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The patient's role development in the process of participating in multidisciplinary team meetings in mental healthcare: From passive attendees to active members or dropouts

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ABSTRACT

Mental health patients are increasingly invited to participate in multidisciplinary team meetings during their admission to inpatient mental health units. To participate effectively, patients must adopt a role that enables them to actively engage and take their place as contributing member of the team. This study aims to understand how mental health patients experience the development of their roles when participating in multidisciplinary team meetings and to identify which dynamics are meaningful to them. A qualitative interview approach, using principles of grounded theory, was employed. Twelve mental health patients in Belgium were recruited for semi-structured interviews. Data were analyzed using the constant comparative method. The conceptual framework which emerged reveals that mental health patients strive to assume a partnership role within the team. To effectively take on this role, they identify three key-components as essential: being informed and prepared, being seen and heard, and being able to understand. Based on their reflections on these components and the perceived value of their contributions and efforts, mental health patients decide whether to become and remain active members, revert to passive attendance, or disengage entirely. These insights can encourage organizations to create an environment where mental health patients can grow into their role as partners in multidisciplinary team meetings. Such an environment would enable collaborative efforts between patients and the treatment team, recognizing each patient as a unique individual capable of making their own choices. By focusing on what is personally meaningful to the patient and addressing their specific needs, this approach ensures that care is tailored to what is crucial for patients' recovery.

Keywords: mental health, mental health services, multidisciplinary care team, patient participation, qualitative research.

INTRODUCTION

In recent years, patient participation has become a key feature of the mental healthcare sector (Jorgensen et al., 2018; Leemeijer et al., 2016). This shift has redefined mental health patients (MHPs) as active agents capable of making decisions in their treatment process (Castro et al., 2016). Globally, various terms are used to describe 'patients' (McLaughlin, 2009). In both international literature and everyday mental health practice, alternatives such as 'clients', 'service users', 'consumers', 'people affected by mental illness' and 'survivors' are frequently employed (Dickens et al., 2011; Hem, 2013; Simmons et al., 2010). In this study we opted for the term 'patients', more specifically 'mental health patients' as research in mental healthcare indicates that this term remains most appropriate (Dickens et al., 2011; Priebe, 2021; Simmons et al., 2010) and is preferred by both professionals and patients (Costa et al., 2023; McGuire-Snieckus et al., 2003). Through this shift to patient participation, MHPs have started to participate in Multidisciplinary Team Meetings (MTMs) during their admissions to inpatient mental health units (Berben et al., 2024; O'Donohue et al., 2023). This participation necessitated the development of new roles for MHPs within these meetings, supported by mental health professionals and organizations (Grundy et al., 2016; Jorgensen et al., 2018). Despite this progress, research on patient participation in MTMs within inpatient mental health settings remains limited. Only recently have studies begun examining this phenomenon from the perspective of patients' lived experiences (Berben et al., 2024; O'Donohue et al., 2023). Overall, research revealed that MHPs are satisfied with their involvement in MTMs, noting that such participation supports their recovery process (O'Donohue et al., 2023). However, there is a gap in understanding the process MHPs' undergo in developing their roles, including the underlying motives and dynamics. Therefore, theorizing research is needed to facilitate and improve mental health practice.

BACKGROUND

Within the context of inpatient mental health units, decisions about a patient's care are often made in an MTM (O'Donohue et al., 2023; Tondora et al., 2014). Therefore, to ensure person-centered and recovery-oriented care, it is crucial to give inpatients the opportunity to participate in these meetings (Berben et al., 2024; O'Donohue et al., 2023).

To become active members in these meetings, MHPs must evolve from being passive attendees to active agents, using their personal skills and experiences as a patient (O'Donohue et al., 2023). This change process over time can be defined as a transition (Ludin et al., 2013), during which MHPs are challenged to redefine their roles and identities to become active members in MTMs (Ellis, 2010, O'Donohue et al.,2023). Therefore, MHPs must navigate a dual identity: as patients and as contributors to the care team (O'Donohue et al., 2023; Simpson, 2017). The transition that MHPs need to go through in developing their role and new identity within MTMs is still unclear. While most patients prefer to take an active role in MTMs (Choy et al., 2007; Efraimsson et al., 2006; Lindberg et al., 2013), there is limited understanding of the motives and social dynamics that explain why patients become and remain active, become passive, or drop out (Bangsbo et al., 2014; Berben et al., 2024; Taylor et al., 2014; van Dongen et al., 2016 & 2017). Patients also do not know precisely what is expected of them when they take on a role in the participation process (Berben et al., 2024,

Choy et al., 2007; van Dongen et al., 2017). Within mental health settings, recent research has explored the lived experiences of MHPs when participating in an MTM (Berben et al., 2024; O'Donohue et al., 2023). These studies found that MHPs felt that they and their treatment were the subject and focus of the MTMs, allowing them to express their opinions and make their own decisions regarding their treatment (O'Donohue et al., 2023). Further, most MHPs expressed feeling honoured to be invited to participate in MTMs. However, alongside this sense of honour, MHPs also experienced a sense of obligation and often felt nervous about participating. Several factors were identified as influential in shaping the experiences of MHPs. Reflecting on their experiences, MHPs underscored the importance of receiving comprehensive information and adequately preparing for these meetings. Moreover, they highlighted the importance of limiting the number of healthcare professionals in the MTM. Additionally, MHPs emphasized the value of receiving support from a primary nurse, whose presence provided reassurance and advocacy during MTMs (Berben et al., 2024). While the insights of these studies have led to a partial understanding of the subject under study, there are still questions regarding the process of participating in such meetings that remain unanswered (Berben et al., 2024; O'Donohue et al., 2023). Therefore, the necessity of exploring this process in more detail is highlighted. In order to address the limitations in previous research, this study aims to understand how mental health patients experience the development of their roles in MTMs and to identify which dynamics are meaningful to them. Specifically, this study explored the following question: "How do mental health patients experience their role development in the process of participating in an MTM during their admission to an inpatient mental health unit?"

METHODS

Research design

Given the focus of the research question and the study's objective, a qualitative study was set up based on the principles of a grounded theory approach using constant comparison (Glaser & Strauss, 2017). The consolidated criteria for reporting qualitative research (COREQ) were used to report the study (Tong et al., 2007).

Setting

The study was conducted in two mental health units of a medium-sized psychiatric hospital in Flanders (Belgium). Both units provide mental health services to adults (range 18-65 years) with various mental health conditions, based on the principles of recovery-oriented mental health practice. Despite their common principles, both units differ in terms of the maximum length of hospital stay (eight weeks versus 16 weeks) and the focus of treatment (short stay versus psychosocial rehabilitation). In each unit, the multidisciplinary team meets every week to discuss the MHPs progress and patients can participate in an MTM twice as standard during their hospital admittance; (i) halfway during the admission where their treatment is discussed and (ii) at the end where discharge is prepared. Patients admitted to the psychosocial rehabilitation unit can, if they are interested, also participate between these two moments to outline their evolution. In both units, participation in an MTM is voluntary and the MTMs in which patients participate are organized in the same way in both units.

Participants

Participants were recruited purposively through a contact person who was also a multidisciplinary team member in one of the units where the study was performed. In order to guarantee anonymity and to avoid influence, the contact person only gave potential participants an information sheet with which they had to contact the researcher themselves. In a next step, participants were informed about the aim and method of the study by the primary investigator of the interviews (author 2), after which informed consent was obtained. Participants were recruited based on the following inclusion criteria: (i) native Dutch-speaking, (ii) aged between 18 and 65 years, (iii) either fully admitted or partially admitted while attending a day program in the mental health unit, and (iv) having at least one prior experience of participating in an MTM during their current hospital admission. After interviewing the first participants, the emerging concepts from the constant comparison of data guided the process of sampling, as recommended in grounded theory research (McCrae & Purssell, 2016). During this iterative process, diversity of the participants was taken into account in terms of gender, age, educational level, mental health symptoms or DSM-V diagnosis, the number of times they had participated in an MTM, and a participant's choice to drop out and no longer participate in an MTM. Recruitment continued until saturation of the core categories was established (Glaser & Strauss, Holloway & Galvin, 2017).

Data collection

Data were collected between November 2017 and April 2018. A junior female researcher (author 2), coached by one experienced qualitative researcher (author 6), conducted the one-off semi-structured interviews with twelve MHPs. The interviewer did not have a close relationship with the participants. An interview guide was used comprising open questions based on a brief literature review and the opinions of practitioners who have experience with patient participation in an MTM. Interviews were initiated with open questions, such as 'I understood that you participated in an MTM. Can you describe to me what that meant to you?'. The outline of questions is provided in Table 1. The interviews lasted on average 50 min (range: 25-95 minutes) and were conducted in a comfortable and quiet room in the hospital (separate from the mental health unit). All the interviews were face-to-face, audio-recorded and transcribed verbatim.

Reflecting the evolving nature of grounded theory studies, after interviewing the first six participants, the emerging concepts guided the process of data collection (Glaser & Strauss, 2017). This stepwise approach resulted in data-informed sampling decisions to broaden, deepen, confirm, and disconfirm the insights emerging from the preliminary analysis. It was observed that the first participants reported generally positive experiences with taking a role in the process of participation in an MTM. To diversify the experiences, six additional participants were included, three of whom participated in an MTM once and three who participated more than twice. These participants had mixed experiences with developing their role during participation in MTMs. Following Morse's (2015) recommendation, the researchers considered that understanding a range of MHPs' experiences with varying levels of intensity would enable them to enhance the comprehension of the processes under study. Additionally, after the third interview, five participants who had dropped out of the process of participating in an MTM were included. This decision was based on preliminary analysis indicating

that MHPs felt nervousness and a sense of obligation when participating in MTMs. It was observed that MHPs encountered nurses who persistently encouraged them to join the meetings by promising psychological safety. Although patients acknowledged these efforts as well-intentioned, the repeated reassurances inadvertently created pressure and a sense of obligation, leading to ambivalent feelings and causing some MHPs to withdraw from the process of participating in MTMs.

Data analysis

For the data analysis, the constant comparative method was used (Glaser & Strauss, 2017). Three researchers (author 1, author 2, and author 6) participated in the iterative data collection and analysis process. For each interview, author 2 made field notes and reported a synthesis to enhance the understanding of the research context and to identify preliminary categories. All three researchers read the transcripts repeatedly and added memos to retain their reflections. Following these steps, a coding process was initiated using the NVivo 11 software. By systematically comparing the coded fragments with the new data within and between interviews, and the analysis of the field notes and memos, codes were refined and conceptually formulated. The three researchers regularly crosschecked their codes and memos to identify relations between concepts. The codes were then grouped and tested iteratively by rereading the original text fragments. To ensure the richness of the analysis, the three researchers discussed the concepts, and meanings until all agreed on the structure of the conceptual framework. Finally, to support the explanatory power of the framework, findings were compared with insights from a previous literature review.

Quality assurance

The criteria of Lincoln and Guba (2000) were applied to establish the trustworthiness of the study process. Three strategies were used to enhance the credibility of the findings. First, the researchers followed the insights of Glaser and Strauss (2017) to evaluate whether the emerging categories were meaningful, explanatory, and applicable to the data under study. Second, research triangulation was established by involving three researchers in data analysis. Third, by analyzing data from participants with varying characteristics and experiences, discussion about possible explanations of the emerging categories was encouraged. This facilitated a broader exploration of diverse perspectives, allowing for the consideration of a wide range of possibilities and enriching the depth of analysis. In addition, dependability and confirmability were enhanced through an audit trail consisting of transparent reporting of the research steps and decision-making. Regarding reflexivity, the interviewer (author 2) systematically reflected on her interview skills, her professional background as a mental health nurse, and her view on implementing patient participation in an MTM. As part of peer debriefing, a transcript of these reflections was shared and discussed with an experienced qualitative researcher (author 6).

Ethics

The study was approved by the participating organization's local and central ethics committees (B670201733470). One researcher (author 2) fully informed the participants about the goal of the study, the voluntary character of their participation, and the confidential treatment and anonymity of the data. All participants provided verbal and written informed consent prior to inclusion.

RESULTS

Sample description

Twelve MHPs were recruited, consisting of four males and eight females. Eight participants attended an MTM at least twice during their current hospital admission. Seven participants completed the process, while five decided to stop participating in an MTM. Of the five participants who dropped out during the participation process, four chose to withdraw before the second MTM, and one participant opted out before the third MTM. The demographic data of the participants are summarized in Table 2.

Patient's role development in the process of participating in an MTM

The experience of becoming and remaining an active member in the process of participation in an MTM is depicted as a journey of weighing both the advantages and disadvantages with this involvement. Initially, MHPs are drawn to the perceived advantages of participating in an MTM. However, participants are also aware of the disadvantages and uncertainties. As participation in an MTM evolves and their experience grows, these disadvantages and uncertainties are brought more clearly in the interviews. Participant quotes that illustrate the findings are included in Table 3. These quotes were translated from Dutch into English.

Striving for a role as a partner

Although they did not expect to be invited to participate in an MTM at the start of their admission, MHPs quickly recognized the potential benefits and opportunities that such participation could offer. Engaging in these meetings gave MHPs a valuable chance to collaborate with the team, thereby influencing their admission, treatment and recovery process (Table 3, Q1-Q3).

During their participation in MTMs, MHPs experienced their role as meaningful when they saw themselves as partners. For MHPs, this meant developing a partnership with the team in which both parties have roles that do not need to be weighed against each other but allow each to act from their uniqueness. MHPs reported several key-components as essential for striving for a role as partner. In this, they referred to an approach in which they consider it important to be informed and prepared, to be seen and heard, and to be involved in the MTM in such a way that ensures they understand how things work. In this way they feel that they can have an impact and form a valuable part of the team. By addressing these key-components, MHPs indicated that they can better assume a partner role in their treatment, fostering collaboration with the team and a more effective recovery process.

An unexpected proposal that creates the need for information and preparation

MHPs described feeling surprised when they were first asked to take an active role during an MTM. At that initial point, most MHPs did not understand the purpose of an MTM and were unsure of what to expect from their participation. This unexpectedness, combined with their lack of understanding, led to feelings of insecurity and stress. To manage these feelings, MHPs expressed the importance of being informed and prepared. While this need for information and preparation was most mentioned upon admission to the hospital, MHPs noted that clear information and adequate preparation

remained crucial for each subsequent MTM. MHPs reported that receiving comprehensive information was essential for gaining insight into what to expect when participating in an MTM. In addition, they also want to receive information that would make the meeting predictable so they knew what to do. For example, information can be provided about the purpose of the meeting, its progress, the team members present, and the role they may take before, during, and after the meeting. Most MHPs sought this information primarily from their primary nurse, though some MHPs also consulted fellow patients with experience participating in an MTM. In addition to receiving information, MHPs expressed a need for thorough preparation. All patients described how preparation created a sense of involvement and provide guidance throughout their trajectory of participating in an MTM. According to MHPs, such a preparation offered various insights and benefits. Firstly, MHPs mentioned that it provided transparency regarding the content of the MTM and the potential questions that might be posed by the different team members (Table 3, Q4). Secondly, MHPs reported that preparation tracked their progress, allowing them to understand and cope with their vulnerabilities and reason(s) for their current hospital admission. Moreover, by reflecting about their progress at regular intervals, MHPs mentioned that they were confronted with their personal life story and important life events, making it a way to process them. Additionally, a preparation also helped them to define their goals more personally and to describe what is currently important. MHPs emphasized the importance of this as it made them more aware of themselves and it increased their self-knowledge. This helped MHPs to regain clarity in life in order to be able to move on in their recovery process (Table 3, Q5-Q7). Thirdly, MHPs also reported that being prepared can be helpful when they cannot or do not want to participate in an MTM, as it could serve as a preparation for their primary nurse, enabling them to advocate on their behalf (Table 3, Q8). Fourthly, participants also described how their preparations helped them to have a real impact in the MTM. Despite the benefits of these preparations, MHPs described the energy-intensive nature of these preparations. Particularly at the start of hospital admission, when dealing with negative thoughts and feelings of fear or failure, preparation often felt like a weight. MHPs mentioned that getting some rest at this early stage could make a difference. Reflecting on their process of participating in an MTM, MHPs also reported that these preparations became increasingly important as they provided a sense of control. They also highlighted the crucial role of their primary nurse in facilitating these preparations. In this regard, MHPs appreciated primary nurses who offered both familiar support and new insights that encouraged deeper reflection.

Ensuring to be seen and heard

MHPs emphasized the importance of being accepted by the team members with whom they collaborate. In their pursuit of recognition, MHPs expressed a profound need to be genuinely seen and heard by the various team members. For MHPs, this entailed the ability to describe, in their own words, the journey they had undertaken so far, their current personal functioning, their coping skills, and what matters most to them. By describing and reflecting on these aspects with the team members in an MTM, MHPs felt that the team member's understanding of their situation was enhanced and that treatment goals were formulated more tailored to their needs (Table 3, Q9).

MHPs reported that their preparations were crucial for ensuring they were seen and heard, whether or not they physically attended the MTM. More specifically, MHPs indicated that presenting their preparations in an MTM, either personally or through their primary nurse, provided insights that

helped team members truly understand their perspective. Additionally, many MHPs mentioned that their preparations gave them a sense of control during an MTM. Specifically, if MHPs chose to speak in the meeting, their preparations served as an anchor, helping them stay focused when they felt emotional overwhelmed or stressed by the large number of team members present in the meeting. Conversely, some MHPs questioned whether their preparations could help prepare the team members attending an MTM. They wondered if this approach might lead to a better understanding by the team members, given that the time allotted for MHPs to participate and speak during an MTM is limited (Table 3, Q10).

Reflecting their desire to be seen and heard, MHPs expressed a need for a clear summary outlining the final decisions reached in consultation with the various team members at the end of an MTM. They found this summary necessary, as processing the information discussed during the meeting could be overwhelming. Additionally, they wanted assurance that the team members truly understood them. For the creation and presentation of this summary, MHPs emphasized the psychiatrist's role as the coordinator of the MTM. Most MHPs believed the psychiatrist was best positioned to provide a comprehensive summary, given their expertise and knowledge. Moreover, MHPs reported placing greater importance on the psychiatrist's decisions compared to those of other team members due to their knowledge. In addition to a clear summary, MHPs also expressed an expectation for a debriefing session with their primary nurse and a written report after participating in an MTM. MHPs found these interventions important as they served as an additional check to ensure they were truly heard and the team had the right focus (Table 3, Q11-Q12).

Being able to understand

MHPs generally reported that invitations from team members to participate in an MTM fostered a sense of openness. This expectation of engagement made them feel they could collaborate effectively with the team. However, during the meetings, MHPs frequently encountered boundaries and inconsistencies. More specifically, they indicated that the information provided did not always align with reality, and their experiences and expectations regarding participation in an MTM did not match. For example, some MHPs reported that they were not allowed to make meaningful contributions on critical issues related to their recovery, or that their input was limited to trivial matters. Others observed that decisions were made for them, with their input becoming less relevant as discharge approached.

These boundaries and inconsistencies induced a sense of duality, prompting MHPs to seek clarification and stability. In their quest, they aimed to create a coherent and understandable picture of their environment. They sought to understand the role they played in the care process, how they related to the team members, and the value they were given as patients. Assembling this puzzle and understanding their value was crucial, as it enabled MHPs to evaluate whether they could grow in their partner role.

Evaluating their role and value

While striving to develop a role as partner, MHPs simultaneously indicate that they need to grow into this role. This growth requires efforts and contributions from themselves, as well as support from the team. For example, attending team meetings necessitated making time for preparations, attending

the meetings themselves, participating in debriefings, and other related activities. All while managing their recovery journey. Reflecting on their experiences, MHPs mentioned that this engaging led to a boost in their self-esteem. It allowed them to expand their capabilities and assume roles they had not previously explored or been encouraged to undertake.

In order to grow in the partner role, MHPs evaluate the results of their efforts. MHPs described that this evaluation not only occurs during or immediately after participating in an MTM, but also becomes meaningful beyond the MTM through their daily interactions with the team members. For this, they mentioned that they monitor the team members' behavior and how they respond. To gain a comprehensive understanding of their efforts, MHPs also conversed with fellow patients, comparing their experiences and reflections (Table 3, Q13). In addition to evaluating their efforts, MHPs emphasized the importance of evaluating the significance of their contributions. They continually assessed whether their preparations are appreciated, their narratives are valued, and whether the various team members address their ambiguities and questions.

Essentially, when MHPs feel that they are valued and recognize their own ability to contribute valuable, it signifies their role in the process of participation in an MTM is significant for their recovery journey. This recognition of their value and impact influences MHPs' decisions regarding their participation. They may choose to become and remain actively engaged, revert to a more passive role, or potentially discontinue their involvement (Table 3, Q14).

DISCUSSION

This study mapped out the patient's role development in the process of participating in an MTM when admitted to an inpatient mental health unit. The participants experienced their role development as an active and challenging process, requiring them define their role in which they gain control. This role development occurred through the interplay of factors related to their experiences before, during and after they participated in an MTM, as well as through the encounters they experienced with team members and fellow patients. These findings are important as they add the MHP perspective to the limited evidence base regarding the process of participating in an MTM in an inpatient mental health unit (Berben et al., 2024: O'Donohue et al., 2023).

In this study, the participants explain that participation in an MTM offers opportunities to collaborate with the team. This finding appears to be consistent with previous research in oncological and elderly care (Carey et al., 2014; Parker-Oliver et al., 2014; van Dongen et al., 2016; Wittenberg-Lyles et al., 2013). However, in these studies collaboration is seen as an outcome variable. In contrast, in our study it is described as an important condition for creating and achieving goals together. For this, MHPs mentioned that they strive to a role as partner. With this, our study confirms the scientific literature on recovery-oriented mental health practice in describing that building a partnership between patients and mental healthcare professionals is an important basis for daily care practice (Anttila et al., 2023; Matoba et al., 2023; Waldemar et al., 2016 & 2019).

The MHPs in our study identified three key-components crucial for their growth process towards achieving a partner role: (1) being informed and prepared, (2) being seen and heard, and (3) being able to understand. The first component highlighted by MHPs is the importance of being informed

and prepared. MHPs find this aspect valuable as it clarifies what to expect and what to do in an MTM. This finding aligns with previous research that underscores the significance of information provision in preparing patients for participation in an MTM (Berben et al., 2024; O'Donohue et al., 2023; van Dongen et al., 2016). Our study confirms that MHPs consider it essential to receive detailed information about the team members present and their roles, the purpose and duration of the MTM, and the role they may fulfill in the meeting. Importantly, our study adds a novel dimension to the information-giving process, emphasizing that information must be tailored to the patient's specific stage of role development. This nuanced approach ensures that MHPs receive the appropriate level of detail and guidance necessary for their role development. Previous research illustrated the importance of preparation before an MTM (Berben et al., 2024; O'Donohue et al., 2023). In addition, our study reveals the ongoing need for preparation each time MHPs participate in an MTM, regardless of their physical presence. MHPs in our study emphasized that being prepared provides transparency, involvement, a sense of control, and a feeling of having impact. Additionally, preparations also offer insights into their progress and help them formulate personal goals, thereby increasing their self-awareness and self-knowledge. Therefore, our study is among the first in mental healthcare to confirm findings from studies in elderly and oncological care (Carey et al., 2014; Donelly et al, 2013; Parker-Oliver et al., 2009), which suggest that participation in an MTM impacts patient empowerment and self-knowledge. This finding is valuable as it can support evidence that preparing in the trajectory of participating in an MTM also has a therapeutic effect for a patient. The second component mentioned by MHPs is the importance of being seen and heard. For MHPs, this meant having the opportunity to directly communicate their personal journey, personal functioning, coping skill, and what matters most to them in life to the various team members. By doing so, MHPs aimed to ensure that team members thoroughly understood their situation, thereby facilitating collaborative decision-making. The importance of being seen and heard as a vital component of meaningful interactions is well-documented in literature (Shipley, 2010) and is related to broader perspectives on patient participation (Andersen-Hollekim et al., 2020; Bjonness et al., 2020; Weiste et al., 2020). Therefore, our findings can provide an explanation and further depth to the insights of O'Donohue et al. (2023) guiding health professionals in making the trajectory of participation in an MTM even more person-centered. However, earlier research in mental healthcare has highlighted a long-standing tradition of stigma and regulation, where MHPs were often excluded from their care processes and decisions were made without their input, frequently based on incorrect information (Bjonness et al., 2020; Kaushik et al., 2016). This history likely contributes to the strong desire of MHPs to provide their information firsthand to ensure accuracy and to feel genuinely seen and heard in their care. To assess whether they have been seen and heard, MHPs mentioned the need to receive a summary, debriefing session, and written report. Similar findings were reported in previous research (Berben et al., 2024; O'Donohue et al., 2023) where MHPs expressed a desire to reflect on their experiences and receive a copy of notes from the meeting. The last component that was experienced as important by MHPs is being able to understand. For them, this meant actively seeking clarification about the boundaries and inconsistencies they experienced, with the goal of better understanding their environment and the functioning of the healthcare system. Previous studies have demonstrated the importance of effective information provision (O'Donohue et al., 2023; Taylor et al., 2014: van Dongen et al., 2016) and open, honest communication between patient and healthcare professionals (Matoba et al. 2023) in promoting this understanding. However, our study is, to our knowledge, the first to describe the

deeper, meaningful processes for MHPs that go beyond basic information provision. While providing information is vital, the ability to understand extends beyond mere knowledge transfer. This process requires a holistic understanding of their situation, allowing MHPs to observe and construct a coherent picture of the dynamics at play. Patients critically evaluate the information they receive, questioning whether their involvement in MTMs reflects authentic participation based on a shared vision or is primarily institutional in nature. This insight is essential for MHPs to understand their position within the care process, how they relate to team members, and whether they can grow in their partner role. These findings are particularly valuable as they highlight the mechanisms MHPs use to create predictability in their environment. In doing so, they contribute to their psychological resilience or sense of coherence as described by Mittelmark et al. (2022).

In addition, our study is also the first in mental health where MHPs indicate that their self-esteem increases by taking an active role in the process of participating in an MTM. This finding is valuable as it provides insight into the outcome variables associated with participating in an MTM. In this current study, it became clear that MHPs continually evaluate their growth in a partner role by reflecting on the extent to which the team members value them. MHPs gauge this value by assessing whether their contributions and efforts are appreciated and have a meaningful impact on their recovery process. When MHPs feel valued and recognize that their involvement contributes positively, they are more likely to remain actively engaged in the process of participation in an MTM. While a previous study reported a positive impact in supporting recovery (O'Donohue et al., 2023), the insights from our study may deepen previous research and open the debate regarding whether more is expected of a patient in the context of mental health care concerning participation in an MTM. Unlike other healthcare contexts, the dynamics and interactions between MHPs and mental healthcare professionals differ significantly. This results in MHPs being more dependent on themselves to influence their recovery process. Therefore, it is plausible that MHPs undergo a more complex and intensive process when it comes to participation in an MTM, characterized by a centralization of various needs and the utilization of diverse skills. This includes making (various) written preparations, attending multiple MTMs, actively contributing during MTMs, speaking in front of a group, debriefing, and more, all in a period while dealing with their own mental health challenges. As a result, the role development process for MHPs may be distinct from other healthcare contexts, suggesting a set of challenges and expectations for MHPs in mental health settings.

Limitations

This study had some limitations. The study was conducted in a region where patient participation in MTMs was still under development. Participants belong to a relatively select group and were recruited in one medium-sized psychiatric hospital in Belgium. In addition, all the participants had no previous experience with participating in an MTM during a prior hospital admission, meaning that their involvement in MTMs during the current admission was their first opportunity to engage in such meetings. This might have strengthened deeper insights but possibly reduced the transferability of the findings. To understand the barriers to participation, we also included participants who dropped out at different stages of the process. Despite the careful selection process to include these participants, their experiences remained positive. A more heterogeneous selection of participants (e.g. gender, educational level) was desirable as previous research indicates that women and

individuals with higher education levels tend to have more positive perceptions of participation in MTMs. Additionally, participants under the age of 35 were underrepresented in this study, raising questions about whether the process differs for younger individuals.

Recommendations for further research

Future research could further focus on exploring the role development process of MHPs in different settings and contexts such as acute mental health units, long-term mental health units and community-based mental health in different regions. This is particularly important to understand the transferability of the findings. Our findings highlighted that participation in MTMs affects patient empowerment, self-esteem, self-awareness, and self-insight among MHPs. In addition, it supports MHPs' recovery. Given these insights, performing quantitative studies to confirm these findings is recommended. Future research could also focus on other outcome variables such as patients' therapy adherence, patients' satisfaction, and the feeling of trust. Future qualitative research could focus on further theorizing patient participation in an MTM. In this study, the focus was on the MHPs' perspectives. It may also be relevant to explore how mental healthcare professionals experience the participation process and what it means for them when MHPs participate in an MTM. Moreover, the perspectives of nurses and psychiatrists is particularly important given that they are experienced as meaningful by MHPs.

CONCLUSION

While MHPs are increasingly participating in MTMs during their stay in inpatient mental health units, little is known about how they develop their role. The evidence is clear: overall, MHPs want to participate in an MTM as it offers collaboration with the team. For this, they strive to a role as partner. MHPs reported three key-components as essential for striving for a role as partner: they find it important to be informed and prepared, to be seen and heard, and to be able to understand how things work. Based on their reflection of these key-components and their evaluation what of the value given to their efforts and contributions, MHPs decide to either become and remain an active member, return to a passive attender or drop out. Taking these insights into account can help optimize the complex process of participation in MTMs in inpatient mental health units.

RELEVANCE FOR PRACTICE

The emerged conceptual framework can inform the establishment of work contexts in which mental health patients can take on an active role when participating in MTMs. By considering these findings, mental healthcare professionals gain insight into the patient's role development process, allowing them to provide more person-centred care when inpatients participate in an MTM. Knowledge on this topic can be applied to inform role descriptions and training programs to support patient participation in an MTM in daily mental health practice. In this context, the framework can provide a structure for mental healthcare professionals to rely on. The participants' experiences in this paper can only accentuate the important role of the healthcare environment in shaping a form wherein MHPs can develop their own role. From a patient perspective, it is therefore recommended that mental healthcare professionals focus on a therapeutic relationship in which a patient can develop a partner role. Hereby, it may inspire mental healthcare professionals that skills like informing, preparing,

guiding, reflecting, listening and valuing are meaningful for MHPs when developing their role in the process of participation in an MTM. This may necessitate additional training and education to equip mental healthcare professionals with the necessary skills and knowledge to facilitate patient participation in MTMs effectively. Additionally, the current research clarified that a MHPs' role development also had a therapeutic effect. After all, going through the dynamic role development process has an impact on patient empowerment, self-esteem, and self-knowledge. However, questions remain regarding the impact on other outcome variables. For the latter, additional research is recommended. Finally, other mental health patients can also benefit from these findings as it can help them to put feelings and thoughts into perspective when they develop their role in the process of participation in an MTM during hospital admittance.

Table 1. Questions from the interview guide

(opening question): I understood that you participated in an MTM, can you describe to me what that meant to you?
Can you tell us a bit more why you participated in an MTM?
What did it mean for you to participate in an MTM?
Did your role change during the process of participation in an MTM? And if so, how did your role change?
What aspect did you find most stimulating when you participated in an MTM?
Can you describe any challenging experiences in the process of participating in an MTM?

Table 2. Characteristics of the participants

	N = 12
Gender	
Male	4
Female	8
Age (in years)	
18 – 29 years old	1
30 – 39 years old	2
40 – 49 years old	3
50 – 59 years old	5
60 – 65 years old	1
Level of education	
Certificate	1
Secondary education	6
Higher education	5
University education	0
Mental Health Diagnosis (according to DSM-V, comorbidity possible)	
Adjustment disorder	4
Dysthymic disorder	2
Problems with partner and relationship	1
Depressive disorder	2
Bipolar disorder	1
Borderline personality disorder	1
Dependent personality disorder	1
The number of times of participating in an MTM	
1 time	4
2 times	5
3 times	1
4 times	2
The moment of dropout of participating in an MTM	
None	7
Before the first MTM	0
Before the second MTM	4
Before the third MTM	1

Table 3. Quotes illustrating the patient's role development in the process of participating in an MTM

Striving for a role as a partner		
Q1	Participant A., woman, 60 years	Yes, I felt really good after participating in the team meeting. It truly felt like I had a say and a voice in the decision-making process. That gave me the sense that I could collaborate with the team to find the right treatment plan. Normally, we aren't used to being on equal footing with 'our' team like that. So yes, it was a nice experience.
Q2	Participant Q., woman, 50 years	I believe it is crucial for me to participate in team meetings. It allows me to collaborate with the team and to coordinate our efforts to identify what is needed for my personal recovery.
Q3	Participant A., woman, 60 years	Participating in the team meeting was actually a very positive experience for me. That's the conclusion. For me, it's not only about increased participation but especially about consultation. I find that particularly important. It's about listening to each other, both they to us and we to them.
Key component: Being informed and prepared		
Q4	Participant X., woman, 53 years	It was only since my primary nurse started asking some pointed questions that it became clear what I could expect in the MTM. This meant that I could write my answers more clearly in advance.
Q5	Participant P., woman, 43 years	In those preparations, there is also an element of self-knowledge. How do you deal with your problems? How do you behave? How do you feel? How do the people around you feel? Consider a concrete situation. What is the impact? These are all aspects to consider, and indeed, how do you feel about them and how do you react to them. You can't answer these questions from day one because you don't yet know what they entail. It is a process that unfolds throughout your hospitalization.
Q6	Participant E., man, 55 years	Making those preparations is incredibly beneficial. It compels you to contemplate what you're doing and what you aim to accomplish after hospital admission. It assists in highlighting the bright spots.
Q7	Participant Q., woman, 50 years	During those preparations, you ponder the question: "What have I done in my life?" You pause, reflecting, and then you ask yourself: "What has happened to me?" It can be quite confronting. Then, you discuss it with a nurse who helps you view it from a different perspective.
Q8	Participant V., man, 37 years	Since it wasn't beneficial for me the first two times, I've chosen not to participate in a team meeting anymore. It was too stressful! Instead, I continue to provide input through my written preparation. I trust that my input will be discussed by my primary nurse in the team meeting. That's sufficient for me.
Key component: Being seen and heard		
Q9	Participant A., women, 60 years	Yes, I am indeed happy. Happy that my participation in the meeting went smoothly and that the team shares the same vision as me. I'm pleased that I had the chance to clarify a few things about myself. It was very beneficial. It gives me a sense that true collaboration is possible.
Q10	Participant X., woman, 53 years	I had to rush through my written preparation to ensure it was conveyed, but I wonder what the team members retained from it. I doubt much. If copies could be distributed (to the team members) before the meeting, perhaps participation would be more meaningful.

Q11	Participant B., woman, 56 years	Yes, it can all feel a bit overwhelming. That's why I believe it's beneficial to schedule a conversation afterwards, preferably on the same day, to discuss what transpired during the team meeting.
Q12	Participant O., man, 24 years	Absolutely. The reports afterwards are very helpful! You can always seek clarification. Why this perspective? What's the reasoning behind that decision? You're free to ask questions and make corrections if needed. This ensures that the team maintains the right focus.
Key component: Being able to understand		
Q13	Participant L., man, 44 years	At first, I thought I was truly part of the team, that my voice mattered. But then I started noticing that, in the meetings, my say was often limited to smaller issues, like my daily routine. When it came to the big decisions about my recovery, it felt like they were already made for me. And that was confusing.
Q14	Participant M., woman, 44 years	I kept trying to piece together where I actually fit in this process. Sometimes, I felt like a partner in my care, but then I'd hit a wall where my input didn't seem to count. It made me wonder what my role really was. So, I started asking question to my primary nurse.
Evaluating their role and value		
Q15	Participant Y., woman, 50 years	During a team meeting, technically, you can express anything, but sometimes the rapid pace makes it difficult. It moves so swiftly that there isn't always enough time to respond adequately to what's being said. I didn't appreciate that. Despite everything, you still feel like just a number here. One patient outside, the other inside. It's reminiscent of a factory setting. And that's how many patients in the group perceive participation in such a meeting.
Q16	Participant V., man, 37 years	The first time, I wasn't in the mood to join the team meeting at all. I just didn't feel well. I think it's a great initiative to have the option to join, but for me, that first time was not good. I didn't get anything out of it. The second time, I did feel better and, despite hesitating for a long time, I decided to give it another chance because I believed in the initiative. However, the atmosphere in the meeting was not good. There were too many people, which stressed me out. Afterwards, I had to ask for everything to be reviewed again because I didn't understand any of it. So, the third time, I chose not to attend the team meeting. Yes, and the third time, I didn't go to the team meeting because I got nothing out of the first two times. I know my input is conveyed there by my primary nurse, and that's fine with me!

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