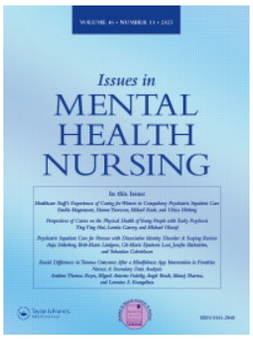

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Facilitators of Change: Mental Health Staff's Role in a Lifestyle Programme in Psychiatric Outpatient Care in Northern Sweden

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ABSTRACT

Individuals living with mental disorders are at heightened risk of lifestyle-related health problems and premature mortality. Lifestyle programmes with both individual support and group interactions with a person-centred focus in outpatient psychiatric care may help mitigate these risks. However, mental health staff's experiences of implementing such programmes remain underexplored. The aim of this study was to explore the experiences of mental health staff in facilitating a person-centred lifestyle programme within psychiatric outpatient care. Using a descriptive qualitative design, 10 mental health staff educated to group leaders were interviewed in semi-structured formats following their delivery of a 12-session lifestyle programme. Data were analysed using qualitative content analysis. Three main categories emerged: *Programme planning and implementation*, *Programme content and structure,* and *A supportive relationship*. Subcategories addressed challenges, such as lack of preparation time, organisational barriers, and the need for programme adaptation. The findings suggest that aligning lifestyle programmes with person-centred care emphasising both empathy and structure can enhance participants' health while fostering professional fulfilment among staff. To ensure long-term sustainability, enhanced organisational support and integration into routine practice are recommended.

Introduction

It is well-known that individuals with mental disorders or neuropsychiatric disorders face a higher risk of poor health and premature death (Catalá-López et al., 2022; Peckham et al., 2023; Walker et al., 2015). Underlying factors of poor health may include modifiable lifestyle habits, such as smoking, alcohol consumption, physical inactivity, and low consumption of fruits and vegetables (Metse et al., 2021; Peckham et al., 2023). Additionally, contributing factors may include loneliness, social exclusion (Fan et al., 2024; Linz & Sturm, 2013), cognitive impairments (Culpepper et al., 2017; McCleery & Nuechterlein, 2019), and financial and social difficulties (Kirkbride et al., 2024; Nagasu et al., 2019).

The need for support with lifestyle changes for individuals with mental disorders is complex. Therefore, lifestyle programmes that is tailored to individual needs and include learning components for both mental health staff and persons with mental disorders may be a way to achieve lifestyle changes (Hawes et al., 2022). These programmes aim to improve both physical and mental health by promoting changes in diet, physical activity, sleep, and stress management. Evidence shows that such programmes may reduce symptoms of depression and anxiety, enhance quality of life, and may increase life expectancy in persons with mental disorders. Accordingly, these programmes are increasingly recommended as part of the regular psychiatric care (Çelik İnce & Partlak Günüşen, 2021; Correll et al., 2025; Fernández-Abascal et al., 2023; Gallagher et al., 2021; Manger, 2019).

Although lifestyle programmes may not yield immediate improvements, they may enhance individuals' awareness of their habits, with even small, incremental changes proving meaningful and rewarding (F. Walburg et al., 2022; F. S. Walburg et al., 2022). Mental health staff are well-suited to lead lifestyle programmes and may bridge the health gap, ensure necessary support, and improve overall health (Hartley et al., 2020). Even if the need for support may vary, practical group activities and active engagement from mental health staff are among the most beneficial components for individuals with mental disorders (F. Walburg et al., 2022; F. S. Walburg et al., 2022). It should also be noted that mental health staff own behaviours and attitudes towards lifestyle change influence the nature and quality of the lifestyle support provided to individuals with mental disorders. By acting as role models, they can inspire motivation and engagement, highlighting the importance of supporting staff in developing healthy practices themselves (Rosenbaum et al., 2020).

Lifestyle programmes, especially in a group format may provide a supportive environment are a notable approach to sustainable healthy lifestyle changes in individuals with mental disorders (Holt et al., 2019; Luciano et al., 2022). Previous research has highlighted the importance of social relationships,

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routines, physical activity, and cognitive support in achieving healthier lifestyle habits (Sharma et al., 2024).

Extensive research has demonstrated the health benefits of lifestyle programmes that may focus on one or more components, mostly within community-based or inpatient settings. These programmes have been associated with improvements in physical health, mental well-being, and reduced risk of comorbid conditions (Fernández-Abascal et al., 2023; Fernández-San-Martín et al., 2014). Although lifestyle programmes can be helpful, their long-term effects may be limited, and some participants may feel pressured (Schuch & Vancampfort, 2021). This highlights the need for more comprehensive support, especially since persons with mental disorders often have complex, unmet health needs and limited resources.

Indeed, our previous studies have highlighted the importance of collaborating to identify opportunities and adapt a lifestyle programme in clinical practice (Björk et al., 2020, 2021; Rönngren et al., 2024). Integrating lifestyle programmes that address physical, mental, and social wellbeing supports person-centred care by focusing on the whole individual and their unique needs. Central to this approach is building relationships, being present, and working collaboratively (McCance & McCormack, 2025). However, there is a notable gap in the literature regarding the implementation of such lifestyle programmes within outpatient psychiatric care that supports holistic lifestyle changes. This addresses multiple aspects of health, which includes physical, mental, and social well-being, and the role of mental health staff. To address this gap, the present study was conducted within outpatient psychiatric services in Northern Sweden. It was part of a regional initiative in collaboration with a university, aiming to implement a structured, group-based lifestyle programme grounded in person-centred care principles. The aim of this study was to explore the experiences of mental health staff in facilitating a person-centred lifestyle programme within psychiatric outpatient care.

Materials and methods

Study design

This study employed a descriptive approach within real-life contexts from the perspectives of those directly engaged in clinical psychiatric nursing (Sandelowski, 2000). Data collection was guided by the principles outlined by Kvale and Brinkmann (2009) and conducted by qualitative content analysis. To ensure transparency and reporting standards, the study followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines (Tong et al., 2007). All pertinent criteria related to study design, data analysis, and the researchers' roles were meticulously addressed.

Context

In Sweden, primary care providers manage mild to moderate mental disorders with medication and psychosocial support, while severe mental disorders (psychiatric conditions, such as schizophrenia, bipolar disorder, and major depressive disorder, that are associated with functional impairment) often are referred to specialist psychiatric services (Silfverhielm & Kamis-Gould, 2000). Specialist psychiatric services are provided at specialist clinics and community services, such as sheltered housing or housing support (Perera, 2020). The outpatient specialist psychiatric units offer medical treatment, therapies, and support, with a team of psychiatrists, nurses, psychologists, physiotherapists, and occupational therapists working together (Silfverhielm & Kamis-Gould, 2000). The study was conducted at a medium-sized specialist psychiatric outpatient unit in Northern Sweden with a catchment area of ~1,800 patients, comprising seven municipalities, that conducts psychiatric outpatient treatment at five different localities. In 2021, the psychiatric outpatient clinics received government funding to promote the health of psychiatric patients with comorbidities, and a collaboration with the university commenced. The intention was to improve the health of psychiatric patients with comorbidities by funding mental health staff and group education expenses.

Recruitment and participants

The first step was to email the operations managers of the five psychiatric outpatient clinics (two for affective disorders, one for psychosis, one for general psychiatry, and one for psychiatric outreach services). We obtained permission to contact the unit managers, who were responsible for the day-to-day operations of each unit. In the next step, the managers ($n = 15$) were contacted, received an information presentation about the lifestyle programme, and were invited to support participation in the study.

Eight managers subsequently recruited 11 members of the mental health staff who agreed to undertake education by the researchers (AB, YR) to become group leaders (GLs) and deliver the lifestyle programme. The staff included five mental health nurses, five treatment assistants in psychiatric care, and one peer support worker, with professional experience ranging from 4 to 30 years. Of these 11 individuals, one withdrew, and one went on sick leave after completing the education, leaving nine GLs who implemented the programme. However, 10 GLs were interviewed for this study, as the individual who withdrew before implementation still participated in the interview to share perspectives on the education and initial preparations.

Education for group leaders

The staff attended a 2-day education provided by the researchers to be GLs. After that, they received supervision and support from the researchers during the time the lifestyle programme was running. The education provided to GLs covered the planned research and consent procedures, participant recruitment, the structure and content of the group sessions (see Figure 2), and the role of the GL and practical exercises. A central element of education was the use of non-judgemental and empowering communication strategies to promote collaborative and respectful engagement with participants. Additionally, we collaborated with a regionally funded health retreat that gave two inspirational lectures: motivation for lifestyle changes (from a senior

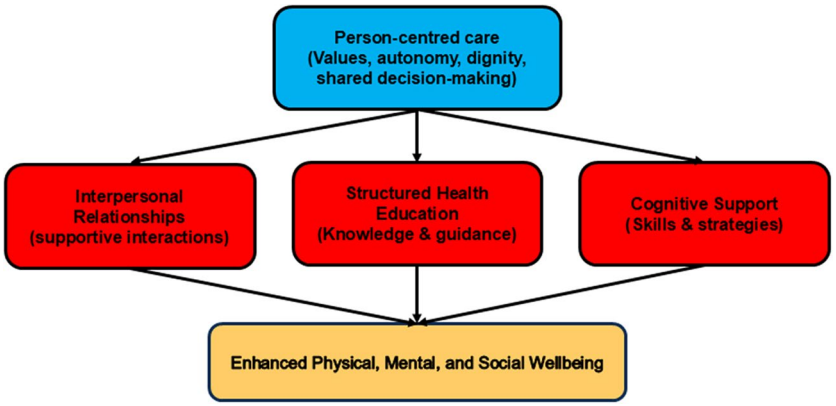

Figure 1. The core of the lifestyle programme.

physician in lifestyle medicine) and theory and practical exercises in mindfulness and basic body awareness (from a physiotherapist).

The lifestyle programme in a group format

This lifestyle programme is intended for adults in outpatient psychiatric care with a broad range of diagnoses, including affective, psychotic, and anxiety disorders, as well as ADHD and other common conditions. The programme combines both individual and group-based support. The group format fosters social connection, mutual support, and the sharing of experiences. The programme consists of three key components: building interpersonal relationships, providing structured health education, and offering cognitive support to facilitate individual lifestyle changes. Together, these elements create a flexible framework that can be adapted to each participant's needs and goals (Björk et al., 2020; Rönngren et al., 2018). The programme encourages participants to continue supporting one another beyond the structured sessions. Staff are encouraged to facilitate ongoing engagement and help normalise setbacks as part of the change process rather than signs of failure, thereby sustaining motivation and fostering a sense of shared progress.

A key feature of the programme is shared decision-making, where staff and participants collaborate as equals to making choices about lifestyle habits. To avoid a moralising approach, staff are educated in non-judgemental, empowering communication. The focus is on providing health education, exploring options together, and supporting participants in making realistic and meaningful lifestyle changes and learn from one another (Björk et al., 2020; Rönngren et al., 2018). Furthermore, the programme applies a holistic, person-centred approach, addressing physical, mental, and social health. It respects individual values, promotes autonomy, and encourages active participation. Group discussions highlight lived experiences and strengths, while individual support is tailored to personal goals (McCance & McCormack, 2025) (Figure 1).

After 2 days of education, the GLs conducted 12 group education sessions, each lasting ~120 min. The programme was integrated into routine outpatient care, with sessions held weekly in designated group rooms at the psychiatric clinics. Each group was facilitated by two GLs and included between six and 12 participants with mental disorders. Recruitment was carried out through the GLs' personal contacts, psychiatric clinic waiting lists, primary care, and the employment service, as well as via written information displayed in public spaces.

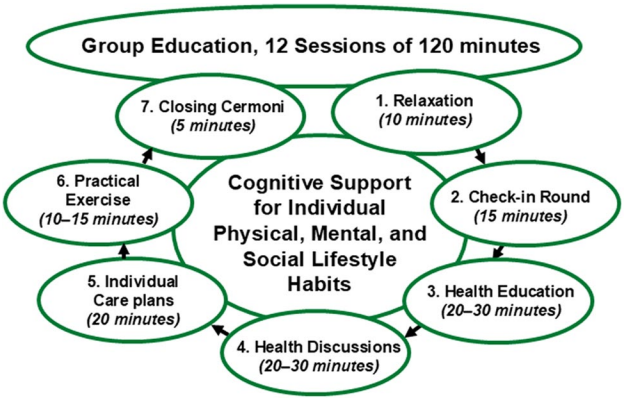

Figure 2. The structure of the group education.

Confidentiality was emphasised as part of the education structure, with participants reminded at the start of each session that discussions were to remain private. To ensure confidentiality and create a safe environment, all participants were required to sign a confidentiality agreement regarding information shared during the meetings.

Each group meeting was structured into seven parts, see Figure 2. Part 1: The purpose of the relaxation session was to give participants the opportunity to settle into themselves and feel present for the group meeting. Part 2: The check-in aimed at seeing how everyone was doing. Parts 3 and 4: Health education and the subsequent health discussions aimed to equip individuals with evidence-based knowledge from recent research and practical tools thorough discussions to better manage health and be empowered to make informed lifestyle decisions. Part 5: The participants identified personal health goals and documented planned changes to lifestyle habits. These plans were reviewed in subsequent sessions. Part 6: Every meeting also included practical exercises, e.g. walking together. Part 7: Each meeting ended in the same way, with the light that had been lit at the beginning of the session being blow out.

Between the meetings, GLs supported participants through cognitive assistance strategies, such as schedules, reminders, and joint exercises. Participants also used a logbook to track activities, such as physical exercise, diet, emotions, and thoughts. Light refreshments, such as fruit, water, coffee, and tea, were provided during the group sessions to create a welcoming atmosphere and support participant engagement.

The health education content (3) was adapted with mental health nurses to suit the practical context of outpatient psychiatric care. The programme had earlier been developed with patient organisations, so the nurses' role was to ensure the material was feasible and appropriate for this setting. The health education topics covered included: Health, Acceptance and Motivation, Physical Activity Habits, Sleep, Diet, Stress, Anxiety, Depression, Addiction and Substance Abuse, Cognitive Impairments, and Social Relationships. The participants had the opportunity to build relationships and form peer support networks.

Data collection

After completing the programme, 10 GLs chose to participate in an interview. These semi-structured interviews were conducted between September 2022 and November 2022, inspired by Kvale and Brinkmann (2009) guidelines. The following questions were addressed: How were participants recruited, and what organisational challenges did you encounter during the planning and implementation of the programme? What role did managers play in this process? How were the programme content and structure designed to support participants' development, and what adaptations were needed? Discuss the relationships within the programme.

The interviews ranged from 35 to 75 min. They were audio-recorded, transcribed verbatim, and checked for accuracy. The interviews were performed by two of the authors (YR, AB), who are registered nurses in psychiatric care.

Data analysis

Each interview was read thoroughly for an overall understanding, and meaning units related to the aim were identified and coded. The analysis followed a descriptive qualitative approach as outlined by Graneheim and Lundman (2004), focusing on manifest content rather than latent interpretation.

Two authors (AB and YR), who also conducted the interviews, carried out the initial coding independently to establish a shared understanding of the coding process. After comparing and discussing their coding, they agreed on a coding framework. The transcripts were then analysed by YR, with continuous discussions with AB, DH to ensure consistency.

Codes were grouped into subcategories based on conceptual similarities through a dynamic and iterative process involving several rounds of discussion between YR, AB, and DH. Discrepancies were resolved through dialogue until consensus was reached, see Table 1, example from the analytical process. Subcategories were then abstracted into three main categories (see Table 2), which were reviewed and refined collaboratively by all authors.

Table 1. Example from the analytical process.

Meaning units	Codes	Subcategories	Main categories
"The start-up was rushed through. More time for planning and recruitment would have been beneficial"	Rushed start-up	Lack of preparation time	Programme planning and implementation
"The GLs learned just as much as the participants. The programme reminded them of important lifestyle issues."	Mutual learning between GLs and participants	A tool for development	Programme content and structure
"Many participants felt seen and heard, which they had not always experienced in healthcare."	Feeling acknowledged and valued	Building confidence	A supportive relationship

Table 2. Overview of the main categories and subcategories.

Main categories	Subcategories
Programme planning and implementation	Lack of preparation time Organisational challenges Managers' role
Programme content and structure	A tool for development Need for adaptation To overcome barriers
A supportive relationship	To build confidence To build a friendship

To enhance trustworthiness, regular peer debriefing sessions were held with the broader research team to critically examine interpretations and minimise individual bias. Reflexive discussions were also undertaken to address preunderstanding; both have professional backgrounds in psychiatric care. This preunderstanding was acknowledged as both a resource providing contextual insight and a potential source of bias, which was mitigated through reflexivity and peer review. Finally, all authors reviewed the final categories to ensure clarity and consistency (Graneheim et al., 2017; Graneheim & Lundman, 2004).

Ethics

Ethical approval of the study was obtained from the Ethical Review Authority in Sweden (Dnr 2021-06212-02). Ethical considerations followed the research ethical rules presented in the Declaration of Helsinki (World Medical Association, 2025). All participants received written and verbal information about the study, were informed that participation was voluntary and that they could withdraw whenever they wished and provided informed consent. The GLs were assured confidentiality and that the findings would be

presented anonymously. Therefore, no pseudonyms were included in the presentation.

Results

The results highlight key aspects of planning and implementation, the content and structure of health education, and the supportive relationships developed within the groups. Planning revealed a lack of preparation time, organisational challenges, and the important role of managers. The programme content facilitated participant development, allowed for adaptations, and provided strategies to overcome barriers. Furthermore, the programme fostered confidence, active participation, and friendships, thereby enhancing a sense of community (see Table 2). In the presentation of these results, interviewees are referred to as GLs, and individuals with mental disorders as participants.

Programme planning and implementation

Programme planning was challenged by limited preparation time, recruitment difficulties, and organisational constraints. GLs highlighted the need for stronger managerial support, clearer structures, and broader professional involvement to ensure long-term sustainability.

Lack of preparation time

The GLs described that when the collaboration commenced, the management decided to start groups just a short time before the first session. Because of this, the recruitment of participants had to be carried out swiftly. The reason was that the region had allocated funding that needed to be spent within a specific timeframe. Due to this, much responsibility was put on the GLs. Therefore, the GLs emphasised that in future recruitments, other staff members must be more involved in informing and recruiting participants with mental disorder. Recruiting participants face-to-face was considered easier than through written communication. One GL expressed, "It would have been better if participants had received clear information well ahead of the group start about how the education may support them and what is expected of them. More participants could also have been invited from the waiting list, and more groups could have been initiated for those on sick leave while they were waiting for treatment." Another GL said, "The start-up was rushed through. More time for planning and recruitment would have been beneficial."

Further aspects were stressed by another GL: "It was difficult to form a group in the beginning. Participants joined the group at different times, which delayed the process. It would have been better with a fully enrolled group from the start." Additionally, "The external recruitment of participants from, for example, primary care, contributed positively, but the group was stressed."

Organisational challenges

The GLs agreed that thorough planning was essential to ensure that the group education was as applicable as possible. The initial group session required additional planning, as it took time to get used to the working methods. Some GLs also wanted to prepare their material and chose not to use the content included in the manual. A GL expressed, "It was difficult to keep to the schedule and cover everything. More preparation time was needed before each group session. Each session required careful planning, but it was difficult to find relevant topics and exercises." The GLs also stressed that, regarding education, it was important that all GLs had completed every part of the education and that everyone be at the same level and able to work with all aspects of the programme. The GLs requested that more GLs be educated so that all the responsibility would not rest on just a few individuals. "It is difficult to run a group alone; more GLs are needed for long-term sustainability." One GL became ill during the programme and was not replaced, which left a group without two leaders and eventually led to its discontinuation. In total, five groups were initiated, and four completed all 12 sessions.

A GL noted: "A GL got ill but was not replaced, and not all GLs had the proper knowledge about, for example, the tests. Because of this, some tests were not conducted correctly." The tests referred to here were basic health assessments, such as blood pressure measurement and waist circumference, which were part of the lifestyle programme's initial health evaluation.

Another GL emphasised: "More GLs and better structure are needed to avoid vulnerability in case of illness." The group dynamics were also negatively affected when a GL became ill, and one group could not continue due to the absence of a GL.

The GLs expressed the importance of having a clear structure from the start and the need for support and follow-up from the researchers. Another GL said, "The preparation time was sufficient, but not the time for follow-up." However, another GL stressed that more time was needed for preparation and follow-up of the individual lifestyle changes. Due to many other commitments, the quality of the group activities was affected.

One GL conveyed that there were differences in how the programme was implemented: "We didn't have any closing ceremonies and had another view on nursing plans and follow-ups." Some GLs reported that nursing plans created and revised during each session to support small, manageable lifestyle changes were documented but not always followed up consistently between sessions.

Managers' role

The GLs agreed that support from managers was very important. One GL said, "We received some appreciation, but more engagement from management would be desirable. Managers need to be present and see the results by themselves." The GLs described it as important to report progress to the managers and keep up the work. One GL said, "The managers should be focused on health rather than medication."

Managers' primary role was to provide organisational support, such as approving staff participation, allocating time for

preparation and follow-up, and facilitating resources for practical activities (e.g. refreshments). However, several GLs reported that managerial engagement sometimes was limited. Some GLs highlighted that closer collaboration with managers, including regular feedback and visible involvement, would have strengthened the programme's sustainability.

The GLs also desired more time for preparation and resources for practical activities, such as refreshments. "Better support from management would further improve the programme. Management is not so engaged in lifestyle issues. The focus is mostly on medication, and physiotherapy is rarely offered. Greater focus and support for lifestyle issues are needed, both from management and in practice." One GL said that it was difficult to involve the management in the work; "Senior managers are distant and absent."

Regarding the involvement of other professionals, the physiotherapist contributed primarily through a lesson focused on physical activity and movement strategies for the GLs. Apart from the physiotherapist, no other external professionals were systematically involved in delivering health education during the sessions. Instead, health education was primarily facilitated by the GLs, who were educates in the programme's content. The GLs noted that a multidisciplinary approach, with more active contributions from physiotherapists, dietitians, and occupational therapists, may have enhanced the programme's quality.

One GL mentioned that the physiotherapist in clinical practice only was available via a video link, which did not have much effect on the health of individuals with mental disorders.

Practical issues, such as providing refreshments highlighted the importance of managerial support. While some clinics approved minor costs, others restricted funding, despite the low expenses. GLs noted that these small gestures were highly valued by participants and contributed to group cohesion.

Programme content and structure

The programme content was generally seen as useful and easy to follow, with clear goals and practical tools that supported participants' engagement. However, GLs stressed the need for more tailored material, greater focus on physical activity, and strategies to address sensitive themes, such as shame and self-contempt.

A tool for development

The GLs stated that the participants were able to share their own experiences and adapt to the exercises effectively. Small tools and everyday care plans strengthened the participants' engagement. The group structure worked well and made it easy to follow the programme. One GL said, "The GLs learned just as much as the participants. The programme reminded them of important lifestyle issues." According to GLs, the programme has worked well overall, with reasonable and concrete interim goals that participants have appreciated. Examples of goals include choosing an apple instead of a Snickers bar and exercising more often. The participants have made great progress, which has been rewarding to see. One woman went from lying on the sofa to using walking poles after the course.

The GLs mentioned that they always provided fruit, water, coffee, and tea, which the participants greatly appreciated. Some mentioned that it was the only time during the week they had fruit. This led the participants to start eating more fruit at home.

Some GLs expressed that the programme structure was clear and helped both leaders and participants. Tasks between sessions worked well, and reminders via SMS were appreciated.

Some GLs said that the theoretical material is brief, simple, and easy to understand. "It's important not to make it too complicated, especially since participants may have cognitive impairments. It's important to be clear and specific. Participants appreciated a level that was easy to understand."

A combination of listening and reading (flip charts, handouts) and relaxation at the beginning of the sessions was appreciated.

Some GLs also expressed that setting health goals each week and following up has worked well. The laminated cards and spontaneous discussions were appreciated. The participants with mental disorders were positive and eager to continue with the programme, and they especially appreciated the trip to a health retreat.

The GLs stated that, even though no improvements were detected according to measurements, some participants made lifestyle changes and became more aware of their health, and some improved their balance with simple exercises. Becoming aware of poor balance was an eye-opener for many participants.

Need for adaptation

Several GLs noted that the programme was sometimes too broad, suggesting more targeted lifestyle groups that focus on progression on movement. They also recommended expanding the material with additional practical strategies and addressing themes, such as shame and self-contempt. Some GLs emphasised that the programme content should place greater focus on physical activity, prioritising practical sessions and their health benefits over extensive theoretical information. For example, simple movements and customised body awareness exercises were particularly useful for participants with psychotic disorders, and physical activities became more natural over time. On the other hand, discussions around weight were considered counterproductive and the focus should rather be on maintaining activity than on weight loss. Education and discussions regarding substance abuse were only addressed briefly which highlights the need for deeper discussions and related activities.

Some GLs also wanted improvement in the ability to collaborate between various groups. Different locations can benefit from varied approaches and creativity. Another GL suggested, "Start with more participants (12–15) to compensate for absences. There is also a need for better and more spacious venues, especially after the COVID-19 pandemic. Expand with more outings or social gatherings, such as walks and coffee breaks."

To overcome barriers

The group activities were rewarding but challenging. The examples presented here illustrate common challenges encountered during group sessions and the strategies employed by GLs to address them. One GL said, "It was sometimes challenging for individuals with, for example, hearing impairments or dissociation to fully participate. Managing diverse diagnoses, such as ADHD, PTSD, and social phobia within the same group was sometimes difficult." One GL said, "It was difficult to balance the focus on health when participants had considerable mental health challenges. It was difficult to address certain topics in the group, especially when one participant was going through a deterioration of mental disorder."

Another barrier was that some participants were highly involved, while others needed encouragement to participate. "The use of 'shepherding techniques' (guiding but supportive) was necessary to balance the group." Another GL said, "Smaller groups can make it easier for quiet participants. But in small groups, some may take over too much. It's challenging to balance the role as a GL to guide while still allowing participants to take responsibility themselves."

The GLs said that some individuals found it difficult to attend the group due to mental health challenges. However, the staff of housing support could have accompanied them, but confidentiality regulations prevented housing support from participating in group activities. One GL also said that planned outdoor activities had to be cancelled due to the physical limitations of some participants.

Another GL said: "One participant with mental disorder was very negative towards mindfulness, which created a tense atmosphere and affected the others. The person was offered the option to leave the room during the exercises. Group dynamics are important, and a negative attitude from one participant can affect the entire group. Flexibility and support are crucial to managing such challenges."

A supportive relationship

The programme fostered trust, confidence, and friendships, creating a sense of belonging among participants. GLs emphasised the importance of collaboration, encouragement, and flexibility in managing group dynamics and ensuring a supportive environment.

Building confidence

The GLs said that many participants felt seen and heard, which they had not always experienced in healthcare. All participants were involved, although some spoke more than others. There was a possibility to "pass" if someone didn't want to speak.

The GLs described that the discussions became livelier after the first session, and the participants bonded quickly. To succeed, the participants need to feel safe and supported. Many participants with mental disorder found the group sessions very positive. One GL stressed that the programme worked well, with concrete goals and methods. The programme was shaped according to the group's needs. Participants shared their own experiences and "recipes" for lifestyle changes. The focus was on encouraging each other. One GL said that it was perceived meaningful that the GLs and participants collaborated, everyone was on the same team, and no one was the sole leader. Everyone supported each other, and there was an understanding that not everyone wanted to do everything. One challenge was that the group sessions could be disrupted when certain participants were absent, which led to less dynamic discussions. One GL said, "Shame and self-contempt were common topics that came up, but it was considered important for participants to feel confident before addressing such difficult subjects. It is crucial to encourage and give praise to help participants grow."

Building friendship

The GLs stated that loneliness, especially involuntary, was a major challenge for many participants. Some participants became close friends and supported each other outside the group. Some participants broke their isolation and appreciated the sense of connection. "Some also made new friends and found a social context where they did not feel alone and outside." "Everyone tried to participate, and it was enjoyable to meet each time."

The participants supported each other and built a sense of community, and the group provided a sense of belonging and support. A GL said, "It's positive that several participants have started chatting and keeping in touch outside the group."

Discussion

The aim of this study was to explore the experiences of mental health staff in facilitating a person-centred lifestyle programme within psychiatric outpatient care.

This study highlights several challenges and opportunities experienced by GLs facilitating a lifestyle programme. One challenge is enabling participation for individuals with mental disorders. The recruitment of participants was complicated by organisational factors, including limited outreach capacity, insufficient planning time, and a lack of structured support systems. GLs considered personal contact the most effective approach. However, the limited timeframe for implementation, combined with a rushed education and recruitment phase, likely hindered enrolment. As recruitment was solely the responsibility of GLs, this may have further restricted the process's reach. Therefore, the programme was not accessible to all individuals who could have benefitted from it. Previous research emphasises the need for sufficient recruitment time and clear preparation, especially to help participants with mental health challenges to consider what to expect and what would be required of them (Gamble et al., 2021; Iflaifel et al., 2024).

Despite the high prevalence of cardiovascular disease and diabetes among individuals with mental disorder, access to screening and lifestyle support remains insufficient (Chew-Graham et al., 2021; De Hert et al., 2011; Solmi et al., 2021; Xue et al., 2023). Although mental health

services remain central for supporting individuals with mental disorders, limited staffing, funding, and infrastructure have increasingly shifted responsibility for health management onto patients themselves (Beyene et al., 2019; Porter et al., 2024). In a person-centred group education setting, individuals' involvement in their own care may be enhanced as participants collectively strengthen each other's health literacy through, for example, shared health discussions (Wu et al., 2023). To meet challenges, it is important that GLs provide empathy and offer resources to help (Yarborough et al., 2019). GLs play a crucial role in ensuring equitable care by interpreting complex symptoms and bridging the gap between mental and physical health. They hold primary responsibility for adapting care to meet individual needs and alleviating suffering (Antonsson et al., 2024). In this programme, nurses held the primary responsibility even though other staff acted as GLs. Nurses also helped determine the content of the health education component to ensure it was tailored to patients in psychiatric outpatient care.

Some GLs faced challenges as not all had completed the full education due to illness or other reasons. GLs fell ill, and no replacements were provided. Challenges also included reduced group energy when participants were absent. Several GLs reported insufficient time for preparation and expressed a wish for greater support and involvement from their managers. Björk et al. (2025) emphasise the importance of supportive leadership in enabling staff to engage in health-promoting care. A leadership style characterised by inspiration, support, and trust emerged as essential for the lasting integration of health-promoting approaches. In this study, we recognised the need for a stronger collaboration between managers, staff, and researchers which were less established but suggested crucial for long-term sustainability.

GLs stressed the need for shared responsibility, equal involvement, and adequate education to feel secure and committed. Some GLs were nurses while others had another background. The differences in experience of leading groups may affect to what extent you feel comfortable, which underlines the importance of clear roles and supportive structures to ensure that all GLs feel equally valued. The GLs were offered supervision and support by the researchers, but none made use of it. Simpson et al. (2024) showed that factors, such as strong leadership, teamwork, and involving individuals with lived experience of mental disorder can help improve health (Simpson et al., 2024). It is, therefore, important that future lifestyle programmes promote increased participation and collaboration with managers and researchers. Although this study showed that GLs have a huge interest in working with lifestyle programmes, a potential gap exists between willingness to engage in lifestyle-related work and what may be carried out in practice (Voort et al., 2024). To bridge this gap, GLs should receive support, resources, and positive feedback from managers in their vital work.

The GLs encouraging participation, adapting sessions, promoting trust, and offering tailored support which reflect key principles of person-centred care, including empathy, respect, shared decision-making, and mutual engagement (Håkansson Eklund et al., 2019; McCance & McCormack, 2025). To address concerns about stigma and individual responsibility, our lifestyle programme combines group and individual support. The group format encourages shared experience, while individual sessions allow for tailored guidance.

An important finding was that some participants built new friendships through the lifestyle programme. This is particularly noteworthy because loneliness can lead to many adverse health effects, including an increased risk of cardiovascular disease (Hawes et al., 2022; Paul et al., 2021).

Although some organisational setbacks were observed in the programme implementation, it was nevertheless obvious that the individuals with mental health conditions who participated in the programme received person-centred care through both group support and individual support between the group sessions. Boardman and Dave (2020) argued that person-centred care goes beyond diagnosis and treatment—it involves recognising everyone's values, identity, and rights. It emphasises shared decision-making and a holistic understanding of the person's life context (Boardman & Dave, 2020). The programme was a tool for development, adaptation, and overcoming barriers. The GLs collaborated with the participants and adapted, for example, the educational component and other activities to suit the different needs of the group members. The participants also received individual support between group sessions to help implement holistic lifestyle changes tailored to their personal needs. By "holistic lifestyle change," we refer to an approach that addresses physical, mental, and social well-being together, rather than focusing on a single aspect. The programme combined individualised support, group discussions, and practical exercises to help participants integrate sustainable habits into daily life. This stands in contrast to more traditional approaches that typically target only one dimension of health.

The person-centred lifestyle programme may contribute to improved health among individuals with mental disorder while fostering enhanced professional fulfilment and well-being among staff (Boardman & Dave, 2020). The staff who participated in the programme found it both enriching and educational. They expressed a sense of fulfilment in witnessing small but meaningful improvements among the participants—such as talking more about health or starting to go for walks with a friend.

The most important finding of the programme was that persons with mental disorder were given the opportunity to discover their own strengths, together with the other participants and GLs, and to form interpersonal relationships that could support health and enable activities, such as being physically active together. The GLs in this study worked according to the principles of person-centred care (Håkansson Eklund et al., 2019) in creating an environment with empathy and respect that supports interpersonal relationships. The GLs worked to build confidence, noting that participants felt seen and heard—something often lacking in their previous healthcare experiences. A safe and supportive atmosphere enabled open sharing. Individuals with mental disorder also appreciated being seen as equals with the GLs and sharing experiences. Sensitive topics emerged, highlighting the importance of confidentiality. For example, participants

shared personal experiences of overcoming social isolation, discussed challenges related to guilt and self-contempt, and exchanged practical strategies for small lifestyle changes. These examples demonstrate how confidence and trust were fostered within the group.

Other research has supported the idea that person-centred care in a group format shapes peer-to-peer interaction and may create a safe environment (Jensen et al., 2024). Lifestyle programmes are especially important in outpatient care, as individuals in outpatient psychiatric settings understand participation as engaging in both joint and individual activities, such as reciprocal dialogue and independently managing symptoms (Wärdig et al., 2016, 2021). Voort et al. (2024) stated that staff often set goals and define necessary behavioural changes for individuals with mental disorder rather than supporting them in setting their own health goals. In this programme, the GLs supported the participants' own perceptions of what their greatest health concerns were and gave positive feedback. Hawes et al. (2022) showed that building self-efficacy through experiences of success is key to motivating and sustaining lifestyle changes. Unfortunately, individuals with mental disorder may have lower self-efficacy to engage in lifestyle programmes (Richardson et al., 2024). The programme aimed to avoid moralising by emphasising person-centred care, empathy, and collaborative goal setting. Group and individual support fostered flexibility and empowering participants.

Methodological considerations

One methodological limitation of this study is its limited generalisability. The study is based on the experiences of a small number of GLs within a specific outpatient psychiatric context, which means that the findings may not be transferable to other settings or populations (Denzin & Lincoln, 2005). Additionally, there is a potential for sampling bias, as the staff who chose to participate may have been particularly motivated towards the lifestyle programme (Malterud, 2016; Malterud et al., 2016).

To enhance trustworthiness, we applied established qualitative criteria, such as credibility, dependability, confirmability, and transferability (Graneheim et al., 2017). Credibility was strengthened by prolonged engagement with the data, thorough discussions among authors to resolve discrepancies, and peer debriefing within the research team. Dependability and confirmability were supported through documenting coding decisions and category development, as well as reflexive discussions aimed at addressing researcher preunderstanding.

Preunderstanding, arising from the two of the authors' professional backgrounds in psychiatric care, was viewed as both a strength and a potential source of bias. It allowed for a deeper contextual interpretation of the data but also required active reflexivity to minimise undue influence on findings. This was managed by maintaining reflective regular team discussions and critically examining interpretations to balance insider knowledge with openness to alternative explanations. Transferability was considered by providing rich descriptions of the context, participants, and data collection processes, enabling readers to assess the applicability of findings to other settings.

Conclusion

This study provides important insights into the complexities of implementing a lifestyle programme within psychiatric outpatient care. While the GLs reported that patients were generally satisfied and made positive lifestyle changes, the findings also reveal the considerable challenges involved in delivering such programmes to individuals with mental disorder. The results emphasise that successful implementation requires substantial support not only from organisational leadership and managers but also dedication and adaptability from the GLs themselves.

The study highlights the pivotal role of GLs as change agents who demonstrate adaptive leadership by tailoring the programme to individual needs and fostering psychologically safe group environments. Effective GLs must combine clinical expertise with strong relational skills to promote participant engagement and sustainable lifestyle changes. Key factors for success include flexible planning, ongoing supportive leadership, and meaningful relationships between GLs and participants. Additionally, educating multiple staff members within the same care unit helps build a cohesive team that can collaboratively support lifestyle goals, facilitating integration of person-centred lifestyle programmes into routine psychiatric care.

Recommendations for clinical practice

The findings highlight how person-centred lifestyle programmes can provide a foundation for sustainable health initiatives in out-patient psychiatric settings. Professionals' experiences in facilitating the programme emphasised several key points: the importance of thorough planning and organisational support, the need to adapt content to participants' diverse needs, and the value of fostering a safe, trust-based environment. Involving senior managers, tailoring the programme, and creating supportive group dynamics were seen as crucial for overcoming common barriers. These insights offer practical guidance for enhancing everyday clinical practice and improving the effectiveness and sustainability of lifestyle programmes.

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Ethical approval

The study was conducted in accordance with the Declaration of Helsinki (World Medical Association, 2025) and received ethical approval from the Ethical Review Agency in Sweden (Dnr

2021-06212-02). All participants and GLs provided informed consent before participation, and their confidentiality and rights were safeguarded throughout the study. Ethical procedures ensured sensitivity to the needs and experiences of individuals with mental disorders.

Author contributions

CRediT: **Ylva Rönngren**: Conceptualization, Data curation, Formal analysis, Methodology, Project administration, Writing – original draft, Writing – review & editing; **David Haage**: Conceptualization, Formal analysis, Methodology, Writing – review & editing; **Annette Björk**: Conceptualization, Data curation, Methodology, Project administration, Resources, Writing – original draft, Writing – review & editing.

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