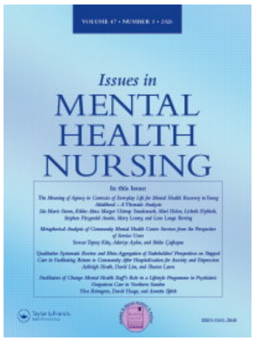

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Managing Boundaries in a Borderland—Experiences of Independent Support Persons in Compulsory Psychiatric Care and Forensic Psychiatric Care

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ABSTRACT

Introduction: In compulsory psychiatric care and forensic psychiatric care, supportive functions with independent roles have been instituted to uphold patient rights, preserve self-determination and personal integrity, work toward recovery and fulfill the obligation to ensure that individuals remain at the center of decision making. In Sweden, *independent support persons* (ISP) provide personal support and companionship to patients during and shortly after involuntary care. Knowledge about the ISPs experiences of the role is needed to expand and further develop the ISP role. This study aimed to illuminate ISPs experiences of their role regarding patients treated in compulsory psychiatric care and forensic psychiatric care.

Methods: The study used a qualitative design with semi structured interviews and inductive qualitative content analysis. Nine ISPs participated.

Results: ISPs experiences were reflected in the main theme *Managing boundaries in a borderland*, interpreted through the themes *Balancing personal and professional approaches, Serving as social support* and *Being in the hands of staff.*

Discussion: Findings highlights the important role of ISPs in mental health recovery through supportive, friendship-like relationships that promote reciprocity. ISPs help bridge social gaps, especially for those lacking networks. However, misunderstandings about their role can limit their impact.

Background

Patients in psychiatric compulsory care describe a lack of information on care, treatment, and rights (Akther et al., 2019; Stylianidis et al., 2018; Sugiura et al., 2020; Wyder et al., 2015), a loss of autonomy, privacy, and control, and a lack of involvement in their care (Akther et al., 2019; Silva et al., 2023). As a response, supportive functions, independent from health care, have been instituted to uphold patient rights, preserve self-determination and personal integrity, support recovery, and fulfill the obligation to ensure that individuals remain at the center of decision-making (Eades, 2018). They are typically mandated to support patients' rights during psychiatric compulsory care, although the terminology, roles, and responsibilities vary in different countries.

In many countries, patients right to independent support in compulsory psychiatric care is established in legislation. To illustrate how the role and responsibilities may vary between countries, Table 1 presents a selection of countries chosen to represent different parts of the world. The roles are partly transferrable between each other.

Research portrays independent support functions in compulsory psychiatric care as a generally beneficial addition to mental health systems. Key findings include empowerment and well-being: involuntary patients with access to such support reported increased empowerment, self-determination, and emotional well-being than those without such support (Weller et al., 2019). Further, 70% of involuntary inpatients admitted to one high secure forensic mental health hospital in the UK reported increased self-rated autonomy after working with an advocate (Eades, 2018). Research shows that patients' access to ISP can help increase individuals' sense of agency and control and contribute to reduced stigma. Furthermore, it can strengthen human rights in a broader sense, including strengthening and supporting citizenship, and addressing inequality and discrimination (Ridley et al., 2018). Research shows that supported patients are more engaged in their treatment and more likely to have their preferences heard. Advocates enable patients to articulate their concerns and seek remedies, which can lead to practical improvements in some cases and higher patient satisfaction with the care process (Newbigging et al., 2015; NICE, 2022). The presence of an ISP addresses ethical issues in involuntary care by promoting dialogue and helping patients feel their dignity is better respected. In other words, advocacy "offers a voice to the voiceless," helping to balance

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Table 1. Overview of roles and responsibilities in a selection of countries.

Country	Roles	Responsibilities
Sweden	Independent support persons	Provide personal support and companionship to patients during and shortly after involuntary care.
United Kingdom	Independent mental health advocates	Help detained patients understand their rights and treatment options, assist in meetings, and support in lodging complaints or appeals.
Denmark	Patient advisors	Counsel patients on their rights and assist with complaints processes when subjected to coercive measures.
Netherlands	Patient advocates	Support patients' rights during compulsory mental health treatment, ensuring their voice is heard and respected.
Canada	Mental health patient advocates or Right advisors	Provide proactive rights advice and support to involuntary psychiatric patients, ensuring they understand their legal status and can communicate effectively with authorities.
USA	Patients' rights advocate	Help involuntary patients understand their rights, prepare for hearings, and file grievances.
Australia	Mental health advocacy service	Supports involuntary patients by informing them of their rights and assisting with decision-making. Patients can also designate a nominated person to represent their interests.
India	Patients appoint a nominated representative	To support decision-making and ensure their wishes are considered during treatment.
New Zealand	Similar roles as above	To support patients' rights and ensure fair treatment in mental health care. These roles emphasize informing patients of their rights, providing support, and ensuring their voices are heard.

the inherent power asymmetry in psychiatric detention (Newbigging et al., 2015; Weller et al., 2019). Although independent support functions offer numerous advantages, research indicates that they are not yet accessible to all potential users. Key obstacles include limited patient awareness of the service, inconsistent referral practices, and, in some areas, inadequate funding resulting in uneven coverage (NICE, 2022). There can also be friction between clinical teams and independent support functions if roles are not clearly understood or respected (Weller et al., 2019). These challenges suggest that merely creating the role in law is not enough—ongoing staff training, stable funding, and culturally sensitive outreach are needed to maximize the impact of ISPs (Newbigging & Ridley, 2018; Weller et al., 2019).

Rationale for the study

In summary, research shows that independent support functions such as ISP can improve patients' experiences of compulsory care as mental health care moves toward a more rights-focused and person-centered paradigm. However, a review of the literature shows that we have limited knowledge of ISPs' experiences with the role. Such knowledge is needed to expand and further develop the ISP role. Therefore, this study aimed to illuminate ISPs' experiences of their roles regarding patients treated in compulsory and forensic psychiatric care.

Method

The study used a qualitative design with semi-structured interviews and qualitative content analysis (Graneheim & Lundman, 2004).

Study context

In Sweden, general psychiatric inpatient care offers 24/7 treatment for various psychiatric diagnoses. Patients are admitted either voluntarily under the Health and Medical Services Act (SFS 1982:763) or involuntarily under the Compulsory Psychiatric Care Act (SFS 1991:1128), typically in locked wards. Forensic psychiatric care is provided to people convicted of crimes not punishable by fines and diagnosed with severe mental disorders meeting legal criteria. These people are sentenced to compulsory care under the Forensic Psychiatric Care Act (SFS 1991:1129), with or without special court supervision (SCS). SCS applies when the offense was committed under the influence of a severe mental disorder and there is a risk of reoffending (SFS 1962:700). Under SCS, decisions regarding privileges, outpatient transitions, and discharges are made by a county administrative court rather than the chief medical officer.

In Sweden, the politically appointed Patient Board (PB) is responsible for the ISP assignment and individuals who assume an ISP role. PB provides ISPs with information about the assignment and arrange confidentiality agreements. The ISPs perform their duties as volunteers. They receive some compensation and further training via the PB. The assignment can continue if the patient is involuntarily cared for and for four weeks after discharge. The ISP role may include regular visits to the ward, participation in meetings within both inpatient and outpatient care, and support in the administrative court. ISPs are organized in the Swedish Association of Voluntary Social Workers (SAVSW).

Participants

The interviews in the present study were conducted in Sweden in 2023 with ISPs experienced in supporting patients treated according to the Compulsory Psychiatric Care Act (SFS 1991:1128) and/or Forensic Psychiatric Care Act (SFS 1991:1129). The SAVSW and PBs in four Swedish regions were contacted and sent an information letter about the study. PBs and the association forwarded the information letter to ISPs via a mailing list. Those interested in participating in the study reached out to the authors and expressed interest. Oral and written information was given and all participants signed informed consent before the time for the interview was scheduled.

Purposive sampling was used to reach ISPs with different genders, ages, levels of education, experience, and geographical areas. The inclusion criteria were ISPs with at least 6 months' experience in the role. In total, nine ISPs participated—six women and three men—located across Sweden. Their ages ranged from 37 to 73 years (median = 60). Professional affiliations and levels of education ranged from upper secondary school to bachelor's degree, with social worker as the most common profession. ISP experiences ranged from six months to 23 years (median = 7). Five ISPs reported supporting patients cared for under both compulsory and forensic care. The ISPs met with patients once a month for 4 h and up to twice a week, either by phone or in person. The schedule depended on the patient's well-being and willingness to go on outings.

Data collection

Semi-structured telephone interviews were conducted using an interview guide with open-ended questions and encouragement techniques, followed by follow-up questions to elicit elaboration from participants. The interview began with questions about the participants' background before proceeding with the interview guide. For example, questions like 'Can you tell me about what it means to you being an ISP?' and 'Tell me about your experiences of being an ISP?' were asked. The interviews lasted between 37 and 64 min (median = 45). The interviews were audio-recorded and transcribed verbatim.

Data analysis

The interviews were analyzed using inductive qualitative content analysis (Graneheim et al., 2017; Graneheim & Lundman, 2004; Lindgren et al., 2020), meaning that no predetermined theory or model guided the analysis. The interviews were read several times to get an overall understanding of the content. Each interview was color-coded and numbered to facilitate tracing back to the original text. The text was divided into meaning units, condensed and assigned codes. Codes were combined based on similarities and differences, then abstracted and interpreted into subthemes. Subthemes with similar content were combined, abstracted, and interpreted, resulting in the formulation of themes. The themes were then combined into a single latent main theme. During the analysis, the authors reflected together and discussed the results before agreeing.

Results

The ISPs experiences of their role are presented as subthemes, themes, and one main theme below (Table 2).

Table 2. Overview of subthemes, themes and main theme revealed in the analysis.

Subthemes	Themes	Main theme
Being or not being like a friend Being someone from outside Participating or not in the care	Balancing personal and professional approaches	Managing boundaries in a borderland
Offering a substitute network Contributing to activities and practical things Listening and being a conversation partner	Serving as social support	
Dealing with safety Facing organizational challenges	Being in the hands of staff	

Managing boundaries in a borderland

The main theme reflects the participants' experiences of managing boundaries between being personal and being professional. Participants described various experiences of existing in a borderland, being part of the care system yet not fully, and not being staff yet not quite a friend either. They positioned themselves somewhere in between, sometimes feeling like a kind of friend, a surrogate mother, or a temporary social network, while their role remained paid and time limited. Being in this borderland also meant being in the hands of staff, without access to background information about the patients, yet still operating within compulsory and forensic psychiatric care. Participants described having some insight into this care but lacking the authority or opportunity to act on it or to gain a comprehensive understanding of the patients' situations.

Balancing personal and professional approaches

The main theme, *managing boundaries in a borderland*, captures how staff navigate the often-blurred line between the professional and the personal in their work. The subtheme balancing personal and professional approaches focuses specifically on this negotiation. Its three subthemes, *being or not being like a friend*, *being someone from outside*, and *participating or not in the care*, each illustrate different ways in which workers position themselves within this "borderland." These positions reflect ongoing efforts to define and maintain boundaries between their professional roles and their personal involvement, moving back and forth across the border between private and professional spheres.

Being or not being like a friend

Participants described that they tried to be personal without sharing details about their private lives. The role was described as beyond professional in some ways, but still not entirely so. They stated that it was not a job but still a professional role. Being professional was considered important, as patients often struggled with friendships. They tried to separate their private selves from the role because the role was time limited and they wanted to protect the patients from challenging separations.

Participants described it as acting like a friend and building friendly connections, while others saw it as an arranged, paid role without equal exchange. One participant stated that the ISP was neither a staff member, a friend, nor a family member.

> It's personal in a way, because […] I'm just a regular person, I have no authority […] but still, it's not like you socialize in a family way, or whatever you want to say, and then it's not really personal. […] You are not the staff, you are not family, and you are not a friend, but you are some kind of, what should I say, 'paid friend' sounds like a really strange term, but that's what I tend to call it in my head. (IP 7)

Some participants found the task clear, while others found it ambiguous and lacked a framework. It was noted that the absence of a framework was positive, as it could lead to greater freedom. At the same time, it could be challenging to know what was permitted, for example, whether it was allowed to bring the patient home. Further, it was important to be clear about the role's boundaries, as patients can struggle with boundaries but also need clarity and structure. Setting boundaries was sometimes challenging, especially among ISPs with limited experience.

Being someone from outside

Participants stated they were not part of the staff but could serve as a complement by providing time and offering support. Participants emphasized that, unlike the staff, they had time to sit, talk, and go outdoors with the patients.

> I think it's very significant to have someone, someone from outside, someone who, you know, they feel that someone cares […] the fact that I am not staff, I am a fellow human being coming from the outside. (IP 1)

The participants felt that they could offer patients an external contact—someone outside the staff and other patients. They served as a break from the hospital environment and the monotonous daily life on the ward, as well as a link to the outside world. As fellow human beings outside the healthcare system, they could focus on patients' experiences of involuntary care without needing to defend or explain coercive measures or hold any power over the patients. Participants also described how they helped patients interpret statements from doctors and other healthcare staff and better understand the care they were receiving. They tried to support patients who were critical of the care by helping them express their wishes to the staff. Additionally, they could offer these patients a chance to vent their frustration, and they described trying to act as mediators between the patients and the healthcare system. At the same time, the descriptions varied somewhat—some participants emphasized that they did not want to interfere with the care.

Participating or not in the care

Participants generally described their involvement in administrative court proceedings and care planning meetings as infrequent, although attendance at court hearings was somewhat more common. One contributing factor was that some patients preferred not to have them present. Additionally, notifications of such proceedings were often provided on short notice, limiting participation. Further, they noted that healthcare staff did not always inform patients of their right to have a support person present during court hearings. When participants attended court, their role was primarily to offer emotional support or to be present as a listener. Views varied regarding the necessity of their presence. While some participants valued the opportunity to gain insight into the patient's background and challenges, others expressed concern that patients might not want them to know everything about their mental illness.

> When they go to court, I always ask if they want me to come along, and it's rare that they want anyone there, even if they have had a support person for a long time, and I don't know if it might be because they feel that they don't want me to know about their illness, yes. They want to have a connection with me from the outside and, you know, to the healthy side if I may say so. (IP 3)

Participants reported that their involvement in care planning was infrequent and generally not considered part of their core responsibilities. They did not view active participation in clinical decision-making as necessary. Instead, their role was described as supporting patients in voicing questions or concerns to healthcare staff. Participants emphasized the value of maintaining an outsider perspective—focusing on patients' strengths and well-being rather than engaging with their complete medical histories.

While not routinely involved in care planning, participants acknowledged potential benefits. Their presence could facilitate collaboration, support patients who struggled to express themselves, and offer a broader perspective informed by interactions outside the clinical setting. Participation in care planning was also seen to enhance understanding of the patient's treatment. They noted that patients often lacked clarity about their care plans and questioned whether patients were even aware of their right to participate in such planning.

Serving as social support. The theme of *serving as social support* connects to the main theme *of managing boundaries in a borderland* by illustrating how ISPs navigate their role in the social lives of patients who lack supportive networks. The subthemes of *offering a substitute network*, *contributing to activities and practical things*, and *listening and being a conversation partner* show how ISPs operate within a borderland between professional care and personal companionship. Through these forms of support, they manage the boundary between providing professional assistance and becoming part of the patients' social world.

Offering a substitute network

Participants reported offering a substitute network for patients who were isolated and lacked stimulation. This involved visiting patients and maintaining phone contact. Participants shared their personal phone numbers or provided prepaid card numbers to the patient. They could also contact the patient through the healthcare staff, and vice versa. Sharing phone numbers was described as positive, as it allowed patients to reach out if they were admitted to compulsory care again. However, experiences of boundless calling and texting occurred, which could be challenging. Participants stated that it was equally common for patients to reach out as for patients to reach out to them. When a patient was feeling unwell and lacked initiative, participants often took the lead in maintaining contact.

Participants explained that they offered a relationship where they functioned as an extra person in the patients' network: a surrogate mother, an older and reassuring figure, a grandmother, a fellow human being, a positive mirror, or a companion. Additionally, they noted that patients often had few friends, unhealthy networks, and that their families needed relief.

> Getting someone from the outside, often they don't have many people in their network when they get admitted to the ward. I can experience that many might have people around them who are very tired, and when they are placed under compulsory care, it's like relatives or others take a step back to get a little time for themselves or some recovery as well. (IP 6)

Being part of a substitute network involved encountering loneliness and building a sense of community. Further, it meant providing predictability and serving as a stable point in patients' lives. Participants described trying to support the patient in regaining their original network by helping patients reconnect with their family members. Some maintained contact after the role ended, while others saw the connection end or fade away with the role's end. Sometimes, participants became contact persons.

Contributing to activities and practical things

Participants described their efforts to contribute to everyday activities, including walking, cooking, yoga, shopping, having lunch or coffee, playing chess, and driving, as well as supporting patients with shopping and banking tasks. They could also facilitate outings for patients who were not allowed to go outside alone. Participants noted that the healthcare staff lacked time for outings and that relatives were not always available.

> Just hanging out and being some kind of support when it's time to shop, support or guidance […] nowadays, staff don't go on outings with patients […] regarding those who are out, they have all recently received training apartments, and there are some things they need to get, you know, a bit of advice when shopping for food and things like that. (IP 7)

Listening and being a conversation partner

According to the participants, their role involved active listening and engaging as conversational partners. This engagement encompassed asking questions, providing responses, facilitating discussions, and identifying shared interests. Participants highlighted the importance of being attentive listeners and serving as individuals whom patients could confide in, offering a safe space for conversations about both positive and challenging experiences. They emphasized the importance of creating an environment conducive to open dialogue, where patients felt comfortable discussing their circumstances. Participants described the intention to provide a setting where patients could reflect on their thoughts and practice articulating complex topics. In instances where patients were severely ill and faced communication barriers, the role sometimes entailed simply being present for a brief visit. For example, one participant recounted a situation involving a patient experiencing acute psychosis and fear, during which they remained at the doorway and spoke briefly about themself and recent activities, thereby maintaining a minimal yet meaningful connection.

> She didn't really want to have contact with anyone, but I went there and stood in the doorway, talking a bit about myself and what I had done that week and what I would be doing for the rest of the week. (IP 4)

When the patient recovered from the psychosis and regained the ability to communicate, the participant asked the patient if they had any memory of their initial meetings. The patient responded that they had experienced the participant as a chirping little bird. Participants highlighted the importance of being available, following up on what patients shared, showing interest, and being open. Further, participants described their efforts to see the person beyond the illness and emphasized the importance of accepting the whole person. This could involve showing understanding and curiosity regarding hallucinations.

> Some […] are very unwell. They are in a fantasy world, and it's important to […] engage with that. They are in a fantasy world, so I try to immerse myself in that person's world and meet them in their fantasy […] if I don't manage my cards somewhat correctly, then… the patient can just walk away if they feel… not seen, or… not respected, simply […] really getting into how the patients' world—there's no better way to say it. (IP 2)

Participants emphasized the importance of acknowledging the patient's strengths and supporting their overall well-being. Being a conversation partner meant offering encouragement and motivation. This included engaging in discussions centered on shared interests and future possibilities—rather than focusing solely on medication and illness—thereby fostering a sense of normalcy and providing a counterbalance to the experience of being unwell.

Being in the hands of staff. The theme *being in the hands of staff* relates to the main theme *of managing boundaries in a borderland,* by highlighting how ISPs navigate the limits of their responsibility and control within the care system. The subthemes *dealing with safety* and *facing organizational challenges* illustrate how ISPs must navigate challenging situations, such as managing difficult patient encounters, listening to distressing life stories, or working with limited insight into the patient's care, while balancing their professional obligations with personal involvement. This reflects the tension of operating in a borderland between autonomy and dependence, as well as between personal engagement and institutional constraints.

Dealing with safety

Participants had experiences of outings with patients who became drug-affected or who smuggled objects to self-harm into the unit. They found it uncomfortable and problematic that the healthcare staff did not inform them of the risks. A complicating factor in communication with healthcare staff was the confidentiality regulations, which could mean that participants received no background information about patients. At the same time, some participants believed that confidentiality between them and the healthcare staff was important. Some had experienced health care staff violating confidentiality by sharing patient information. It was also described as problematic that healthcare staff on a forensic psychiatric unit never verified that the patient met with their ISP during outings, especially since these outings were conditional upon these meetings.

Participants highlighted a lack of safety awareness regarding patients who were under compulsory care in a forensic psychiatric setting. They noted that staff always had an alarm button on them, whereas ISPs never did. However, they also mentioned that they were not allowed to go out with the patient alone. One participant said:

> I felt like it was crucial to say the right words and have the right tone […] I understood that now he was alone with me, and there was no guard in the room. If I had been a bit careless, it could have… gone very wrong. That was the feeling, at least. (IP 5)

Facing organizational challenges

Participants described organizational issues, such as abrupt admissions and discharges, difficulties in patients receiving help in time, insufficient time, and poor follow-up after discharge. They described experiences of inadequate treatment by healthcare staff, noting that staff sometimes appeared unable to cope with patients and had difficulty handling patients' concerns. Some expressed frustration with the care for these patients, while others saw some positive aspects. Further, participants described challenging situations in which healthcare staff advised them not to visit patients who had appointed an ISP. They stated that staff cited the patient's poor condition as the reason a meeting would not be beneficial for anyone. Participants also described that the care did not always work well for patients. They reported that patients were sometimes punished and described such situations as tough. They also found it difficult, not knowing how to handle the situation when they did not have a complete picture of the care.

> A woman with severe anorexia […] she spent quite a long time in the unit, and I felt she couldn't influence anything […] she became very isolated. There, I felt several times that she was stripped of the small right to just be rolled out to a dining table and eat with others instead of being isolated in a room, and those kinds of things for a longer time. You can understand such things perhaps at first, but then it felt like so much was, like, punishment. (IP 8)

Participants experienced that patients lacked influence in their care and were offered few activities. It was observed that silent patients were often forgotten, and that patients frequently referred to each other for social interaction. Participants sometimes found units to be confining and monotonous. However, even though patients' participation in care was perceived as low, they argued that it was a natural part of compulsory psychiatric care, especially in forensic psychiatric care. Additionally, it was stated that the care could not always provide the help that patients needed.

Participants generally reported good cooperation with forensic psychiatry. However, some experienced challenges in communication and collaboration with psychiatric units, although others shared positive experiences in that area as well. Lack of knowledge about the ISP role was highlighted as a complicating factor and could lead to misconceptions. Experienced staff were described as having more knowledge of the ISP's role, which could facilitate collaboration.

Discussion

This study aimed to illuminate ISPs' experiences of their roles regarding patients treated in compulsory and forensic psychiatric care. These experiences are reflected in the theme *Managing boundaries in a borderland*, interpreted through the subthemes *Being personal and professional, Offering social support*, and *Being in the hands of staff.*

Our findings show that ISPs can play a meaningful role in supporting mental health recovery, particularly by offering forms of social connection and everyday normality that are often missing in institutional care. By operating in a borderland between professional and personal involvement, ISPs can bridge gaps between patients and their social worlds, helping to reduce isolation and foster a sense of belonging. Their ability to engage in genuine, personal relationships creates opportunities for trust, recognition, and social participation, all of which are central to recovery processes. According to Topor et al. (2006), people in professional roles can contribute to patients' recovery process by conveying information and resources based on their expert status, exceeding expectations for their formal role, and acting in ways that deviate from conventional professional norms. The concept 'like-friends' describes an alternative form of professionalism, characterized by relationships marked by closeness and engagement beyond expected norms (Topor et al., 2006). Recovery research suggests that persons in recovery highlight the significance of a particular helper and their actions. A recurring theme in recovery narratives is reciprocity, where people in professional roles go beyond their formal roles, either by exceeding expectations or by engaging in atypical supportive behaviors. Such actions foster a sense of being seen, heard, and respected. The results showed that ISPs experienced offering patients social support and viewed themselves as a link to the community. Social interaction and support are known determinants of mental ill-health (Huggard et al., 2023), and Bjørlykhaug et al. (2022) show that social support promotes patients' personal recovery by acting as a protective factor against mental ill-health. However, there is evidence concluding that persons with severe mental ill-health can lack social capital and resources that can boost their social support. Further, mental health services rarely intervene to strengthen patients' social networks (Webber & Fendt-Newlin, 2017). Recovery is fundamentally a social process that occurs within and through interpersonal relationships, enabling persons to redefine their experiences. One way for mental health staff to do this could be to recognize ISPs and their role as valuable in helping patients build social networks.

At the same time, our findings highlight the fragility of the ISPs being positioned in a borderland. Limited access to background information, unclear boundaries, and dependency on staff decisions can constrain ISPs' agency and continuity in their relationships with patients. Thus, while ISPs have significant potential to contribute to recovery through relational and social support, realizing this potential depends on organizational structures that acknowledge and protect their unique role within the care system. Despite its positive impact, reciprocal relationships are often discouraged within institutional settings, where they may be deemed unprofessional. However, for persons in recovery, these deviations from institutional norms signal a prioritization of personal connection over bureaucratic constraints, enhancing the perceived value of the relationship (Topor et al., 2011). Based on this, we believe our results describe not only challenges of ISPs operating in a borderland, but also the potential of ISPs to support recovery due to their in-between status of 'like-friends'. Advancing mental health systems, including the ISP role, requires developing and implementing approaches that recognize the inherently relational nature of recovery, ensuring that social connections remain central (Price-Robertson et al., 2017).

Our results showed that the organizational challenges experienced by ISPs could stem from staff's misconceptions about the ISP role. McKeown et al. (2014) found that mental health staff have described that ISPs can be unfamiliar with mental ill-health and that this becomes a barrier to successful work. Further, they discuss that mutual understanding and appreciation of each other's roles are fundamental and facilitate patients' right to access ISP. As we see it, the reverse might mean that patients' access to ISPs can be hindered. We argue that it would be beneficial if ISPs and mental health staff were united through recovery-oriented practice models. It is reasonable to believe that such a common ground could help avoid misconceptions and facilitate collaboration on the patient's journey toward recovery.

Our results also show that ISPs need to navigate ethical challenges when they witness patients being subjected to inadequate care, while at the same time not knowing how to respond to the situation or feeling that they did not have the full picture. This is an important finding that points to the need for further research. The occurrence of moral distress among staff in psychiatric care is well documented, as are its potential negative consequences in terms of poorer outcomes (Lamoureux et al., 2024). Given the specific conditions of the ISP role, more knowledge is needed about how moral distress affects ISPs and how it could be addressed. Based on our findings, better collaboration and a shared understanding of the content and purpose of care between ISPs and staff could provide ISPs with improved conditions for managing ethical challenges.

Methodological discussion

Participants were recruited from different genders, ages, experiences, and geographical locations, which strengthens the credibility of the study (Graneheim et al., 2017; Graneheim & Lundman, 2004). The participants represent several regions in Sweden, which may increase transferability (Graneheim & Lundman, 2004). Although the participants varied due to age, experiences, and geographical locations it can be seen as a limitation that they were only nine people participating. However, adding more participants do not necessarily guarantee richer data (Sandelowski, 1995). The conducted interviews had high quality and provided detailed and rich data. The interviews were conducted by telephone which may be considered a limitation. On the one hand, telephone interviews can make it more difficult to perceive non-verbal cues, which can be challenging when the interviewer is assessing the participant's reactions and state of mind. Technical problems and distractions can also interfere with the interview, and the rather impersonal format can contribute to shorter answers (Enoch et al., 2023). On the other hand, telephone interviews are considered time-efficient and enable contact with informants from other geographical areas. Further, telephone interviews can create a sense of anonymity for the informant, which can make it easier to talk about difficult issues (Enoch et al., 2023; Musselwhite et al., 2007). One of the authors conducted all the interviews, which can be seen as a strength, as a similar interview procedure is considered desirable (Graneheim & Lundman, 2004).

Conclusion

This study underscores the valuable role of ISPs in mental health recovery, particularly through their ability to form supportive relationships that go beyond traditional professional norms. Acting "like-friends," ISPs foster reciprocity, which is central to recovery-oriented practices. ISPs also bridge social gaps by offering support and community connections, critical for persons who lack social networks. However, organizational misunderstandings about the ISP role can hinder their contribution. Also, ISPs face ethical challenges that need to be further understood and addressed. Promoting shared recovery models and collaboration between ISPs and mental health staff could address these challenges. We recommend that PBs and mental health staff support ISPs, recognizing their involvement to relational and recovery-oriented mental health services.

Implications for practice

Our findings shows that the role of the ISP is not well understood by mental health staff, resulting in a lack of appreciation and support. Thus, we suggest that PBs should support and advocate for the ISP role, ensuring it is embedded in policy and practice as a valued component of mental health services. We encourage mental health services to integrate ISPs into strategies to build patients' social capital and further, mental health staff and ISPs to work collaboratively, with a shared understanding of each other's roles. To make that possible, we urge PBs and mental health services to organize joint training for them in recovery-oriented practices to reduce misconceptions and enhance mutual respect. In doing so, it is important not to compromise the ISP's independence.

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Ethical approval

The study has been approved by the Swedish Ethical Review Authority (Dnr 2022-06503-01).

The participants received both written and oral information about the voluntary nature of participation, the purpose of the study, the right to withdraw, and the processing of data. Informed consent was obtained before each interview.

Author contributions

CRediT: **Britt-Marie Lindgren**: Conceptualization, Formal analysis, Methodology, Supervision, Writing – original draft, Writing – review & editing; **Jenni Lahti Nilsson**: Formal analysis, Investigation, Writing – review & editing; **Sebastian Gabrielsson**: Conceptualization, Methodology, Writing – original draft, Writing – review & editing; **Jenny Molin**: Conceptualization, Formal analysis, Methodology, Project administration, Writing – original draft, Writing – review & editing.

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Data availability statement

The data that support the findings of this study are not publicly available due to privacy and ethical restrictions.

References

Akther, S. F., Molyneaux, E., Stuart, R., Johnson, S., Simpson, A., & Oram, S. (2019). Patients' experiences of assessment and detention under mental health legislation: Systematic review and qualitative meta-synthesis. *BJPsych Open*, *5*(3), e37. https://doi.org/10.1192/bjo.2019.19

Bjørlykhaug, K. I., Karlsson, B., Hesook, S. K., & Kleppe, L. C. (2022). Social support and recovery from mental health problems: A scoping review. *Nordic Social Work Research*, *12*(5), 666–697. https://doi.org/10.1080/2156857x.2020.1868553

Eades, S. (2018). Impact evaluation of an Independent Mental Health Advocacy (IMHA) service in a high secure hospital: A co-produced survey measuring self-reported changes to patient self-determination. *Mental Health and Social Inclusion*, *22*(1), 53–60. https://doi.org/10.1108/mhsi-12-2017-0054

Enoch, J., Subramanian, A., & Willig, C. (2023). "If you don't like it, I'll just pop the phone down!": Reflecting on participant and researcher experiences of telephone interviews conducted during the COVID-19 pandemic. *SSM - Qualitative Research in Health*, *4*, 100351. https://doi.org/10.1016/j.ssmqr.2023.100351

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

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

Huggard, L., Murphy, R., O'Connor, C., & Nearchou, F. (2023). The social determinants of mental illness: A rapid review of systematic reviews. *Issues in Mental Health Nursing*, *44*(4), 302–312. https://doi.org/10.1080/01612840.2023.2186124

Lamoureux, S., Mitchell, A. E., & Forster, E. M. (2024). Moral distress among acute mental health nurses: A systematic review. *Nursing Ethics*, *31*(7), 1178–1195. https://doi.org/10.1177/09697330241238337

Lindgren, B.-M., Lundman, B., & Graneheim, U. H. (2020). Abstraction and interpretation during the qualitative content analysis process. *International Journal of Nursing Studies*, *108*, 103632. https://doi.org/10.1016/j.ijnurstu.2020.103632

McKeown, M., Ridley, J., Newbigging, K., Machin, K., Poursanidou, K., & Cruse, K. (2014). Conflict of roles: A conflict of ideas? The unsettled relations between care team staff and independent mental health advocates. *International Journal of Mental Health Nursing*, *23*(5), 398–408. https://doi.org/10.1111/inm.12069

Musselwhite, K., Cuff, L., McGregor, L., & King, K. M. (2007). The telephone interview is an effective method of data collection in clinical nursing research: A discussion paper. *International Journal of Nursing Studies*, *44*(6), 1064–1070. https://doi.org/10.1016/j.ijnurstu.2006.05.014

Newbigging, K., Ridley, J., McKeown, M., Machin, K., & Poursanidou, K. (2015). 'When you haven't got much of a voice': An evaluation of the quality of Independent Mental Health Advocate (IMHA) services in England. *Health & Social Care in the Community*, *23*(3), 313–324. https://doi.org/10.1111/hsc.12153

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

National Institute for Health and Care Excellence (NICE). (2022). *Advocacy services for adults with health and social care needs*. NICE Guideline, No. 227. https://www.ncbi.nlm.nih.gov/books/NBK588858/

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

Ridley, J., Newbigging, K., & Street, C. (2018). Mental health advocacy outcomes from service user perspectives. *Mental Health Review Journal*, *23*(4), 280–292. https://doi.org/10.1108/mhrj-10-2017-0049

Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing & Health*, *18*(2), 179–183. https://doi.org/10.1002/nur.4770180211

Silva, B., Bachelard, M., Bonsack, C., Golay, P., & Morandi, S. (2023). Exploring patients' feeling of being coerced during psychiatric hospital admission: A qualitative study. *The Psychiatric Quarterly*, *94*(3), 411–434. https://doi.org/10.1007/s11126-023-10039-6

Stylianidis, S., Peppou, E. L., Drakonakis, N., Iatropoulou, G., Nikolaidi, S., Tsikou, K., & Souliotis, K. (2018). Patients' views and experiences of involuntary hospitalization in Greece: A focus group study. *International Journal of Culture and Mental Health*, *11*(4), 425–436. https://doi.org/10.1080/17542863.2017.1409778

Sugiura, K., Pertega, E., & Holmberg, C. (2020). Experiences of involuntary psychiatric admission decision-making: A systematic review and meta-synthesis of the perspectives of service users, informal carers, and professionals. *International Journal of Law and Psychiatry*, *73*, 101645. https://doi.org/10.1016/j.ijlp.2020.101645

SFS. 1991:1128 The Compulsory Psychiatric Care Act [Lag om psykiatrisk tvångsvård, LPT] Socialdepartementet. https://www.riksdagen.se/sv/dokument-och-lagar/dokument/svensk-forfattningssamling/lag-19911128-om-psykiatrisk_sfs-1991-1128/

SFS. 1962:700 The Criminal Code [Brottsbalken]. Justititedepartementet. https://www.riksdagen.se/sv/dokument-och-lagar/dokument/svensk-forfattningssamling/brottsbalk-1962700_sfs-1962-700/

SFS. 1991:1129 The Forensic Psychiatric Care Act [Lag om rättspsykiatrisk vård, LRV]. Socialdepartementet. https://www.riksdagen.se/sv/dokument-och-lagar/dokument/svensk-forfattningssamling/lag-19911128-om-psykiatrisk-tvangsvard_sfs-1991-1129/

SFS. 1982:763 The Health and Medical Services Act [Hälso- och sjukvårdslagen, HSL]. Socialdepartementet. https://www.riksdagen.se/sv/dokument-och-lagar/dokument/svensk-forfattningssamling/halso-och-sjukvardslag-1982763_sfs-1982-763/

Topor, A., Borg, M., Mezzina, R., Sells, D., Marin, I., & Davidson, L. (2006). Others: The role of family, friends, and professionals in the recovery process. *American Journal of Psychiatric Rehabilitation*, *9*(1), 17–37. https://doi.org/10.1080/15487760500339410

Topor, A., Borg, M., Di Girolamo, S., & Davidson, L. (2011). Not just an individual journey: Social aspects of recovery. *International Journal of Social Psychiatry*, *57*(1), 90–99. https://doi.org/10.1177/0020764010345062

Webber, M., & Fendt-Newlin, M. (2017). A review of social participation interventions for people with mental health problems. *Social Psychiatry and Psychiatric Epidemiology*, *52*(4), 369–380. https://doi.org/10.1007/s00127-017-1372-2

Weller, P., Alvarez-Vasquez, S., Dale, M., Hill, N., Johnson, B., Martin, J., Maylea, C., & Thomas, S. (2019). The need for independent advocacy for people subject to mental health community treatment orders. *International Journal of Law and Psychiatry*, *66*, 101452. https://doi.org/10.1016/j.ijlp.2019.101452

Wyder, M., Bland, R., Herriot, A., & Crompton, D. (2015). The experiences of the legal processes of involuntary treatment orders: Tension between the legal and medical frameworks. *International Journal of Law and Psychiatry*, *38*, 44–50. https://doi.org/10.1016/j.ijlp.2015.01.006