfries, 1991; Fakhoury & Priebe, 2002), which has resulted in a reduction of psychiatric inpatient services, a downsizing of hospital beds, shorter hospital stays, service gaps between institutional and community services, and a lack of continuity of care between the different care settings (Aagaard et al., 2014; Brown, 2005; Schmidt, 2018; Vandyk et al., 2013). The above findings may indicate that persons

CONTACT Manuela Schmidt manuela.schmidt@hkr.se Faculty of Health Science, Kristianstad University, 291 88 Kristianstad, Sweden.

who frequently visit PERs have needs for care, support and treatment interventions that could offer them the opportunity to become better socialised.

In a mental healthcare context, the concept of need has been suggested to broadly cover needs of care, support and treatment in various life domains such as health, social integration, private economy and everyday basic needs (Slade, Phelan, & Thornicroft, 1998). One Canadian study (Sirotich, Durbin, & Durbin, 2016), investigating the need profile of persons with mental health problems who frequently visited an emergency department, adopted a broad need perspective by using the Camberwell assessment of need tool (Phelan et al., 1995). In that study (Sirotich, Durbin, & Durbin, 2016), the most prevalent unmet needs were found in the life domains of psychological distress, alcohol/drugs use, money/benefits, and company. However, few studies have—from a broad point of view—investigated self-reported needs in persons who frequently visit PERs.

Aim

The aim of the study was to investigate self-reported needs for care, support and treatment among persons who frequently visit PERs.

Methods

The study has a cross-sectional design. Both qualitative and quantitative data were collected during a 6-month period from December 2015 to May 2016. Frequent visits were defined as five or more visits to the PER during a 12-month period. The definition was based on clinical experience of the staff at the involved PER and previous research within the field (Aagaard et al., 2014; Aagaard, Buus, Wernlund, Foldager, & Merinder, 2016; Schmidt et al., 2018). The PER was a hospital-based unit, located in the south of Sweden, that covered a catchment area of roughly 200,000 inhabitants (Statistics Sweden, 2015) and consisted of both urban and rural areas. The PER had open access 24 h/day, 7 days/week and used an open referral system and the Rapid Emergency Triage and Treatment System (RETTS-psy) for care assessment (SBU, 2010).

Participants

The participants were informed about the study by posters at the PER. Immediately after receiving triage assessment, the patients were orally informed about the study and invited to participate by triage staff including nurses and assistant nurses. Once a patient was asked to participate, a note was made in the registration system. Patients were eligible for participation if they had made at least five PER visits within the last 12 months and if they were aged ≥18 years. Exclusion criteria were if the patients, though fulfilling the inclusion criteria, could not give oral and written consent to participate, came to the PER with police assistance, suffered from acute psychosis or severe aggression, or were intoxicated.

In total, 177 persons frequently visited the PER during the study period, of whom 47 (26.6%) were omitted due to the exclusion criteria. In total, 130 persons were eligible to participate in the study. Eleven declined to participate and 38 were not asked to participate due to a high work load of triage staff. The final sample therefore comprised 81 persons, resulting in a response rate of 62.3%. A combined drop-out analysis with focus on variables age and gender found no significant differences between the participants and non-participants.

Data collection

Data were collected by triage staff in face-to-face structured interviews using a manual developed in collaboration with the third author, service user organisations, and PER professionals. The interview lasted around 30–45 min and all answers were written down by the interviewer. Triage staff received 1 day of training in how to perform interviews according to the manual. Though one triage nurse was given the main responsibility and collected the vast majority of the data ($n = 50$), in total, 16 triage staff were involved due to the stressful workplace situation.

The first part of the interview manual covered background characteristics such as gender, age, home municipality, and number of PER visits within the last 12 months. The next part of the manual contained the qualitative part of the study, including open questions about reasons for current and previous visits to a PER, and needs with which the PER helped them as well as how many contacts they had with other healthcare and social care services. In this part, the participants' answers were written down mainly verbatim or at times in condensed meaning units. The third part of the interview manual contained instruments commonly used for assessing needs in persons with mental health problems. This part included the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS) (Ericson, 2013; Phelan et al., 1995). CANSAS is a well-validated instrument (Phelan et al., 1995) for assessing persons' needs of care, support and treatment within the last month in a psychiatric care context. It consists of 22 predefined need domains and permits to add supplemental domains. For the purpose of this study, the domain "dental care" was added (Bengtsson-Tops & Hansson, 1999). Need is assessed using a three-point rating scale: 0 = no need, 1 = met need, and 2 = unmet need; a rating of 9 was used when the participant did not know or did not want to answer questions in specific domains. The instrument produces three scores: *total needs*, *total met needs*, and *total unmet needs*.

Since CANSAS does not assess exposure to interpersonal violence, which is common among persons with mental health problems (Howard et al., 2010; Oram, Trevillion, Feder, & Howard, 2013) the four following dichotomous questions were added: Have you within the last year been exposed to (1) verbal threats of physical abuse; (2) verbal threats to be killed; (3) physical violence, and (4) sexual abuse/violation.

Furthermore, to collect more detailed data than CANSAS permits with regard to self-reported frequency and amount of alcohol and drug intake, the Swedish version of the Alcohol Use Disorders Identification Test (AUDIT) (Babor, Higgins-Biddle, Saunders, & Monteiro, 2001; Bergman & Källmén, 2002) and the Drug Use Disorders Identification Test (DUDIT) (Berman, Bergman, Palmstierna, & Schlyter, 2003) were used. The scales consist of 10 and 11 questions, respectively, resulting in score ranges of 0–40 and 0–44. AUDIT scores of eight in men and six in women indicate alcohol-related problems (Källmén, Wennberg, Berman, & Bergman, 2007). DUDIT scores of six in men and two in women indicate drug-related problems (Berman, Bergman, Palmstierna, & Schlyter, 2005). Both AUDIT and DUDIT are used in various psychiatric care contexts and have shown good psychometric standards (Hildebrand, 2015; Lundin, Hallgren, Balliu, & Forsell, 2015).

Finally, in order to better elaborate the persons' self-reported social network than the CANSAS allows, the Interview Schedule for Social Interaction (ISSI) (Eklund, Bengtsson-Tops, & Lindstedt, 2007; Undén & Orth-Gomér, 1989) was used. The participants answered four questions related to the availability of social interaction by choosing one of six options ranging from "I have no-one" to "I have more than 15 persons".

Analysis

Qualitative data

Eighty-one participants answered the open questions included in the qualitative part of the interview-based manual. The answers resulted in 405 text segments, with ranging segment length from 3–4 words up to 70–80 words. The answers were analysed using manifest content analysis (Graneheim & Lundman, 2004). Initially the first and third author read all the answers several times in order to get a sense of what was said in the interviews. Then the two authors met and discussed the content of the answers. In relation to the aim of the study, statements were extracted and openly coded. The codes were then compared to each other to find differences and similarities, and sorted into clusters. In the next step, the clusters were labelled into subcategories and finally into main categories. This procedure was conducted until the authors reached agreement on the manifest content of the data.

Quantitative data

In CANSAS, ratings of nine were recoded to zero. Thereafter, *total met needs* per person were calculated by counting the numbers of rating 1 in the different domains. Likewise, the *total unmet needs* were the sum of rating 2 in the domains. The sum of met and unmet needs was used as the *total needs* score.

For continuous variables (for example, age and number of visits) and variables with a natural rank order (for example, ISSI), associations between variables were investigated by using the Spearman rank order correlation coefficient (denoted r_s). Chi square tests including Bonferroni correction were used to test for differences in proportions concerning categorical variables. Concerning drop-out analysis, a Chi-square test was used to investigate differences in gender, and a Mann–Whitney U-test to investigate differences in age. Associations and differences were considered significant at p values of $\leq .05$. Quantitative data were transferred to and analysed in SPSS, version 23 (SPSS Inc., Chicago, IL) (Field, 2013).

Ethics

Ethical approval was obtained from the Ethics Board in Lund (Dnr. 2015/645). An informed consent form was first read out to the participants and thereafter signed by them. The consent included recognition that in the case of self-harm, harm to others, or maltreatment of children, the interviewer was obliged to make a report to the responsible physician or to social services. If participants were exposed to any interpersonal violence, contact information on support services was provided by the interviewer.

Results

Background characteristics

Of the 81 participants, 56.8% ($n = 46$) were men and most of them, 66.7% ($n = 54$), lived within the municipality where the PER was located. The mean participant age was 39.74 years (SD ± 15.61, range 20–82 years). The mean of visits was 12.63 (SD ± 14.37) while the median of visits was 8 (5–112).

Regarding additional contacts with healthcare and social care services, 50.6% ($n = 41$) of the participants reported having contact with social services, 34.6% ($n = 28$) reported enrolment with an open psychiatric healthcare unit, 21.0% ($n = 17$) reported contact with a primary care centre, and 9.9% ($n = 8$) reported having no contact with healthcare or social services. Nearly two-fifth of the participants ($n = 30$; 37.0%) reported multiple contacts with these services.

Self-reported needs in persons who frequently visit PER, the qualitative part of the study

The manifest content of the qualitative data resulted in the three main categories presented in Table 1.

Table 1. Categories and subcategories of the qualitative content analysis.

Subcategories	Categories
Need to talk to someone	Need to reduce acute suffering
Need for medication	
Need for hospital admission	
Need for a professional approach	Need to feel secure
Need for PERs to be accessible	
	Need to have caring encounters with staff

Need to reduce acute suffering

Having a need to reduce acute suffering included for participants to find relief from troublesome psychiatric symptoms, such as anxiety/panic attacks, suicidal thoughts/actions, substance abuse, depression, self-harm, sleeping problems, and severe stress, and everyday problems that become obvious when trying to handle the current life situation. "*Today, I have come to a point where I do not trust myself not to hurt myself impulsively, to prevent internal pain*" (woman, 24 years, fifth visit).

The category included the three following subcategories: (1) *need to talk to someone*, (2) *need for medication*, and (3) *need for hospitalisation*.

The "*need to talk to someone*" was expressed by most of the participants. They needed someone to tell their stories to and to discuss their problems with. Having someone to talk to generated a sense of relief and was expressed in terms of "*unburdening my heart*" (man, 48 years, fifth visit) or "*getting relief from my depression [through supportive counselling from here]*" (man, 34 years, 21st visit). The "someone" to talk to could include triage staff, the physician at the PER or other visitors at the unit. Needing to reduce acute suffering also included "*need for medication*". It involved the necessity to obtain immediate medication, for example analgesic, hypnotic or sedative medicine or new prescriptions of permanent psychotropic drugs such as neuroleptics and hypnotics. "*Need for medication*" also included to get individually adjusted medicine dosages of medication such as neuroleptics. Furthermore, needing to reduce acute suffering included "*need for hospital admission*". A number of participants wanted to be hospitalised due to their troublesome acute symptoms of mental illness. However, being hospitalised was not always easy: "*[I get help with] admission and counseling but usually they send me back home*" (woman, 25 years, 20th visit).

Need to feel secure

The need to feel secure involved the sense of being safe with regard to the physical and social environments. The PER was experienced as a safe environment: "*There are not that many knives here that you could hurt yourself with*" (man, 23 years, 19th visit), or "*I can come here instead of sitting alone and brooding; it's reassuring to know you can land here when your thoughts are their worst*" (man, 32 years, fifth visit).

The category included two subcategories: (1) *need for a professional approach* and (2) *need for the PER to be accessible*.

The "*need for a professional approach*" involved being guaranteed privacy and secrecy when talking to staff, and that there would be no interruptions in such conversations. It also involved meeting non-stressed staff with competence in assessing the participants' needs. The need for a professional approach also included that staff responded by taking them seriously, and being assured that the triage process was fair regardless of what staff members were working. The need for a professional approach was sometimes communicated by pointing out what they were missing, for example: "*Don't feel I'm getting any help. Being unfairly treated by the doctors. Feeling like an experiment*" (woman, 49 years, 11th visit) or "*The staff are substandard, not all are well suited for working in psychiatry*" (man, 27 years, sixth visit). The participants also expressed a "*need for the PER to be accessible*". This involved an available PER being located nearby and that the PER was open day and night. It was expressed in terms of knowing "*that you can come round the clock*" (woman, 21 years, fifth visit) or that "*you have somewhere to turn when everything feels hopeless*" (man, 65 years, fifth visit).

Need for caring encounters with staff

The need for caring encounters with staff involved being cared for and understood as well as to feel welcomed, and being treated well in terms of kindness, humanity, and fairness: "*Getting a smile makes me feel better*" (man, 37 years, seventh visit); "*They listen and understand. Don't give you the cold shoulder*" (woman, 24 years, fifth visit); or "*[You] always feel welcome*" (woman, 57 years, 16th visit).

Self-reported needs in persons who frequently visit the PER, the quantitative part of the study

CANSAS

According to CANSAS (23 need domains), the mean number of total needs was 9.52 (SD ± 3.85, range 2–18), met needs 2.89 (SD ± 2.00, range 0–8), and unmet needs 6.63 (SD ± 4.09, range 0–16).

Regarding the figures for total needs score, total met needs score, and total unmet needs score, there were no significant correlations with gender or age. However, a significant positive association between total needs and number of visits was found ($r_s = 0.262$, $p = .018$). While a positive significant association was also found between unmet needs and

Table 2. Total needs, met needs, and unmet needs according to CANSAS ($n = 81$).

	Total needs		Met needs		Unmet needs	
Needs	*n*	%	*n*	%	*n*	%
Psychological distress	76	93.8	17	21.0	59	72.8
Psychotic symptoms	63	77.8	27	33.3	36	44.4
Daytime activities	55	67.9	6	7.4	49	60.5
Intimate relationships	47	58.0	12	14.8	35	43.2
Company	46	56.8	12	14.8	34	42.0
Safety of self	46	56.8	8	9.9	38	46.9
Money	45	55.6	20	24.7	25	30.9
Physical health	41	50.6	16	19.8	25	30.9
Food	40	49.4	19	23.5	21	25.9
Dental care	37	45.7	14	17.3	23	28.4
Information about condition and treatment	35	43.2	12	14.8	23	28.4
Household skills	32	39.5	11	13.6	21	25.9
Sexual expression	32	39.5	7	8.6	25	30.9
Public transport	30	37.0	8	9.9	22	27.2
Social benefits	27	33.3	10	12.3	17	21.0
Self-care	25	30.9	11	13.6	14	17.3
Accommodation	24	29.6	7	8.6	17	21.0
Drugs	19	23.4	6	7.4	13	16.0
Alcohol	18	22.2	3	3.7	15	18.5
Child care	18	22.2	4	4.9	14	17.3
Basic education	7	8.6	2	2.5	5	6.2
Safety of others	6	7.4	1	1.2	5	6.2
Telephone	2	2.5	1	1.2	1	1.2

Note: Rounded numbers, thus the sum may differ from 100%.

Table 3. Social interactions, %.

Availability of social interactions	No-one	1–2	3–5	6–10	11–15	>15
1. How many people do you know with the same interests as yours?[a]	21.3	25.0	33.8	3.8	8.8	7.5
2. How many people do you know who you meet or talk to during a week?[a]	6.3	28.8	36.3	18.8	2.5	7.5
3. How many friends, not relatives, can visit you and feel at home?[a]	38.8	26.3	25.0	3.8	2.5	3.8
4. To how many, friends and family, can you speak openly?[b]	29.1	29.1	26.6	11.4	2.5	1.3

Note: Rounded numbers, thus the sum may differ from 100%.
[a] One missing value.
[b] Two missing values.

number of visits ($r_s = 0.231$, $p = .038$), no significant association between met needs and number of visits was found.

Table 2 presents the numbers of total needs, met needs, and unmet needs according to CANSAS. There are eight domains in which more than half of the participants assessed needs: "psychological distress", "psychotic symptoms", "daytime activities", "intimate relationships", "company", "safety of self", "money", and "physical health". The lowest proportions of self-assessed needs were in the domains "telephone", "safety of others", and "basic education".

Regarding met needs, the highest proportions were found in the domains "psychotic symptoms", "money", "food", and "psychological distress". Concerning unmet needs, the highest proportions were in the domains "psychological distress", "daytime activities", "safety of self", "psychotic symptoms", "intimate relationships", and "company", whereas the fewest met and unmet needs were reported in the domains "telephone", "safety of others", and "basic education".

Besides needs related to symptoms of mental illness, the patients also assessed somatic needs, such as "physical health" and "dental care", which were reported by 50.6% and 45.7% of the participants, respectively. "Safety of others" was one of the least reported need domains. In contrast, "safety of self" was assessed as a need by the majority and remained unmet in 82.6% of those who assessed it.

A significant association between gender and the CANSAS domain concerning "safety to self" was found ($r_s = 0.231$, $p = .038$), indicating that females have more needs or more unmet needs within this domain. Moreover, age was significantly negatively associated with domain "safety to self" ($r_s = -0.316$, $p = .004$), i.e., the younger the participants, the more often they experienced need in this domain. There was a significant positive association between age and the domain "dental care" ($r_s = 0.226$, $p = .042$). Regarding the number of visits, there were significant positive associations with the domains "accommodation" ($r_s = 0.314$, $p = .004$), "money" ($r_s = 0.254$, $p = .022$) and "drugs" ($r_s = 0.256$, $p = .021$). There was also a significant negative association between the need domain "physical health" and number of visits ($r_s = -0.258$, $p = .020$), i.e., the more needs in this domain, the fewer the visits to the PER.

Interpersonal violence

In total, 41.8% of the participants[1] ($n = 33$) reported being exposed to some sort of interpersonal violence during the last year. More than a third ($n = 29$, 36.7%) reported being exposed to verbal threats, of which 22.8% ($n = 18$) were threats of being killed. More than a fifth reported being exposed to physical violence ($n = 17$, 21.5%) and 11.4% ($n = 9$) reported being sexually abused. Concerning the latter, significant differences in gender were found ($p = .009$), i.e., with one exception, all such reports were from women. Concerning death threats, there was a significant positive association between exposure and number of visits ($r_s = 0.289$, $p = .010$).

AUDIT/DUDIT

According to the AUDIT score,[2] 29.5% ($n = 23$, 16 men and 7 women) of the participants reported alcohol-related problems. According to the DUDIT score,[3] 28.8% ($n = 23$, 14 men and 9 women) of the participants reported drug-related problems. A significant positive association between AUDIT and DUDIT score was found ($r_s = 0.391$, $p \leq .001$). Moreover, total DUDIT score showed a significant negative association with age ($r_s = -0.275$, $p = .014$), i.e., the younger the participants, the higher the DUDIT score.

Social interactions

Table 3 presents the frequencies of social interactions according to the availability subscale of ISSI. Nearly two-thirds of the participants (65.1%, $n = 52$) reported that no-one or up to two persons could visit them and feel at home, and more than half of the participants (58.2%, $n = 46$) reported having no-one or up to two people to whom they could speak openly. Furthermore, 46.3% ($n = 37$) reported knowing no-one or up to two people who had the same interests, and more than a third (35.1%, $n = 28$) reported meeting no-one or up to two persons to talk with during a week.

No significant association between gender, or number of PER visits, and each of the four questions about social interaction was found. However, concerning how many friends, not relatives, that could visit the participants and feel at home (Question 3), there was a significant negative association with age ($r_s = -0.221$, $p = .048$), i.e., the older the participants, the fewer friends to visit they had. Regarding how many people the participants could speak openly with (Question 4), there was a significant negative association with age ($r_s = -0.223$, $p = .048$), i.e., the older the participants, the fewer people they had with whom they could speak openly.

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[1] Two missing values.

[2] Three missing values.

[3] One missing value.

Discussion

The aim of the study was to investigate self-reported needs for care, support and treatment among persons who frequently visit PERs.

The results indicate that persons who frequently visit the PER report needs in many life domains, involving physical and psychiatric health problems as well as financial, emotional, and social problems. The results are in line with a recent study in which case managers rated needs in persons with mental health problems who frequently visited emergency rooms (Sirotich et al., 2016). In that study, most of the participants had needs for care, support and treatment with regard to psychological distress, psychotic symptoms, safety to self, and substance abuse. Previous studies within the research area have reported similar results (Aagaard et al., 2014; Bruffaerts et al., 2005; Chaput & Lebel, 2007; Ellison et al., 1989; Ledoux & Minner, 2006). Furthermore, the present study found that the number of visits increased when participants had unmet needs, yet no such association was found with met needs. Those results could indicate the necessary nature of the visits made when needs remained unmet. A qualitative study by Vandyk et al. (2018) found similar results showing that each visit made by persons who suffered from mental health problems and visited the emergency department frequently, was needed, necessary and unavoidable.

In addition, the qualitative part of the present study contributed more in-depth knowledge about the participants' current needs when attending PERs. They wanted to be relieved from their suffering as soon as possible. They also wanted to feel secure and to be accepted by staff as the suffering persons they were. Given the results from previous studies and especially the results from the present study, persons who frequently visit PER do so because they are in fact in need of care, support and treatment, and not out of a repetitive habit, as suggested by Aagaard et al. (2014).

Previous research has shown that persons who frequently visit PERs have weak social networks (Ledoux & Minner, 2006; Pasic et al., 2005). In the present study, the persons' social networks were investigated in more detail, revealing that most participants had few available people to interact with in their daily lives. It was notable that the older participants had fewer interactions than did the younger ones. Also a high proportion of the participants reported unmet needs in the domains of company and intimate relationships. Accessible social network and trustful social interactions are of great importance for recovery and empowerment in persons with mental illness (Barker, 1999). It may therefore be suggested that community-based psychiatry services take their responsibility more serious to develop and offer support interventions through which persons who frequently visit PERs can become more socialised and integrated in society. For example, supported socialisation programmes have shown to increase social integration and inclusion as well as the sense of belonging in persons with mental illness (Sheridan et al., 2018).

Furthermore, the present study showed that more than two-fifths of the participants had been exposed to some type of interpersonal violence during the last year. Previous research has found interpersonal violence against persons with mental illness leads to poorer self-esteem, fear, anxiety, and worries, as well as problems in social relations, especially with regard to close relationships and reliance on others (Bengtsson-Tops & Tops, 2007).

Although most of the participants in the present study reported one or more established contacts within the health and/or social services, high proportions of self-reported unmet needs were found in both the health and social domains. These results are in line with the findings in the study of Aagaard et al. (2014), which reported that persons who frequently visit PERs have numerous contacts with health and social care services. To some extent the results may be explained by shortcomings in the cooperation between the two service systems, and by the lack of an overall policy indicating how to best respond to the needs of these persons. Literature reviews covering interventions targeting persons who frequently visit primary and hospital-based somatic emergency departments have noted that interventions like case management have positive outcomes in terms of improved social and clinical outcomes and reduced visits and costs (Althaus et al., 2011; Soril, Leggett, Lorenzetti, Noseworthy, & Clement, 2015). However, transferring interventions from one context to another may be associated with difficulties, as cultural differences may exist among PERs, primary care centres, and somatic emergency departments. For example, Aagaard et al. (2014) found that persons who frequently visited PERs saw this as a supplementary or alternative solution. It has also been found that PER staff had difficulties in identifying alternative services for persons who frequently visit PERs (Arfken et al., 2002). For functional case management interventions, a key factor is that there is access to services that can meet the person's needs (Hudon et al., 2017).

Conclusions

It may be concluded that frequent visitors to PERs have comprehensive problems in various life domains and complex intertwined need patterns that are important for leading life on equal terms as the rest of society. The high proportions of self-rated unmet health and social needs combined with their need to reduce acute suffering may reflect a difficult life situation from which they want to be relieved.

This study contributes both empirically and clinically to the research field. It is the first study conducted in a PER context that investigates self-reported needs in persons frequently vising PERs, nationally and internationally. Those results can be used to inform the clinical practice, for example, by adjusting the triage process for this group or suggesting a need-oriented clinical practice approach, i.e., a more person-centred approach when triaging those patients. It also furthers the existing literature by providing evidence of the non-habitual nature of the visits, which contrasts with the findings of Aagaard et al. (2014) in a Danish context, suggesting that context-specific differences need to be taken into account when performing and comparing different studies.

Limitations

The study has several limitations. A number of persons who frequently visited the studied PER ($n = 47$) had to be excluded due to their condition, even though they represented the target group, which raises questions about the participants' and the study's representativeness. Other eligible patients were not invited to participate ($n = 38$) due to the high workload of the triage staff, and 11 patients declined participation. However, the drop-out analysis found no differences in age and gender between those persons included and those not included in the study. Despite the number of participants who were not invited to participate, the response rate was considered high, which strengthens the validity of the study. That the data were collected in one PER might threaten the inference transferability of the study; however, the inference quality of this study was strengthened by the use of both qualitative and quantitative data. Furthermore, there may be a risk of lack of subjectivity with regard to AUDIT and DUDIT where the results were interpreted by the authors in line with the guidelines of the screening tools, while those participants identified as having drug and alcohol-related problems may not experience such problems themselves. To enhance the trustworthiness of the qualitative part of the study, the first and third authors analysed the qualitative data independently, and thereafter together. Quotations were used to validate the findings. For future research, a larger sample size could be considered, given the limited number of participants in this study.

Relevance to clinical practice

To more effectively meet the needs of persons who frequently visit PERs and thus reduce the repetitive pattern of their visits, it would be advisable to introduce a person-centred approach to their care, involving an overall policy of cooperating with other services involved in their life situation. Furthermore, it may be useful for clinical practice to use assessments tools that cover problems in basic health, social, emotional, and financial life domains. By doing so, a more holistic caring approach will be applied.

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ORCID

Manuela Schmidt http://orcid.org/0000-0002-3113-6432
Joakim Ekstrand http://orcid.org/0000-0001-7364-1683
Anita Bengtsson Tops http://orcid.org/0000-0001-5904-8664

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Paper III

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Professionals' Perspective on Needs of Persons Who Frequently Use Psychiatric Emergency Services

Manuela Schmidt, PhD Student[a,b], Pernilla Garmy, RN, PhD[a,b], Sigrid Stjernswärd, RN, PhD[b], and Ann-Christin Janlöv, RN, PhD[a]

[a]Faculty of Health Science, Kristianstad University, Kristianstad, Sweden; [b]Department of Health Sciences, Lund University, Lund, Sweden

ABSTRACT
This study explores how professionals experience persons who frequently use psychiatric emergency services (PES) in terms of their needs in Sweden. The data comprise 19 semi-structured individual interviews and one focus group interview with healthcare professionals (i.e., assistant nurses, psychiatric nurses, intern physicians, and resident physicians), which are analyzed using qualitative content analysis. The overall findings suggest that persons who frequently use PES suffer from illness, unfavorable life circumstances, and inadequate care, which together emphasize the need for more sustainable support. The findings indicate that the professionals saw beyond illness-related needs and could also acknowledge patients' needs originating from social, existential, and care- and support-related aspects of life.

Introduction

Use of psychiatric emergency services (PES) has increased in recent decades (Aagaard, Aagaard, & Buus, 2014; Brown, 2005; Schmidt, 2018). One user group contributing to this increase is persons who frequently visit PES. In a recent Swedish study, persons making frequent PES visits constituted 8.1% of the total sample, yet they accounted for 38.3% of all visits made during the investigated 3 years (Schmidt, Ekstrand, & Bengtsson Tops, 2018a). Previous research arrived at similar results, finding that this relatively small group is responsible for a disproportionately high number of visits in both Scandinavian (Aagaard et al., 2014) and international contexts, including North America (Chaput & Lebel, 2007; Lincoln et al., 2016), Europe (Boyer et al., 2011; Ledoux & Minner, 2006; Richard-Lepouriel et al., 2015), and Australia (Wooden, Air, Schrader, Wieland, & Goldney, 2009; Zhang, Harvey, & Andrew, 2011). Thus, it is a global phenomenon regardless of the healthcare system.

Persons who frequently visit PES are often described as a heterogeneous group, and previous studies have identified several factors predicting frequent PES visits, including male gender (Ledoux & Minner, 2006), young age (Chaput & Lebel, 2007), single status (Boyer et al., 2011), homelessness (Arfken et al., 2004), and unemployment (Pasic, Russo, & Roy-Byrne, 2005). This diverse group also reportedly does not receive or has difficulties complying with aftercare (Bruffaerts, Sabbe, & Demyttenaere, 2005), can be uncooperative (Pasic et al., 2005), and has unreliable social support (Pasic et al., 2005). Furthermore, persons who frequently visit PES are more likely to be prematurely discharged (Botha et al., 2010); suffer from personality disorders (Richard-Lepouriel et al., 2015), substance abuse disorder (Bruffaerts et al., 2005; Ledoux & Minner, 2006), and schizophrenia (Aagaard et al., 2014); and have a history of hospitalization (Pasic et al., 2005). While useful in identifying the characteristics of this group, all of these are quantitative studies and have not focused on explaining what aspects apart from demographics and diagnostics could identify the needs of these persons that make them frequently visit PES.

Healthcare professionals working at PES play an important role in providing multifaceted services to persons who frequently use PES. These professionals have been described as an integrated and valued part of the social networks of persons who frequently visit PES, providing them with safety and security (Aagaard et al., 2014; Barker & Buchanan-Barker, 2010; Schmidt, Ekstrand, & Bengtsson Tops, 2018b). Given their numerous encounters with and extensive knowledge of these patients, healthcare professionals might represent a valuable source of information regarding their needs. They are also the ones addressing the patients' needs, and therefore their understanding of the patients' needs may be crucial for care provision.

Persons who frequently visit PES have been shown to have complex and multifaceted needs (cf. Fleury, Grenier, Farand, & Ferland, 2019; Schmidt et al., 2018b), some of which may remain unmet if people have difficulties expressing them in the first place. Compounding this challenge may be the fact that persons who frequently visit PES are a

CONTACT Manuela Schmidt manuela.schmidt@hkr.se Kristianstad University, 291 88 Kristianstad, Sweden.

heterogeneous group that varies greatly in diagnostic profile, socioeconomic characteristics, and temporal utilization patterns (Schmidt et al., 2018a). In a recent Swedish mixed-methods study including persons who frequently visit PES, the participants self-reported having needs to reduce acute suffering, feel secure, and have caring encounters with PES staff, as well as needs to reduce psychological distress and psychotic symptoms and to have daytime activities (Schmidt et al., 2018b). Reviews of studies focusing on persons who frequently visit PES or emergency departments, and on their needs in particular, indicated that explanatory research has dominated the field so far (Schmidt, 2018; Vandyk, Harrison, VanDenKerkhof, Graham, & Ross-White, 2013), while exploratory research has been scarce (Vandyk, Bentz, Bissonette, & Cater, 2019; Vandyk, Young, MacPhee, & Gillis, 2018; Wise-Harris et al., 2017). In-depth qualitative studies of an explorative nature may be required to more fully understand this complex group's needs and the reasons and life circumstances underlying those needs. The perspective of healthcare professionals at PES could provide one piece of this puzzle, since their voices have been largely missing from studies so far. Healthcare professionals at PES may have an understanding of the patients' needs that differs from the patients' own understanding. While patients might emphasize their acute healthcare needs in moments of despair when presenting at PES, healthcare professionals might be able to look beyond those acute needs and also discern the patients' other, longer-term needs. Taking a novel perspective of the professionals, this study aims to explore how the professionals experience persons who frequently use PES in terms of their needs, thus contributing to the in-depth understanding of the needs of this group of people. Further, this study contributes to a better understanding of the professionals' experiences with this patient group, which could potentially help improve patient outcomes and satisfaction.

Methods

Within the context of this study, healthcare professionals in psychiatric care include assistant nurses, registered nurses with additional specialized education in psychiatry, as well as intern and resident physicians,[1] all of whom are hereafter referred to simply as "professionals." Persons who frequently use PES are hereafter referred to as "patients."

Design and context

The study has a qualitative, explorative design. A qualitative design is considered suitable for exploring people's experiences, perceptions, opinions, and feelings in order to cast light on the phenomenon of interest (Polit & Beck, 2016). As data collection methods, both individual interviews and a focus group interview were used. "Within-method triangulation," a form of methodological triangulation using several data collection methods (Thurmond, 2001) such as the different qualitative interview types used in this study, helps to provide a clearer and more comprehensive understanding of the phenomenon of interest. It also increases the trustworthiness of the study and improves authenticity of the results (Holloway & Wheeler, 2015; Polit & Beck, 2016). While the individual interviews can contribute to in-depth data collection, focus group interviews can add variety and breadth of the data.

Healthcare in Sweden, including psychiatric healthcare, is based on a socialized welfare system financed mainly by taxes. Both municipalities ($N = 290$) and county councils ($N = 21$) share responsibility for providing psychiatric healthcare and social care services. According to the Swedish Association of Local Authorities and Regions there are 54 psychiatric emergency units in Sweden. Organization and staffing differ between locations as does the triage process, which in some PES is conducted by registered nurses with or without additional specialized education in psychiatry and in other places is conducted by resident physicians. Staff competences and educational levels vary within Sweden and internationally, as do the clinical profiles of the persons who frequently visit PES. However, the persistent frequent visits to PES by certain groups of people are similar across both national and international contexts.

Data were collected at one PES in southern Sweden comprising a psychiatric emergency department and an acute psychiatric care unit. The PES serves a rural/urban catchment area of approximately 200,000 inhabitants. The PES is open 24 hours a day, 7 days a week, and is operated by assistant nurses (2-year vocational education), registered nurses (3-year tertiary education plus 1 year of specialization), intern physicians (5.5-year tertiary education plus 1.5-year intern training) and resident physicians (5-year additional specialization training), an on-call physician, and, during the daytime, a medical secretary (2-year vocational education), which are the most common profession categories that work at PES in Sweden in general. The PES uses a well-integrated 24 hour/day, 7 days/week telephone counseling service, and most patients call before visiting. Thus, the professionals included in this study talked about both patients' frequent PES visits and their frequent use of telephone counseling services, which were operated by registered nurses.

Participants

The participants were informed about the study by the first author during workplace meetings and/or by a video recorded by the first author. Furthermore, an information letter was sent to all potential participants informing them of the study's aim, the data collection methods, and their right to refuse participation. To be included in the study, it was originally decided that participants should: (1) be either assistant nurses, registered nurses, or physicians; (2) have been in contact with and cared for persons who frequently used PES; and (3) have been employed at the PES unit for at least 6 months before the interview. However, intern physicians undergoing practical educational placement at the PES for 3-month periods and who met with patients extensively were also viewed as a valuable information source, so the inclusion criteria were relaxed for them despite their shorter employment terms. Sixty-two professionals fulfilled the extended inclusion criteria. To achieve variation in the

Table 1. Overview of the participants.

	Individual interviews ($n = 19$)	Focus group ($n = 1$)
Gender		
Male	6	4
Female	13	1
Age, median (range)	47 (29–70)	38 (32–49)
Profession		
Assistant nurse	3 (13–17)[a]	2
Registered nurse	10 (1–40)[a]	2
Intern physician	2 (n/a)[a]	0
Resident physician	4 (1–4)[a]	1
Country of birth		
Sweden	15	4
Other	4	1

[a]Range of professionals' experience of working in a PES, years.

sample, purposeful selection (Holloway & Wheeler, 2015) was applied among the eligible participants based on profession, work experience, age, and gender. In total, 21 professionals were asked to participate in the study; two professionals (i.e., one assistant nurse and one resident physician) refused participation due to high workload, so the final sample comprised 19 participants. When recruiting focus group participants from those 19 participants, seven professionals were purposefully selected and invited based on their working schedules and professions. However, as two female professionals could not participate due to sickness and work schedule changes, the final focus group comprised five participants, in line with Krueger and Casey's (2015) recommendation of five to eight participants. A detailed description of the participants can be found in Table 1.

Data collection

Data were collected via individual face-to-face interviews (Polit & Beck, 2016) and a focus group interview (Krueger & Casey, 2015).

Individual interviews

The individual interviews used a semi-structured interview guide comprising open-ended questions about the professionals' experiences and perceptions of the patients and their needs (e.g., "Can you freely tell me about your experiences with persons who frequently use PES? Who are they? What problems do they have?"). Each individual interview started by referring to one of the most common definitions of frequent PES visitors as persons with at least five contacts within a 12-month period (Aagaard et al., 2014; Blonigen et al., 2017; Schmidt et al., 2018b).

The individual interviews were conducted during October and November 2018 by the first author and lasted an average of 51 minutes (range, 27–86 min). Before data collection, two pilot interviews, also included in the analysis, were conducted by the first and the fourth authors, resulting in the addition of two questions to the interview guide. The individual interviews took place at the participants' workplace during working hours and were scheduled by the care unit manager to fit participants' shift schedules in order to ensure sufficient staffing of both the psychiatric emergency department and the acute psychiatric care unit. At the beginning of the individual interviews, all participants were asked to complete a form containing questions about their age, country of birth, gender, education, and work experience.

Focus group interview

After all individual interviews had been conducted, one focus group interview was held in January 2019. Focus group interviews capitalize on communication between the participants, and those group interactions offer a direct indication of similarities and differences among the participants' experiences, opinions, and feelings (Morgan, 1996). Focus group interviews are conducted by a moderator and observer, who should be fully grounded in the purpose of the study (Krueger & Casey, 2015). In this study, the use of a focus group interview constituted a source of complementary data used to increase the trustworthiness of the results and to add variety and breadth of the data. It also allowed further validation of the preliminary results of the individual interviews and made it possible to report preliminary results back to the focus group, thus ensuring credibility of the study (Shenton, 2004). The semi-structured interview guide used in the focus group interview was based on the preliminary results of the individual interviews and further addressed the six problem areas identified at this stage: suffering from disease, not fitting into society, loneliness, hopelessness, being let down by social structures, and PES availability. The guide consisted of open-ended questions, allowing for an open discussion among the participants.

The focus group interview took place at the participants' workplace during working hours. It was conducted by the first author as a moderator and the fourth author as an observer and lasted 100 minutes. Both the individual interviews and the focus group interview were audio recorded and transcribed verbatim.

Analysis

The data were analyzed using qualitative content analysis (Graneheim & Lundman, 2004) with an inductive approach that allowed for a deeper understanding of the professionals' experiences and perceptions of the patients and their needs, facilitating the search for patterns in the data (Graneheim, Lindgren, & Lundman, 2017). During the analysis, we sought similarities and differences in the data, leading to the formulation of four categories capturing the manifest content of the text as well as one theme capturing the latent content of the text. Though the emerging categories focus on describing the manifest content, and the theme focuses on interpreting the latent content, both require a level of interpretation, yet of varying depth and level of abstraction (Graneheim & Lundman, 2004; Graneheim et al., 2017). Because the interviews focused on narrating the patients' problems and life circumstances, the analytical process started with the patients' challenges and problems, which, in a later stage of the analysis, the authors interpreted in terms of needs.

The individual interview texts were analyzed following a systematic and stepwise process starting with reading all individual interview texts to obtain a sense of the whole.

Then, the text about the participants' experiences of the patients' needs (i.e., units of analysis) was identified and brought together in one document. The text was then divided into meaning units, which were condensed while keeping their core meaning (Graneheim & Lundman, 2004). The next step involved labeling the condensed meaning units with codes. As the meaning units were sometimes rather large and comprehensive, more than one code could be assigned to a condensed meaning unit to preserve content relevant to the study's aim. The codes were then compared in terms of similarities and differences, and sorted into subcategories and categories.

After the preliminary analysis of the individual interviews was done, the focus group interview was conducted based on those preliminary results. The focus group text was then analyzed following the procedure described above; it largely validated the categories and advanced the analytical process by exploring and clarifying the preliminary results of the individual interviews. After analyzing all the texts from all interviews, some categories and subcategories were merged and/or renamed. The analysis process was repeated by all authors individually at different analysis stages. Thereafter, the authors discussed and reflected upon the categories and subcategories together until a consensus was reached. The validity of the categories and subcategories was checked against the condensed meaning units and codes. Table 2 presents examples of the aggregation of the text and the analysis process.

The overall theme emerging from beneath all the texts, representing the latent, underlying meaning of the texts, was derived through in-depth interpretation and abstraction (Graneheim et al., 2017). The theme ran through all the categories as a unifying "red thread" (Graneheim et al., 2017) throughout the analysis. The analysis involved all the study's authors at different stages. The first, second, and fourth authors—following the systematic analysis approach—repeatedly discussed the findings over a longer period of time and agreed on them, and these were then presented to and critically reviewed by the third author. A joint discussion was then initiated between all authors, and the analysis was completed when consensus was reached.

Ethics

The Swedish Ethical Review Authority had no ethical concerns about this study (Dnr 2018/569). Both written and oral information about the study was provided to the participants, and a letter of consent was signed by each participant before participation in the individual interviews and the focus group interview. In the information letter, at the information meetings, in the information video, and before the individual and focus group interviews started, it was stressed that participation was voluntary and that participants could withdraw without having to provide a reason. Furthermore, participants were informed that the collected data would be treated confidentially and that only the authors of the study would be able to access it.

Pre-understanding

The authors had varying levels of pre-understanding. The second, third, and fourth authors are registered nurses, and the fourth author has solid clinical experience of working in psychiatric care. All four authors are focusing on psychiatric care or mental health in their research.

All authors of this study have extensive experience in conducting qualitative studies using different data collection and analysis methods, including qualitative content analysis.

Results

The professionals viewed the patients, that is, persons who frequently use PES, as common users of PES, forming a large group that would always exist regardless of PES' actions and interventions. The professionals described the patients as heterogeneous in terms of age, diagnosis, and level of self-awareness, though alike in some ways. The professionals further described them as suffering, feeling unwell, and help-seeking. They experienced the patients as either very sick, having been so for many years, or as having mild conditions not covered by specialized psychiatry (e.g., sleeping problems lasting a few days) and having no acute healthcare needs. The professionals narrated that the patients suffered from numerous psychiatric diagnoses and symptoms. The psychiatric diagnoses most frequently mentioned by the professionals were substance abuse (particularly alcohol addiction), neuropsychiatric disorders such as Asperger's syndrome, and personality disorders (particularly emotionally unstable personality disorder). The latter often occurred in combination with self-harm behavior. Despite the variety of illnesses and symptoms, the professionals regarded anxiety as the most common condition among all patients, as it could occur in combination with most psychiatric illnesses. Anxiety was also a condition for which the patients requested immediate treatment. Comorbidity also commonly involved somatic healthcare problems such as high blood pressure or diabetes, which were healthcare needs that the PES professionals felt that they met insufficiently at times. The professionals indicated that the patients had multiple, complex needs. The focus group interactions revealed that the participants across professions were in consensus regarding their experiences and views of the patients.

The data analysis provided an understanding of the professionals' perspective on the patients and their needs. The analysis resulted in one overarching theme: To suffer from illness, unfavorable life circumstances, and inadequate care stresses the need for sustainable support. This theme captured the meaning of the professionals' experiences and perceptions of the patients as suffering human beings who need the support of all involved healthcare functions to establish an integrated caring approach acknowledging the various dimensions of their suffering. The theme includes four categories representing the professionals' perspective on patient needs: need to relieve loneliness, need to relieve hopelessness, need to relieve psychiatric symptoms, and need for cohesive care and support, as presented in Table 3.

Table 2. Examples of the analytical process.

Meaning unit	Condensed meaning unit	Code	Subcategory	Category
A: People don't have … the safety net … surrounding network of contacts—friends, acquaintances, and parents, etc.—so this has sort of become some kind of new … people come here instead of … for things that you could maybe have taken care of within the family or with friends and so on, before. B: Maybe they have some diagnosis or … A: Yes, you could also have that. But that they're actually looking for help with loneliness. C: Yes, true, but that's often how it is. (Focus group)	People don't have a surrounding social network of friends, acquaintances, and parents—they're basically seeking help for loneliness.	People have no network of contacts and they're seeking professional help because they're lonely.	Need for significant others	Need to relieve loneliness
God Almighty! What they need help with … so actually we would need to sit down with the person and look at their entire history, see what it is like, what kind of network they have, what has been done and what has not been done, and what might be helpful, and what the person him/herself wants. Yes, and so … but I'm saying that … it's of course really, really hard! We could, of course … and that is in fact the way it is, that it's all about individual solutions, and that costs money and is totally unrealistic—and yes, that's how it is. (SSK, interview 11)	Actually, we would need to sit down with the person and look at their entire history, see what it is like, what kind of network they have, what has been done and what has not been done, and what might be helpful, and what the person him/herself wants. But that's of course really, really hard. Individual solutions cost money and are totally unrealistic.	No leeway for taking individual backgrounds and wishes into consideration.	Need for a long-term perspective	Need for cohesive care and support
But what we find is that certain municipalities don't function properly. It's as if they are unable to reach the patient … But it seems to me that the municipality could provide more support. … Like you must wait until the eleventh hour before you're supposed to write an urgent care offer about the patient if the patient has, say, acute liver failure and is extremely somatically ill. It's like nothing gets done until the very last minute. Yes. (ST, interview 1)	In certain municipalities it doesn't work. They are unable to reach the patient. Seems to me that the municipality should provide more support. They wait until the last minute before writing an urgent care offer when the patient is very ill.	Municipalities should provide more interventions. Municipalities should provide better service.	Need for improved social and healthcare functions	Need for cohesive care and support
A: Yes, I think that … many of these people, who sometimes might function quite well otherwise, or well enough in any case, that they … they have to go to Emergency then, because there's no other place that can … B: … that's open, right? Even though it may not involve an urgent psychiatric … C: I'm actually about to start working at a municipality now, and there they're talking about … or before I came they were talking about … how someone was going to have extended hours of opening at the support and treatment unit. One Saturday a month or something like that, and that's a bit outside the box. E: Yes, that it is. C: At the same time, society is actually becoming ever more 24/7. But in healthcare and in the municipality things are still extremely rigid—there it's like getting sick is a daytime thing. (Focus group)	People who function well have to go to Emergency because there's nothing else open—even if it's not an urgent psychiatric issue. Society is 24/7, but in healthcare things are still very rigid—as if getting sick is a daytime thing.	PES is the only service that is open round the clock.	Need for PES to be available	Need for cohesive care and support

Table 3. Overview of the theme, categories, and subcategories.

Theme	To suffer from illness, unfavorable life circumstances, and inadequate care stresses the need for sustainable support			
Categories	Need to relieve loneliness	Need to relieve hopelessness	Need to relieve psychiatric symptoms	Need for cohesive care and support
Subcategories	Need for significant others	Need to master obstacles in everyday life	Need for increased well-being	Need for improved social and healthcare functions
	Need to fit into society	Need for meaning	Need for acute hospital admission and medication	Need for PES to be available
	Need for talk and interaction	Need for temporary escape	Need for self-admission	Need for collaboration between involved functions
	Need to be seen and confirmed	Need for caring encounters	Need to feel safe	Need for a long-term perspective

Need to relieve loneliness

The professionals found the patients to be lonely in their lives, which contributed to their frequent use of PES. This loneliness revealed itself in several dimensions. First, the professionals described an inner loneliness among the patients; second, the professionals noted that the patients lacked significant others to share their lives with, often living alone, having no spouse, and having little or no contact with their families; and third, the professionals found that the patients had limited or no social networks, as the patients commonly had few or no friends:

> Many people spend all their time alone in their apartment and are very lonely. Their loneliness is extreme. And sometimes I think, look, I've been working here for seventeen years and I see this—many of the people who come here spend all their time alone in their apartment and they miss this part … (Interview 3)[2]

The professionals saw the reasons for this loneliness partly in the patients' self-chosen withdrawal and partly in society's distancing of persons with mental illness. Other reasons were stigma-related problems in a changing society that the professionals regarded as more individualized, egocentric, and tougher than several decades ago, making persons with mental illness more vulnerable today as the society does not provide places where they can fit in. The professionals described the current society as a factor contributing to the patients' isolation and alienation, making them outsiders to society and increasing their loneliness and use of PES services:

> Yes, they do want someone to talk to. Sometimes they want some medicines, but most of all I think it is that they want … many are quite lonely, so I think many times that could be why they come here. (Interview 16)

Given the loneliness of the patients and related problems, the professionals felt that the patients needed human interaction and someone to talk to in order to relieve their loneliness. The professionals perceived that the patients maintained close relationships with them at the PES because they provided opportunities to talk to someone. The professionals expressed that they represented familiar faces and offered the patients comfort and the prospect of human interaction. Because they had had previous conversations, the professionals could talk at a personal level with the patients, remembering what they liked or disliked. The professionals expressed that both parts of conversation, that is, being able to talk to someone and verbalize one's thoughts as well as being listened to by someone who is interested and willing to invest time, were equally important for relieving the patients' loneliness. The professionals used this form of interaction to strengthen their therapeutic and trustful relationship with the patients.

Due to the patients' loneliness, the professionals felt that the patients needed to be seen and be confirmed to find relief. By taking time to listen carefully, the professionals could temporarily meet the patients' needs for confirmation. The patients' need to be seen and for confirmation was regarded as essential by the professionals, since this need could not be met by absent family, friends, or significant others or by an alienating society at large:

> The first thing—the most important thing, I think—is the listening. It's the patient's story that is the most important thing. I think that surely it's a human need—to be seen. And if you are seen, that's part of it. Then no doubt there are many other needs, but just to be heard and to be seen—for me that's the most important thing. (Interview 2)

Need to relieve hopelessness

The professionals found the patients to be constantly struggling with everyday life, which was characterized by economic challenges, problems, and dissatisfaction with their housing or living situation, and lack of daytime activities. The patients were described as helpless and as having low self-confidence and a negative self-image, which contributed to their difficulties in mastering life. The professionals also felt that the patients had lost their joy in life, viewing it as meaningless, which contributed to a fairly hopeless outlook and a desire to escape from their troublesome lives:

> Yes, but those who come, they are searching for something and most often they search … they search for hope and meaning and structure. Yes, these sorts of inaccessible notions that things will be better … That's why they come here, that otherwise … well, crassly speaking, they could go in the lake right away because they feel frustrated, hopeless, that they don't see any light anywhere. So I guess there might be a purpose for this operation [i.e., PES] to exist//Yes.//Yes.//But I think we give hope to many and that we give meaning to many and we give structure to many. (Focus group)

The professionals felt that PES offered a refuge for the patients, where they could get away from their everyday lives, pause, and reflect.

Because the professionals regarded the patients as dependent on others with respect to mastering everyday life and as having difficulties taking care of themselves, they felt that the patients yearned to be taken care of by someone, a need that was directed toward PES:

> I mean, basically, I don't believe anyone thinks it's fun to be here [i.e., in the PES unit], no … they really don't. And … but it … some people have become so helpless, due to their … due to their alcoholism, that they become … they just want to be taken care of. Almost like children. Yes. They cannot manage their lives … they … they're in debt, they have collection agencies and the enforcement service on them, they can't do their own housekeeping, can't prepare their meals, can't make their own beds. (Interview 8)

The professionals felt that, due to the patients' difficulties mobilizing inner strength and will, the patients could put responsibility on others in their surroundings—particularly PES—to resolve their problems for them simply, quickly, and conveniently. From this perspective, the professionals viewed certain patients as passive recipients of services who lacked resources to overcome crises on their own:

> … many of them have some kind of hopelessness, so that they want us to hospitalize them or start to help them, to fix them somehow … (Interview 10)

All the aspects of hopelessness and lack of independence were understood by the professionals as patients needing caring encounters and to be met in an empathetic and humane way. The professionals understood that uncaring encounters could lead to frequent use of PES and that the patients would not feel that they were being taken seriously.

The professionals also recognized the patients' need for a glimpse of hope, a need originating from their hopelessness. The professionals saw it as crucial to provide hope for the patients and to believe in them even if they did not believe in themselves. They strove to make the patients feel empowered, involving them in decision making, providing autonomy, and maintaining a humanistic perspective:

> But it is extremely important to build them up, to reassure them—"You'll be okay, you'll manage, and you know where to find us … you can call us if you need to chat"—or something like that. That kind of thing is extremely important—that you reassure them but don't take away their responsibility for their own health and their illness, or whatever it is—that's important, for sure. (Interview 5)

The professionals stressed that responsibility for their own health should always remain with the patients, and they understood that if the patients shifted responsibility to others, no lasting changes could occur.

Need to relieve psychiatric symptoms

Regardless of the diagnosis or the severity and urgency of the patients' health condition, overall, the professionals found the patients to be suffering and feeling unwell for reasons that were not always clear nor understood by the patients themselves. The professionals stressed that the patients' subjective experience of their own health conditions was what mattered, not the professionals' perception of the patients' conditions, because the subjective experience was the patients' reality.

The professionals reported that suicidal thoughts were often expressed by the patients who could use this as a tool to emphasize the severity of their negatively experienced health conditions and suffering. Even though the patients might express such thoughts, all the professions participating in the interviews agreed that they did not believe that the patients actually wanted to end their lives but, rather, were expressing their dejection and inability to cope:

> We always ask about it [i.e., suicidal ideation], so it comes up, but usually they don't have such thoughts—more like a longing for death, a death wish, that they feel they can't go on, as they so often describe it. They don't say they're planning to commit suicide but rather that "It would be better if I died, if I got sick and died—that would be such a relief for me." So it's not exactly suicidal ideation—a threat of suicide—from these people, as I see it. (Interview 10)

The professionals reported that, to find relief from psychiatric symptoms and lack of well-being, the patients requested PES admission to find safety, security, a change of environment, stability, and calm. In particular, persons with personality disorders, self-harm behavior, anxiety, and addiction problems valued the possibility of being hospitalized. Persons with addiction problems and anxiety also expressed a need for medication or withdrawal treatments in order to feel better and obtain relief from their suffering. However, the professionals understood that admission and medication relieved the patients' suffering only temporarily, and that the patients could have unrealistic expectations of PES. The professionals found that it was important for the patients to understand that only acute needs could be addressed and eased at the PES, while long-term healthcare needs would remain unmet and would have to be addressed elsewhere:

> At the same time, it [i.e., frequent visiting] … is sometimes a problem, because they choose that as a coping strategy instead of maybe doing something else. So they think "yes," but then they go to Emergency all the time. They want us to calm their anxiety, which isn't the best thing in the long run. (Interview 10)

The professionals felt that there was a need to provide patients with the option of self-admission as an alternative to having staff determine whether to admit patients. This option was introduced by the PES a few years earlier, mainly for persons with emotionally unstable personality disorder and self-harm behavior. The professionals found this option to be successful for both the patients and the PES because it improved patient well-being in both the short- and long-term, as it increased patients' autonomy.

The patients' health conditions and suffering were understood by the professionals as engendering a need for safety, which could be temporarily met by hospitalization and medication, and by being treated by competent and professional staff.

Need for cohesive care and services

To live structured lives outside of acute psychiatric healthcare, the patients depended on the help of municipal social care services and other support and healthcare functions. Besides social care services, these functions could include permanent healthcare contacts with psychiatric outpatient care units, counselors, social workers, employment agencies, social insurance agencies, churches, and homecare services. The professionals noted that the patients frequently needed to use PES because they were often let down by the available support services. The professionals strongly agreed with the patients' dissatisfaction, knowing first-hand that the provided support services were insufficient, lacking in quality, and in short supply.

The professionals reported that the patients, despite being set up with numerous support contacts, were often not helped by them, possibly being redirected from one support service to another. They even felt that the patients could have too many support contacts, which they considered counterproductive, confusing for the patients, and lacking a person-centered approach. Not only were the social services unsatisfactory, the professionals also perceived that the healthcare services needed to be more available to the patients. For example, the psychiatric outpatient care units and primary healthcare centers could not offer enough physician appointments. The primary healthcare centers had long waiting times, and the professionals thought that these centers should be more available to the patients since their responsibility covered milder to moderate mental health conditions. This short supply of social and healthcare services made it clear to the professionals that the patients needed an improved overall support service covering all involved social and healthcare functions, ultimately reducing acute patient needs as well as decreasing the number of PES visits.

Due to the short supply and deficiency of support, particularly at night or on weekends when the patients might experience high anxiety, the professionals believed that the patients needed a PES facility to turn to, as it was the only alternative available 24 hours a day when patients experienced healthcare or other needs.

The professionals believed that sufficient PES availability fostered a sense of security, continuity, and structure that was otherwise lacking in the patients' lives:

> A: Mm-hm. But you [i.e., PES] can't help them with housing, can you?
>
> B: No, we can't. But sometimes they get … they often have anxiety when the structure of their life falls apart somewhere else. Then they can come here, and just being here gives them a certain sense of structure. (Interview 18)

Furthermore, the professionals described a lack of collaboration between PES and the support services arising from unclear division of responsibility, deficient comorbidity assessments, and a lack of resources for improving collaboration between services. This lack of collaboration was yet another perceived reason for the lack of continuity of care, which the professionals thought was essential for the recovery process of the patients. While the lack of support services was mentioned by all participants, the lack of collaboration was mainly noted by the physicians, who usually had to initiate treatment contacts or would need information from other support functions:

> Honestly, I believe we need to have an in-depth dialogue with social services about how we might better handle this type of patient. Maybe someone from the social services could provide 24-hour on-call service about this … since it's often a matter of a social problem when they come to Emergency. (Interview 1)

The professionals criticized the structure of the healthcare system, as none of the support functions adequately addressed the patients' long-term needs. They believed that the patients should be provided with more adequate interventions at an earlier stage elsewhere, for example, in primary care at healthcare centers or by the municipalities:

> Then, too, there are times when you might have wished there was someone else, or a better place for them to go, largely because there might be other interventions they need more than psychiatry, so that … For example, if you have autism and have difficulty with everyday life, then rehabilitation, rather than psychiatry, is what is needed. But we are all that is available in the evening. So there is a risk that they will come here and staff will want to involve a whole lot of medications or do something that may actually not help them, when what they needed was more structure. (Interview 4)

This long-term perspective even included providing person-centered service. Although the professionals embraced this approach when caring for the PES patients, they felt that providing individually tailored interventions would require close, long-term coordination between all support functions. The PES' task of addressing acute healthcare needs could at times collide with a person-centered approach due to the short-term, acute priorities guiding PES care.

Discussion

By applying the perspective of the professionals working at PES, this study sought to explore how the professionals experience persons who frequently use PES in terms of their needs. In the discussion, we first compare our findings to the limited studies about the needs expressed by persons who frequently visit PES or other emergency departments. This is followed by a comparison with those studies about mental healthcare patients in similar or other healthcare contexts, and thereafter we relate our findings to applicable theoretical domains within healthcare. Finally, we bring forward the professionals' own feelings and the issue of malingering related to our findings.

The main finding is that the PES professionals report a complex picture of the patients' needs based on their personal and social life circumstances and on the healthcare and support context. The needs identified by the professionals correspond relatively well with those expressed by persons who frequently visit PES or emergency departments themselves (Fleury, Grenier, & Farand, 2019; Schmidt et al., 2018b; Vandyk et al., 2018, 2019; Wise-Harris et al., 2017), stressing the complexity of the patients' needs and the subjective component of the patients' suffering, lack of health and well-being, and the need for human contact and social interaction. In particular, the patients' feelings of loneliness, their internal and external struggle, and their negative self-image leading to feelings of worthlessness and hopelessness were common topics discussed in studies about persons with (severe) mental illness visiting other mental health or healthcare services (Ådnøy Eriksen, Sundfør, Karlsson, Råholm, & Arman, 2012; Fleury, Grenier, Bamvita, & Tremblay, 2013; Lindgren, Sundbaum, Eriksson, & Graneheim, 2014). Further, the inadequacy of the healthcare services and their shortage of resources or the lack of human interaction were recurring leitmotifs, which also correspond well with the aforementioned studies. Thus, the professionals participating in this study showed high levels of insight and empathetic capacity by perceiving and understanding the patients' personal, social, and healthcare needs. The findings of this study additionally emphasize that even though the professionals at PES could address a number of the patients' needs, the benefits of this were not long lived, and that numerous long-term needs were outside their scope of work and could not be addressed by PES. While Fleury, Grenier, and Farand (2019) reported that over 90% of the persons with mental illness presenting at emergency departments could rely on several close relations for help, the professionals interviewed in our study found the patients at PES to be lonely, with few or no social interactions or network, which was confirmed by a study taking frequent visitors' perspective (Schmidt et al., 2018b).

Although the professionals tried to discern the uniqueness of each patient's experience of psychiatric symptoms and healthcare problems, they felt that the patients were also alike in terms of their unmet needs, suffering, poor health and lack of well-being. The present findings are in line with Eriksson's (2006) categorization of suffering from illness, suffering from care, and suffering from life. Eriksson (2006) compared suffering to a form of dying in that the absence of confirmation of one's worth as a human being leads to a world beyond relationships that is characterized by hopelessness, sorrow, guilt, humiliation, and loneliness. She further acknowledged the importance of confirming a person's suffering, which was what the professionals reported doing, for example, by means of eye contact, words, or gestures. Stratton Hill (1992) developed a typology of suffering distinguishing between acute and chronic forms, with the former relating to illness and the latter to the patient's situation as a whole. Both forms of suffering and their resulting needs were identified by the professionals included in this study. Although they stressed that their task was to offer only short-term ease of acute symptoms at the PES, they could see beyond illness-related needs and also acknowledge the patients' unmet long-term needs originating from other aspects of life. These results further correspond to the four modes of suffering identified by Cutcliffe, Hummelvoll, Granerud, and Eriksson (2015): social suffering (as in category 1), existential suffering (as in category 2), disease suffering (as in category 3), and care and treatment suffering (as in category 4). The existential aspect of the patients' suffering was often described by the professionals in terms of the patients' existential loneliness, need for meaning in life, need to escape, and suicidal thoughts. Those indicate the patients' existential vulnerability and the importance of a sense of coherence (Antonovsky, 1996) and of feelings of connectedness (Ådnøy Eriksen, Arman, Davidson, Sundfør, & Karlsson, 2013).

For persons to move away from those states of suffering, hope–supporting relationships are needed. The professionals participating in this study, regardless of their profession, were aware of the value of supporting and empowering the patients by believing in them and providing them with some glimpse of hope. Provision of hope during periods of illness and vulnerability by nurses, psychiatric nurses in particular (Hammer, Mogensen, & Hall, 2009), has consistently been identified as crucial in previous literature. Hope-inspiring interventions and their therapeutic value have been shown to be essential to the experience of illness and well-being, recovery, and the ability to live meaningful lives (Ådnøy Eriksen et al., 2013; Eriksson, 2006; Moore, 2005). However, the primary focus in this context is usually on the nursing profession, though it could be extended to all professions working at PES, as this study showed. A study including mental health professionals confirmed that inducing hope and recognizing and confirming mental health service users as fellow human beings increases their self-respect, self-worth, and sense of self (Ådnøy Eriksen et al., 2013). Despite the involved professionals' various mandates, focuses, and work descriptions, they all expressed similar views, thoughts, and perceptions regarding caring for the patients.

Another finding of the study is that the professionals identified many of the patients' needs and origins of suffering in their social and everyday lives. The professionals included in this study described persons who used PES frequently as lonely and excluded from society. Furthermore, they lacked daytime activities and were dissatisfied with their housing situation and with the limited availability and quality of the support and healthcare services. Those findings can be confirmed by previous studies of persons with mental illness in an emergency care context that applied a patient perspective (Fleury et al., 2013; Schmidt et al., 2018b; Vandyk et al., 2018). Those findings may support a social–psychiatric approach, implying that more attention should be paid to people's social contexts, that is, not only to the individual's immediate social context, but also to the political responses to societal structures at the local, national, and international levels (Priebe, 2015). By considering all aspects of individuals and their everyday lives, including a social perspective, a more person-centered caring approach is possible that may lead to more empowerment of patients and better meet their long-term needs, thus providing more sustainable support. By providing sustainable support, e.g., in the form of more continuity of care and support, achieved by means of a collaboration strategy applied by all involved social and healthcare functions, the short- and long-term suffering arising from illness, life, and care, together with the associated needs, can be met more effectively.

An additional finding of the study was that, despite the focus on the patients and their needs, all included professionals sometimes felt hopeless. This was because they were aware of the patients' needs yet could not address all of them, stressing that the patients needed healthcare and support services earlier in the caring process and more preventative interventions. This indicated that the patients' and professionals' needs may be somewhat intertwined, particularly in the category *need for cohesive care and services.* Addressing the patients' needs in this category would ultimately address and meet certain work- and health-related needs of the professionals as well, which may lead to greater patient and staff satisfaction.

Finally, there is a growing body of literature (Rumschik & Appel, 2019; Zubera, Raza, Holaday, & Aggarwal, 2015) investigating malingering in PES. Malingering is intentionally fabricating or exaggerating symptoms to obtain external benefits (American Psychiatric Association, 2013) such as hospitalization or medication, and one study reports suspicion of malingering in 33% of patients (Rumschik & Appel, 2019). However, this study could not find evidence of malingering among the patients, which may simply indicate that this was not an issue in the local context under study. Instead, the included professions in this study highlighted the patients' suffering as well as the importance of understanding their subjective experiences, which was supported by other studies stressing the unavoidability and necessity of each visit as expressed by the patients (Vandyk et al., 2018; Wise-Harris et al., 2017).

Strengths and limitations

Certain limitations of the study should be considered. First, the care unit manager was involved in selecting the participants, both to ensure sufficient PES staffing and to achieve sample variation. However, it cannot be guaranteed that the care unit manager was free of any selection bias, which could threaten the confirmability of the study. Second, two informants had to withdraw from the focus group at the last minute and could not be replaced at short notice. As a result, the focus group participants were less representative than the individual interviewees in terms of gender and age. Third, the transferability of the findings may be limited due to their specific organizational and national contexts. Given the limited research in this field, the findings of the study have to be carefully handled when comparing the related yet different studies and contexts. It should also be acknowledged that the study added just one piece of the puzzle by considering the professionals' perspective; another piece ought to be added by conducting more qualitative studies involving the patients themselves. Other interesting future research could include an exploration of malingering of persons visiting emergency departments, since there is an obvious discrepancy between patients' subjectively experienced need for emergency care and the diagnosing and classification of non/-urgent symptoms and the constitution of an emergency by the healthcare professionals. Another important future research path could be the exploration of the experiences of encounters between professionals and patients at PES due to the varying and potentially differing perspectives of the involved parts.

A strength of the study is its use of "within-method triangulation," which allowed for increased trustworthiness and ensured data saturation (Guba, 1981; Thurmond, 2001). We have strived to increase credibility by interviewing different professions at PES and using a multidisciplinary focus group (Guba, 1981). Representative quotations in the "Results" section were used to increase transparency of the analysis process and authenticity of the results (Guba & Lincoln, 1994). Finally, to ensure transparency, the authors followed the consolidated criteria for reporting qualitative research (COREQ) (Tong, Sainsbury, & Craig, 2007) when planning and conducting the data collection as well as when writing the study.

Conclusions

As the underlying meaning of the text revealed in the theme, based on the healthcare professionals' perspective, persons who frequently use PES suffer from illness, unfavorable life circumstances, and inadequate care as a consequence of numerous needs related to loneliness, hopelessness, psychiatric symptoms, and the lack of cohesive care and support.

First, the study contributes to an in-depth understanding of the needs of persons who frequently visit PES by identifying and describing those needs from the professionals' perspective. The PES professionals acknowledge both the patients' short-term and long-term needs, yet they feel that they can only address the patients' short-term needs, while their long-term needs should be met by social care and support services. Second, the study contributes by identifying and describing the professionals' experiences of difficulties in addressing those needs. The professionals found that the social care and support services were in short supply, and that inadequate and inefficient services resulted in frequent visits and telephone calls to PES. To reverse this negative spiral, sustainable support may be required that provides improved coordination and continuity of care and support for the patients. Instead of the patients seeking care and support from numerous and fragmented healthcare and social services, a sustainable service function should be provided that integrates the various healthcare, social, and support services. This in turn would apply a more holistic, person-centered approach to addressing all the needs of the patients.

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Notes

1. In this context, resident physicians are physicians who are undergoing specialization training in psychiatry.
2. Quotations include all professions, but to preserve anonymity they are not disclosed.

Disclosure statement

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ORCID

Manuela Schmidt http://orcid.org/0000-0002-3113-6432
Pernilla Garmy http://orcid.org/0000-0003-1643-0171
Sigrid Stjernswärd http://orcid.org/0000-0002-7152-9206
Ann-Christin Janlöv http://orcid.org/0000-0002-2795-1899

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Paper IV

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Article

Encounters with Persons Who Frequently Use Psychiatric Emergency Services: Healthcare Professionals' Views

Manuela Schmidt [1,2,*], Sigrid Stjernswärd [2], Pernilla Garmy [1,2] and Ann-Christin Janlöv [1]

[1] Faculty of Health Science, Kristianstad University, 291 88 Kristianstad, Sweden; pernilla.garmy@hkr.se (P.G.); ann-christin.janlov@hkr.se (A.-C.J.)
[2] Department of Health Sciences, Lund University, 221 00 Lund, Sweden; sigrid.stjernsward@med.lu.se
* Correspondence: manuela.schmidt@hkr.se; Tel.: +46-44-250-3212

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Abstract: Encounters and interactions between healthcare professionals and patients are central in healthcare services and delivery. Encountering persons who frequently use psychiatric emergency services (PES), a complex patient group in a complex context, may be particularly challenging for healthcare professionals. The aim of the study was to explore healthcare professionals' experiences of such encounters. Data were collected via individual interviews (N = 19) and a focus group interview with healthcare professionals consisting of psychiatric nurses, assistant nurses, and physicians. The data were analyzed with qualitative content analysis. This study focused on the latent content of the interview data to gain a rich understanding of the professionals' experiences of the encounters. Two themes were identified: "Nurturing the encounter with oneself and colleagues for continuous, professional improvement" and "Striving for a meaningful connection with the patient". The professionals experienced their encounters with persons who frequently use PES as caring, professional, and humane processes. Prerequisites to those encounters were knowing and understanding oneself, having self-acceptance and self-compassion, and working within person-centered cultures and care environments.

Keywords: caring; content analysis; emergency care; encounter; experiences; interpersonal communication; person-centeredness; mental health nursing; therapeutic relationships

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1. Introduction

Encounters and its interaction between healthcare professionals and patients are central in mental healthcare services and delivery [1,2], and important across all patient groups and healthcare settings. However, what constitutes an encounter remains difficult to define [3,4], mainly because different context-specific attributes highlight different important factors in the interaction. Encounters grow in difficulty with the growing complexity of the people seeking care, their needs, and the context. Thus, encounters with persons who frequently use psychiatric emergency services (PES), a complex patient group in a complex context [5], may be particularly challenging for healthcare professionals. Understanding how healthcare professionals experience such encounters could contribute to increased awareness about their own attitudes and preconceptions and to improved understanding of the patients' situation and needs.

Background

The quality of encounters and its interactions between healthcare professionals and patients has a profound impact on healthcare outcomes, patients' experiences of healthcare services, and patient satisfaction with care [6–8]. Since any encounter between a healthcare professional and a patient is characterized by power imbalance, asymmetry, and differences in expectations [3,6,9], healthcare professionals ought to be aware of how they encounter the patients.

In healthcare literature, the concept of "encounter" is referred to in different ways, such as interpersonal interactions, relationships, professional communication, meetings, or dialogues, and these are often used synonymously [3]. In the psychiatric context, the term therapeutic relationship or alliance is commonly used [10]. In the healthcare context, some view an encounter as the same as an interaction [3,11], others see it as a special human-to-human relationship [12] or interpersonal process [1], and still others focus on particular kinds of encounters, such as caring, uncaring, or meaningful encounters [2,13–16]. We chose to apply a broad definition in this study to capture as many dimensions as possible of healthcare professionals' experiences of encounters: direct interactions and interplay between healthcare professionals and patients including diagnosing, evaluating, and treating the patient's healthcare needs and any other kind of being and acting around the patient, including the actions, thoughts, and feelings of both involved parties. Those encounters can vary widely in duration and can include the use of information and communication technologies such as telephones, i.e., an encounter can also be faceless. Encounters also include *how* healthcare professionals encounter patients, i.e., how they behave based on their own attitudes and preconceptions.

Healthcare professionals identified "listening", "empathy", and "understanding the subjective experience of the patients" as important interpersonal skills in an acute psychiatric healthcare setting [17] and essential to establishing meaningful and caring interactions with patients. However, the healthcare professionals who participated in that study also felt pessimistic about persons who frequently visited acute psychiatric care settings [17]. Other healthcare professionals were tired of encountering revisiting patients who suffered from mental illness [18] or described such patients as difficult, hard to treat and not benefiting from psychiatric interventions [5,19,20], which would inevitably have an impact on those patients' care.

Persons who frequently use PES may be particularly challenging to encounter as not every encounter may be entered voluntarily by the patients. Police involvement, compulsory treatments, or violent patient behavior could complicate establishing interpersonal interactions and caring encounters. The hectic, stressful, and unpredictable nature of PES may make encountering those patients more challenging [21] and might result in superficial or shallow nursing care [14,22], focused on tasks and administration at the expense of developing interpersonal interactions and person-centered relationships [23]. A literature review of nurses' experiences of delivering care in acute mental care settings revealed that nurses constantly had to balance competing perspectives and conflicting tasks concerning safety, risk assessment, enforcement of treatment, advocacy, and mitigating power with recovery-oriented care, autonomy, and the promotion of patients' rights [23]. Conversely, a study of the experiences of persons with mental illness in need for acute care showed that caring experiences and understanding of their emotional vulnerability were lacking, and the patients felt judged and stigmatized by healthcare professionals [24]. In another study, patients in an acute psychiatric care unit reported receiving care and support from other patients, not healthcare professionals [25].

Caring encounters have been identified by both professionals and patients in Sweden as central need among persons who frequently use PES [26,27]. Not only are those encounters important for identifying patients' healthcare needs [3], but they also become a goal or intervention in themselves meeting patients' human needs such as being confirmed as a person. Providing good encounters within the healthcare system is required by Swedish legislation, local directives, and policies [28–30]. Good encounters are based on respect for all human beings, enhancing the patient's dignity, autonomy, and integrity, and building a trustful and caring relationship.

Because the healthcare professionals are those responsible for establishing, initiating, and inviting patients to encounters, it is important to understand their perspectives on this situation. The aim of the study was to explore healthcare professionals' experiences of encounters with persons who frequently use PES.

2. Method

This study employs a qualitative design due to the study's exploratory nature and focus on human experiences. Hereafter, persons who frequently use PES are referred to as patients and healthcare professionals as professionals.

2.1. Context

Data were collected at one PES in southern Sweden, comprising a psychiatric emergency department and an acute psychiatric care unit. It covers a catchment population of about 200,000 inhabitants of both rural and urban areas. The PES operates 24 h day/7 days a week. Telephone counselling is a well-integrated and common part of the work of the PES.

2.2. Participants

The participants represented different professions working at the PES including assistant nurses, registered nurses with specialized education in psychiatry, and intern and resident physicians. Potential participants were informed of the study by the first author through workplace meetings, a video recorded by the first author, and an information email about the study's aim, data collection methods, and their right to refuse participation. A purposeful sampling approach was applied to secure sample variation among participants in terms of age, gender, profession, work experience, and cultural background. In total, 21 professionals were asked to participate in the study; 2 declined, thus the final sample was 19 participants. A detailed description of the participants can be found in Appendix A.

2.3. Data Collection

2.3.1. Individual Interviews

Data were collected in individual interviews with 19 professionals during October and November 2018. The semi-structured interview guide contained questions about the professionals' experiences of the encounters with the patients as shown in Table 1. The individual interviews were conducted by the first author and lasted an average of 51 min (range, 27–86 min). Two pilot interviews, conducted by the first and last authors, were included in the analysis.

Table 1. Interview guide with main questions for the individual interviews.

Introduction: This interview focuses on your experiences of persons who frequently use PES. Within research, they can be defined in different ways, for example, with a minimum of 4, 5, or 6 contacts within 12 months. This study focuses on your individual experiences on who persons who frequently use PES are. Have you cared for persons who frequently use PES?
Transition questions: What are your thoughts about persons who frequently use PES and their visits? Could you describe your experiences of the encounters with them?
Main questions: How do you encounter persons who frequently use PES (visit or call in)? Can you describe examples of an encounter that you felt satisfied with/experienced as challenging? Why? In what way, if at all, do you encounter persons who frequently use PES differently from other persons? Why do you think that is? In what way, if at all, do you adjust your encounter with them? Why do you think that is? How do you communicate with persons who frequently use PES? How do you create a trustworthy and safe environment for these persons? What emotions does the encounter with persons who frequently use PES trigger in you? Can you describe an example of an encounter that triggered positive/negative emotions? How do you handle those emotions?
Closing questions: Is there anything I have not asked that you would like to add? Can I get back to you if I have any further questions? Would you be interested in participating in a focus group interview? Summary

2.3.2. Focus Group Interview

Of the 19 professionals who participated in the individual interviews, 6 were purposefully selected based on age, gender, profession, and work experience to participate in a focus group interview in May 2019. The focus group provided an important complementary data set as it allowed for deeper exploration of differences of experiences narrated during the individual interviews. The focus group guide was constructed by dividing preliminary results from the individual interviews into five domains: equal treatment for everybody, encounter adjustment, hindrances and facilitators in encounters, the role of the professional, and emotions. The focus group interview was conducted by the first and last authors and lasted 90 min. All interviews were conducted during working hours at the participants' workplace.

Within-method triangulation allowed a more comprehensive picture of the results, and thus a clearer and deeper understanding of the phenomenon [31], and it increased the trustworthiness of the study [32]. All interviews were audio recorded and transcribed verbatim.

2.4. Analysis

The transcribed texts were analyzed with qualitative content analysis based on Graneheim and Lundman [33], which has been useful in nursing and health sciences as it emphasizes the analysis of experiences, perceptions, and attitudes. This study focused on the latent content, making it possible to understand the phenomenon through interpreting the professionals' experiences. The analysis was carried out inductively, i.e., the themes emerged from the data and were thus text-driven [34]. The analysis followed a systematic two-stage process. Stage 1 consisted of several steps: (1) identifying relevant text passages from the individual interviews and forming them into a single text about participants' experiences of encounters with patients, the unit of analysis; (2) reading this text several times to gain a sense of the whole; (3) dividing the text into meaning units; (4) condensing the meaning units into descriptions close to the text considering the context and the aim of the study, and then into interpretations of the condensed meaning units; (5) abstracting the interpreted meaning units into sub-themes which were compared for differences and similarities; and (6) finally formulating the preliminary themes that were used in the focus group guide. Examples of the analysis process and development of the sub-themes can be found in Appendix B.

After the focus group interview, the analysis process continued to Stage 2, analyzing the text from the focus group interview according to steps 2 to 6, which largely confirmed the preliminary results of the individual interviews. The group interactions between the focus group participants revealed consensus among them. The analysis was circular and moved back and forth between the parts and the whole of the text and between the analysis steps [33]. Initially, 20 sub-themes were abstracted through individual and joint discussions among the first, third, and fourth authors. The sub-themes were then aggregated into 11 sub-themes and 2 themes. Thereafter, the second author entered the analysis process by reflecting individually upon the preliminary results, which were then once more discussed by all authors until consensus was reached. The final results consist of 10 sub-themes and 2 themes.

The study was conducted in accordance with the Declaration of Helsinki [35]. The Regional Ethical Review Board found no obstacles to conducting the study (2018/569).

3. Results

The interpretation of the text revealed that professionals experienced encounters with patients, i.e., persons who frequently used PES, as situations in which they aimed to treat all patients equally, with ethical consideration, and in line with human values. The study showed that each patient was acknowledged as any other user of the healthcare system and as a fellow human being who was unique. Each encounter was seen as individual and was conducted with as much respect, kindness, humility, confirmation, and empowerment possible and was adjusted to the patients' healthcare and human needs. The study also showed that professionals thought it was equally important to have a non-judgmental and open-minded attitude towards the patients, which allowed them to meet the patients without preconceptions. The study further revealed that professionals also attempted to reset before each encounter and not allow previous difficult encounters to influence their current and/or future encounters with this patient. This way, the professionals experienced each encounter with the patient as the first and focused on the current encounter in the here and now.

3.1. Structure of the Themes

Two themes emerged from the analysis process. Each theme included several sub-themes, as shown in Table 2. Quotes were chosen to exemplify the themes.

Table 2. Summary of the results of the analysis process in form of sub-themes and themes revealing the professionals' experiences of the encounter with the patients.

Sub-Themes	Themes
Allowing for constant learning from experience Balancing one's emotions Being self-insightful Using critical thinking Finding support in colleagues and managers	Nurturing the encounter with oneself and colleagues for continuous, professional improvement
Becoming a chameleon Working with hope and laughter Seeing the person Mastering the art of interaction Being content with just an encounter	Striving for a meaningful connection with the patient

3.2. Nurturing the Encounter with Myself and Colleagues for Continuous, Professional Improvement

Encounters with persons who frequently use PES required highly professional behavior from the participants. The relationship with oneself and with colleagues played an essential role and was a precondition for good patient encounters and for their own learning process, level of professionalism and well-being.

Allowing for constant learning from experience. Professionals learnt from their numerous experiences of encounters with patients by assessing, analyzing, and sorting them into groups of similar encounters. This way they became familiar and routinized with any possible situation in patient encounters and could eventually rely on their experiences to interact intuitively and naturally with the patients.

> *"And then what happens is that after a while once you've met—as you have the advantage of doing a lot in an emergency department—you get to meet a lot of different people and you add it all to your bank of experience, and sometimes it doesn't always work out right and then you have to work through it and evaluate it, and then next time it will work out. So that, yeah, it's like you build up this bank of experience. Then again, you're not going to be perfect in every encounter—it's a matter of... continuous new learning."* (interview 6)

Even though the professionals acknowledged that their education provided a solid base encountering patients well and remaining professional, they also felt that how to interact with patients in the encounter could not be learnt from books, but only by doing in practice. They admitted that this was a learning process that new employees needed to undertake to become skilled. All professions included in the study showed strong interest in continuing to attend courses and learn more.

Balancing one's emotions. Not showing all their own emotions was necessary to maintain a professional approach during the encounters, to avoid burdening the patients, and to keep the focus on the subjective experience of the patient. However, keeping emotions in check was described as a balancing act. On the one hand, professionals described trying to be neutral, rather quiet, and not too eager, yet on the other, it was also important to show empathy, acceptance, and understanding to connect with the patient. Keeping a certain distance could be helpful in not getting overwhelmed by the difficult life situation of the patients. Keeping a professional distance was not mentioned exclusively by the physicians, but was generally more important to them. The distance also enabled the professionals to prepare for unexpected behaviors during the encounter. Despite knowing the patients, often for many years, professionals could not anticipate patients' reactions and behavior in the most acute encounters. However, when the situation and the patient were calmer, the professionals could rely on their alliance with the patients.

Yet another reason to try not to show certain emotions, feelings, or thoughts was that the professionals experienced the patients as very skilled readers of facial expressions, able to catch their moods or feel their preconceptions. Despite their acute health conditions and suffering, the patients were seen as attentive to the professionals' behavior and able to perceive fatigue, tiredness, irritation, or fear.

Being self-insightful. The professionals understood that they were also "just" human, and mistakes could occur during encounters with the patients. However, they were self-aware, accepted their own limitations, and reflected upon wrong assessments or misjudged situations to learn and improve as professionals. Understanding one's own limits was seen as showing a high level of professionalism. When they were uncomfortable or feeling provoked in an encounter, they acted professionally by acknowledging those feelings and, early on, asking a colleague to take over when possible.

> *"A: I also think about how... certain patients are of course provoking... and they can certainly provoke me.*
>
> *B: Mm-hmm.*
>
> *A: So, it's like I have a hard time with some patients' behaviors. To be sufficiently professional, you can go to a colleague and say, 'Can you please take over here'.*
>
> *C: Mm-hmm.*
>
> *A: Because it's never helpful to continue with something when I have the feeling that this... we're never going to get any alliance with one another.*
>
> *B: Mm-hmm.*
>
> *A: So that, too, I think, is part of what it means to be professional.*
>
> *B: Yes." (FG)*

The professionals remained true to themselves in the encounters, while retaining a professional work role. They understood that this was necessary for them to have genuine encounters with their patients. If their own identity and professional role were too far away from each other (i.e., if they felt they had to pretend emotions or behaviors), they worried that they would not have the energy to cope with work in a long-term perspective.

> *"A: And I also think if I'm not being myself in the encounter, it won't be genuine. It won't be good for either party. It wouldn't feel good for me if I were someone else. I don't think I would have been able to stand it.*
>
> *B: No, I don't think so either, and it wouldn't feel real to the patient either if I were to try to play some sort of role. No, I have to be myself—but obviously also I have to, in some way... as you say, we have to... what we've been saying about being professional." (FG)*

The professionals were also aware their individual personalities could not be changed and could affect the encounter. They also emphasized the importance of personal chemistry, which could help them have a good encounter and establish a better rapport. They viewed it as professional to acknowledge, allow, and accept those kinds of personal preferences.

Using critical thinking. Reflecting upon and re-evaluating encounters with patients and being self-critical were central elements in the professionals' work. This demanded continuous use of their mental capacities, and the professionals could feel mentally tired from the constant mental activity required by encounters with their patients. They reflected on their own actions and thoughts, their work environment, and the patients and their everyday lives and contacts with other support services. While establishing relationships was also seen as important in somatic care, professionals in psychiatric care could often rely on only themselves and their experience, and did not have additional instruments, markers, and tools available to those assessing physical problems.

Finding support in colleagues and managers. Reliable colleagues and supportive managers were seen as resources for providing good encounters. The professionals expressed their need for a good work climate that fosters open dialogue across professions, teamwork and trustful relationships with colleagues, and professional (or clinical) supervision to help encounter their patients well. The professionals expressed that those needs were largely met at PES. All professions praised other professions for their competence, openness, support, and willingness to help and learn, which nurtured both inter- and intra-professional processes for mutual learning. Sometimes staff shortages, the administrative workload among nurses and physicians, and the heavy organizational structures of the healthcare system were mentioned as factors complicating encounters with the patients.

Colleagues also played an important role in handling each other's emotions. While certain feelings were not shown to patients, they were often expressed among colleagues. Feelings of powerlessness, dejection, resignation, hopelessness, or disappointment when persons with frequent PES use did not improve despite years of personal investments from the professionals' side were regularly experienced among the professionals.

> *"B: Yes... certainly I do have a sense of hopelessness sometimes. If you've known someone for 13 years and it never gets... it's the same story every time... despite multiple interventions from the municipality, the county council, and various other entities, it does lead to a sense of... hopelessness, for sure. And... disappointment. Sometimes I think I've given so much, I give so much, and it all still goes to hell... [laughs]... for the patient.*
>
> *A: Mm-hmm. Are you disappointed in the patient?*
>
> *B: No... yes... maybe... The patient... of course I've found myself feeling disappointed in the patient, too. Yes. I have to be honest and definitely say that." (interview 8)*

Colleagues were an important source of information and second opinion and were used for guidance and support in the absence of objective measures.

3.3. Striving for a Meaningful Connection with the Patient

The professionals experienced the encounter as an opportunity to establish contact or connection with patients. Becoming a chameleon, hope and laughter, seeing the person, and mastering the art of interaction helped to create this connection. However, the professionals were also aware that they did not always connect with the patient and they accepted that.

Becoming a chameleon. The professionals learnt to adjust, to become what the patients needed them to be, and to encounter them on the appropriate level: soft and calm, direct and decisive, or physically close or more distanced. They also intuitively adjusted their body position, hand placement, their voice, and the voice pitch etc. Prior to the tuning, a quick assessment was made at the beginning of the encounter, where many factors were considered and analyzed. The professionals were primarily interested in meeting the person and his or her healthcare and human needs; however, knowing the diagnoses of the patients could be helpful, as could knowledge about the cultural and ethnic background of the patient. Also, one's own current position in terms of prejudices, tiredness or frustration were considered, as were situational aspects, for example, the current situation of the waiting room or the time of the day. The professionals tuned their encounter based on this initial assessment and the knowledge from previous encounters. After having gained experiences in encountering the patients, the professionals could allow themselves to *feel* the right responses and trust their senses, which were safely embedded in those previous experiences.

Working with hope and laughter. The professionals tried to provide hope, which had a particular central role in the encounter with the patients, who often could have lost hope. The professionals understood the power of providing a sense of hope for the patients because hope had a future outlook. Another very powerful tool in the encounter was humor. The professionals showed awareness, similar to their sensitivity regarding physical contact, that humor is situation- and person-dependent. As in the case of physical contact, the professionals used their experience and knew, felt, and sensed when it was appropriate to be funny and with whom. The professionals thought that laughter could be useful in strengthening the patient–staff relationship and helped professionals and patients feel connected with each other, which was the essence of a good encounter.

Seeing the person. The professionals saw each encounter as individual. However, encounters with the patients, i.e., persons with frequent PES use, differed from encounters with unknown patients. With known patients, the first part of the encounter was experienced as comparatively easy, flexible, and free since the professionals were knowledgeable about the patients, their previous treatments and outcomes, and the patients' preferences and personalities. Physical contact was one particular example that required a close alliance with the patients and was not experimented on with unfamiliar patients. The knowledge gained from previous encounters allowed for closeness and familiarity that helped the professionals connect with the patients. It also allowed other non–disease-related conversations, letting the professionals discover the patient as a whole.

> *"But yes, still, the patients who show up five times a week, or 10 times a week—I'm still going to go over and greet them, take their hand, welcome them. I think it's extremely important that we do that. That we... that we... that we see the person, regardless of whether it's a matter of addiction or personality disturbance or psychosis or whatever—that we still see the person as a human being and support who they are." (interview 9)*

The professionals also stressed the importance of seeing the person as a fellow human being who had more than just psychiatric and healthcare needs, but also human needs, such as being confirmed and empowered. The professionals found several ways to affirm the persons with frequent PES use as fellow humans being during the encounters, with small gestures such as sitting next to instead of opposite the patient, a touch, eye contact in most cases, using the person's name and talking about other parts of the patient's life than disease. Being personal with the patients was thus, for many professionals, a rather common action. It was also a way to build trust and help the patient feel at ease and secure enough to open up about their lives and problems.

> *"And sometimes the fact that... that it's like... as I say, I don't go into private matters, but I can still be personal—I don't need to... and then I've understood, that goes down well." (interview 5)*

Giving room in the encounter for the patients and their stories, expectations, wishes, and needs was crucial for the professionals. The professionals also tried to confirm the patients' decision to visit and they viewed welcoming and inviting the patient into the encounter as an investment that counteracted possible feelings of shame in patients who could still have difficulty using PES despite frequent use. The professionals showed mutuality by, for example, sitting down during the encounter instead of hovering over the patient.

Mastering the art of interaction. The conversation was one way of interacting to build connection with the patients, yet it was not always needed. For some patients, the professionals felt that being physically close or sharing an emotional and human connection was more important than having a conversation. There could be a meaningful and bonding experience in silence. Other patients, the professionals thought, had a strong need to conversation and be listened to. For those patients, conversations were seen as therapeutic and the professionals experienced those conversations as just as important in many cases as providing medication or other formal interventions.

To genuinely engage in a conversation, the professionals found it helpful to be present and not stressed and to allow sufficient time. Taking time showed respect and built trust. However, the time aspect was not seen as a general prerequisite to a good encounter. Connections between patients and professionals could also be established quickly or last only a few moments if there was mutual trust.

The conversation was, however, the most important part of the encounter for the professionals to diagnose and treat patients correctly. Establishing interpersonal connections built trust and made it easier to hold conversations in which patients felt ready to share their innermost thoughts, feelings, and fears. The professionals were careful not to interrupt and to let the patients decide the pace of the conversation. They tried to keep a clear, calm, and quiet tone of voice.

Conversing with the patients was experienced as an art that needed to be mastered and included skills on several spectra: from listening to talking, from being cautious to being active, from daring to ask questions and be direct to backing, coaxing and encouraging, or from steering the conversation, as several physicians described, to letting it flow loosely, as nurses did by inviting patients to open the conversation with what felt important for them. Those circular processes showed the interaction as a two-person dance requiring sensibility, responsiveness, and reciprocal skills. The professionals always tried to maintain a sense of mutuality, including mutual learning, in the conversation.

Phone conversations were experienced as more difficult than face-to-face conversations because the professionals lacked clues such as the patient's body language and facial expressions. In such circumstances, it was thought helpful to have met the patients previously. As in a face-to-face conversation, coaxing could play an important role in building a dialogue, and attention was also paid to those things that were left out of the patient's story. In a telephone conversation, the professionals stressed the importance of listening somewhat more carefully since there were no other cues than the patient's story and voice.

Being content with just an encounter. Certain conditions such as violence, coercion, involvement of police, or patient anger could make the encounter more challenging. However, despite those obstacles, which were initially experienced as challenging and time-demanding, the professionals understood that each encounter had the potential to become good and meaningful for the patient. They thought that despite previous *uncaring* encounters or not meeting the patients' expectations, wishes, or needs, the patients could still experience the current encounter as good and caring. However, the professionals also met patients with whom, due to lack of receptiveness or understanding from either party, they could not connect. Such encounters, however, were also characterized by respect, humility, and kindness. The professionals experienced them not necessarily as bad encounters, but simply as *just* encounters.

> *"But obviously there are times when you encounter people whom you don't... You simply don't understand one another. You may speak the same language—Swedish—but you... somehow, you cannot meet. I don't know if this has so much to do with the actual diagnosis. Sometimes maybe it does; but sometimes... It doesn't always." (interview 2)*

They accept that they were not always able to make a connection with the patient instead of blaming themselves or viewing themselves as failing. They saw the encounter as a mutual process. Although they felt responsible for initiating the interaction, establishing trust, and building a non-judgmental and respectful foundation, they recognized that it required 2 parties to get involved, make a connection, and interact successfully.

The professionals stressed that only the patients could decide the quality of the encounter. Encounters professionals had forgotten could sometimes be mentioned later by patients as having been life changing, while encounters in which the professionals tried their hardest could be reported by the patients as meaningless.

4. Discussion

This study explored healthcare professionals' experiences of encounters with persons who frequently use PES. The results show that the professionals experience these encounter as having both strongly caring and professional elements. These findings resonate with previous findings from other healthcare contexts, raising the importance of caring encounters and describing them with attributes such as "being there", "uniqueness", and "mutuality" [3]. Another study about caring encounters described the core aspects of professional caring as "being dedicated", "being morally responsible", "being truly present", "being genuinely concerned", and "being open" [13]. Those caring encounters included caring and connecting processes, developing a professional intimacy characterized by respect and compassion while maintaining a professional distance [13]. This study confirms that professionalism and caring as tightly intertwined rather than conflicting elements in encounters with persons with frequent PES use. Other research describes caring and nursing in emergency and psychiatric acute care settings as rather technical and shallow [14,22,23] and encounters with persons with mental illness as generally challenging [21]. However, in this study, professionals described providing caring interactions as meeting the person as an individual and fellow human being by becoming a chameleon and tuning in to the patients, allowing themselves to become what the patient needed them to be. Mutuality, respect, presence in the here and now, and a non-judgmental approach facilitated this caring encounter. Encountering caring healthcare professionals in acute healthcare contexts has been found to be a predictor of patient satisfaction [36]. Studies from Swedish PES found that from a professional's perspective caring encounters were an empathetic and humane way to interact with the patient [27], while from a frequent visitor's perspective they involved being cared for, being understood, feeling welcomed, and being treated with kindness, humanity and fairness [26]. This study is in strong agreement with those findings emphasizing the humane element of the encounter. Applying a person-centered approach in the encounter with persons who frequently use PES and paying attention to their personal stories and experiences can facilitate their recovery [37]. Hope, a positive outlook, and the concept of "power with" rather than "power over" need to be acknowledged to counter the asymmetric relationship between patients and healthcare professionals to empower persons who frequently use PES [37].

Another finding of the study is the professionals' experience of humility and maturity in patient encounters. Despite their substantial knowledge of their patients, the professionals showed high levels of self-insight, self-awareness, and self-criticism by continuously re-evaluating and reflecting upon their preconceptions, prejudices, preferences, or difficulties that could have an impact on the upcoming interaction with the patient. This behavior is well in line with the concept of *therapeutic use of self* [12], which requires comprehensive self-understanding of one's own feelings, values, needs, motivations, and limitations first in order to understand patients and promote their growth and health [1]. The professionals in this study acknowledged and accepted their own limitations and their fallibility as human beings. By accepting patients for who they are while also accepting themselves, the professionals highlighted the humanistic and humble aspects of the encounter. These aspects included both compassion and self-compassion; the professionals understood the importance of caring for and with the patients, but also caring for themselves. The professionals' honest account of critically and collectively reflecting upon their limitations, mistakes, and dislikes, and their admission of occasional mental fatigue reveals and confirms their self-awareness, self-acceptance, and self-compassion [38]. Mindfulness interventions for emotionally and mentally drained mental health professionals have been shown to significantly increase self-compassion [39]. Care as a component of compassion [40] allows professionals to be mindful of their patients' painful feelings without over-identifying and helps them to stay balanced, feel well, and have caring and professional encounters with their patients.

Finally, the results revealed the importance of colleagues, managers, and the working climate in providing caring, professional, and humane encounters. Professionals paid attention and care to their relationships not only with patients and themselves, but also with their colleagues, to create and be part of an enriching work environment. A positive, well-functioning, and satisfying workplace is a prerequisite to good encounters at PES. All interviewed professionals had common moral values and work ethics that facilitated a person-centered approach that was reflected in their encounters with patients. The importance of teamwork [41], including both smaller multidisciplinary teams and the whole organization [42], to the encounter and its interactions in psychiatric acute care is confirmed by the results of this study. Person-centered services empowering patients in their recovery processes are more likely to be facilitated when *person-centered cultures* are provided [43]. Those cultures are formed by the *care environment*, which comprises professional relationships, supportive organizational systems, and leadership, and a common set of values among the different professions [43,44]. To enable person-centered processes in encounters between healthcare professionals and patients, the same person-centered values, attitudes, and processes need to permeate the workplace's physical, organizational and social structures [44].

Even though the infrastructure and organization of acute psychiatric care, as well as educational requirements of staff, vary across settings and contexts, the nature of PES, being an intensive, demanding, and unpredictable workplace, remains universal [5,19]. The challenges reported by healthcare professionals in acute psychiatric care from different studies are alike. They focus on increased use rates and increased workloads combined with staff shortage and limited resources, increased work stress, and unsupportive organizational cultures, loss of professional identity and unethical behaviors [19,23,45]. Thus, the clinical implications of this study for mental health nursing are particularly highlighted. To provide caring, professional, and humane encounters and interactions with persons who frequently use PES, it is necessary to recruit competent professionals who are self-aware and self-critical. Another prerequisite is that the work environment at PES is enriching, open, and supportive of professionals, including their relationships with colleagues and management. Because professionals could sometimes become mentally exhausted from constant thinking and responding in the moment, the organization should provide sufficient staffing and space for staff recovery. An important aspect of facilitating staff recovery is clinical supervision. This would not only give the professionals an opportunity to express their emotions (positive and negative) and to reflect upon themselves, their patients, and related processes or situations, but could also strengthen social structures and relationships at the workplace. PES is a particularly stressful work environment, and can be emotionally and mentally exhausting for healthcare professionals, particularly when encountering persons who frequently use PES. Routine mindfulness and self-compassion interventions could counter those processes. Finally, professionals at PES often work inter- and intra-professionally. As patients frequently encounter professionals with different professions, good communication among all involved professionals are valuable in helping both professionals and patients experience their encounters as meaningful.

To ensure trustworthiness of the findings, the authors took measures appropriate for content analysis according to Lincoln and Guba [46] as recommended by Granheim et al. [47] and followed the Consolidated criteria for reporting qualitative research (COREQ) [48]. Providing example quotes and showing parts of the analysis process helps readers judge the credibility and authenticity of the findings which could otherwise be difficult as the text always carries multiple meanings and is interpreted based on the authors' pre-understandings. Because the authors have varying pre-understandings and interpretative ranges, to address dependability all four authors were involved in the analysis, which was finalized when they reached consensus. The readers' ability to judge transferability was facilitated by (1) describing contexts, demographics, and professions in the introduction and method sections, and (2) emphasizing in the results and the discussion sections the positive working culture that deemed essential to good encounters and interactions between professionals and patients. *Within-method triangulation* was used to address credibility. Using individual interviews first and then conducting a focus group interview made it possible in the focus group interview to present preliminary results, which were confirmed and deepened by discussions across professions that clarified and highlighted conflicting experiences among the professionals.

5. Conclusions

The findings suggest that healthcare professionals at PES experience encounters with persons who frequently use PES as revealing caring, professional, and humane processes. To provide such encounters to patients, professionals need to nurture their relationships with themselves and their colleagues. Self-awareness, self-acceptance, and self-compassion were important elements in this process and required constant critical thinking and learning that could lead to mental tiredness. Each encounter was equally characterized by humility, respect, and kindness, and was highly individual. Professionals tuned in to each patient's individuality and needs and tried to see the patient as a fellow human being. The person-centered approach in patient encounters was mirrored in the care environment at PES, which provided reliable inter- and intra-professional teamwork and supportive managers. Thus, a person-centered care environment was a prerequisite to providing caring, professional, and humane encounters. To our knowledge, this is the first study to explore healthcare professionals' experiences of persons who frequently use PES, including faceless encounters by telephone, which were experienced as more challenging than face-to-face encounters. More knowledge is needed to provide guidance to healthcare professionals to ensure good quality encounters for patients.

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Appendix A

Table A1. Participants.

	Individual Interviews (n = 19)	Focus Group (n = 1)
Gender		
Men	6	3
Women	13	3
Age m (range)	47 (29–70)	48 (30–69)
Professions		
Assistant Nurse	3 (13–17) *	1
Registered Nurse	10 (1–40) *	4
Intern Physician	2 (−) *	0
Resident Physician	4 (1–4) *	1
Country of Birth		
Sweden	15	6
Other	4	0

* Range in years of professionals' experience of working at a PES.

Appendix B

Table A2. Examples of the analysis process and development of the sub-themes and themes.

Example of Meaning Unit	Condensed Meaning Unit-Description	Condensed Meaning Unit-Interpretation	Sub-Theme	Theme
No doubt it's... experience is part of it, plus... Yes, I think it has to do with experience too—that you've experienced similar situations before, that you recognize certain patterns... and so on—but not always. Sometimes it doesn't help. (interview 13)	Experience is part of it: you've experienced similar situations and you recognize certain patterns. Sometimes it helps, sometimes not.	Finding patterns in encounters	Allowing for constant learning from experiences	Nurturing the encounter with oneself and colleagues for continuous, professional improvement
I try not to show (my frustration). Then of course it sometimes happens that you... but I actually try not to do that. I hope not, because... it's like I said before, that they can tell if you... They notice things very, very well... (interview 3)	I try not to show (my frustration). They can tell, they notice a lot of things.	Keeping emotions in check	Balancing one's emotions	
Probably the first thing is just to be able to acknowledge to yourself that this is actually not going to work—like 'Maybe I'm really having trouble connecting with this person'. Or 'It's triggering something in me that's making me kind of uncomfortable'. (interview 6)	The first thing is to acknowledge to yourself that this is actually not going to work—'I'm having trouble connecting with this person'.	Seeing one's own limitations	Being self-insightful	
A: ... because, well, this job requires a lot of energy—mental energyy—because every person who calls wants something from me—emotionally, usually, of course. *B. Mm-hmm.* *A: And then, obviously, you get kind of drained, you know. Everyone has their bucket... how should I put it?...their bucket of energy—how much involvement you can stand.* *B: Mm-hmm.* *A: But that's no doubt something you just have to learn, I think—otherwise you're likely to... you'll get too involved and you won't have the energy for it.* *C: Mm-hmm.* *A: Then again, we have each other to go and vent to.* *B: That's . . . that's an important part afterwards . . . (FG)*	Patient encounters take a lot of energy and leave you drained. Each person has to learn how far they can go in getting involved, how much they have the energy for. We do have one another to vent to afterwards—that's important.	Reflecting on work and encounters Acknowledging the importance of colleagues	Using critical thinking Finding support in colleagues and managers	

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