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The State of Person-Centred Care in Forensic Mental Health Services: Findings from a Nationwide Staff Survey

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Research Article

Keywords: forensic psychiatry, patient participation, person-centred care, quality of health care, shared decision-making, survey

Posted Date: September 14th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-10764171/v1

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Additional Declarations: No competing interests reported.

Abstract

Background

Person-centred care is widely promoted in international health policy, yet its application in forensic mental health services remains insufficiently assessed.

Objective

This study investigated how forensic mental health staff in Sweden rate their provided care as being person-centred and whether these perceptions vary according to staff characteristics and organisational conditions.

Methods

A nationwide quantitative survey was conducted across 13 forensic psychiatric hospitals, yielding responses from 718 staff working in forensic psychiatric rehabilitation wards. The Person-Centred Care Assessment Tool (P-CAT) was used along with contextual background questions and open-text fields.

Findings

The P-CAT total score of 50 (range 13–65) represented a relatively high perceived level of person-centred care. The *Personalising Care* subscale scored higher than the *Organisational Support* subscale. No significant differences were found based on demographic variables. Contextual background questions showed that feeling safe on the ward, being satisfied with hospital security, and experiencing an open communication climate without fear of violence were all positively associated with higher total scores. A summative content analysis of open-text comments highlighted contextual challenges, such as navigating risk during relational communication, as well as insufficient staffing and competence.

Conclusions

Despite the inherent challenges of forensic mental health services, staff rated the person-centredness of their work at levels within the upper end of scores derived from other healthcare contexts in which the promotion of patient agency, holistic care and participation constitutes a more explicit goal of care. These findings suggest that person-centred care is both feasible and clinically relevant in forensic mental health care, indicating that approaches developed in general healthcare may be transferable and meaningfully implemented to forensic mental health services when adapted to the structural and legal constraints of these environments.

BACKGROUND

Person-centred care (PCC) is internationally recognised as a guiding paradigm in healthcare policy and practice, emphasising seeing the patient as a unique person and providing care that is responsive to individuals' values, goals, and lived experiences.

Central principles include mutual relationships, autonomy, and shared decision-making [1–3].

Forensic mental health care operates at the intersection of mental health care and the criminal justice system, providing treatment for individuals with serious mental illness under legal mandate [4]. These settings are characterised by lengthy stays, restrictions and complex psychiatric, social, and forensic needs [5, 6]. Within forensic mental health services (FMHS), implementation of PCC principles can be further complicated by competing demands related to risk management, security, legal responsibilities, and public protection [7].

Nevertheless, there is growing international consensus that PCC should constitute a core component of high-quality FMHS. A recent international Delphi consensus identified PCC, therapeutic relationships, relational security, recovery orientation, and participation of patients as guiding principles for contemporary FMHS [8]. The consensus further concluded that evidence regarding the implementation and evaluation of person-centred models in FMHS remains limited, highlighting the need for implementation and evaluation-focused research.

However, patients and staff report a structural reality that directly hinders core elements of PCC, including challenges in communication and documentation, limited space for autonomy and staff's (un)willingness to share control over decisions (Author, 2024). Several studies have suggested that elements of PCC, such as respect, relational presence, transparency and participation in discussions about care, can be integrated into FMHS and may improve ward atmosphere, therapeutic engagement and staff satisfaction [9, 10] (Author, 2024).

In contrast to FMHS, other healthcare domains treating vulnerable populations with complex needs (e.g. palliative and dementia care) explicitly emphasise quality of life, autonomy and holistic needs, highlighting fundamentally different care goals [11, 12]. Whereas these settings align closely with PCC principles, FMHS remain more tightly bound to societal objectives, such as public protection, legal accountability and the prevention of future crime [13]. Given these differences, a reasonable hypothesis is that staff who work within FMHS will report lower levels of PCC.

Investigating staff-rated PCC and its relationship to contextual conditions can provide insight into barriers and opportunities for implementation. Comparing PCC ratings in FMHS with those in less restrictive settings may further clarify the extent to which existing PCC frameworks require adaptation. The present study provides the first nationwide analysis of staff-rated PCC across Swedish FMHS, drawing on a large, multi-site sample to examine how perceptions of PCC are shaped by contextual and organisational factors.

OBJECTIVE

The primary objective of this study was to investigate how staff in FMHS rate the person-centredness of the care they provide. Secondary aims were to (1) examine differences in PCC scores across subgroups; (2) explore whether contextual features of FMHS influence how staff rate the person-centredness of their care; and (3) compare PCC ratings in FMHS and other healthcare settings to assess whether the distinct FMHS characteristics are reflected in staff evaluations and whether general PCC frameworks are applicable in the FMHS context.

METHODS

Design and instruments

Data were collected using the Person-Centred Care Assessment Tool (P-CAT), complemented by context-specific background questions and open-text fields. The P-CAT is a brief self-report instrument originally developed to measure healthcare staff's rating of PCC in long-term care settings [14]. Since its introduction, it has been validated internationally and the scale has demonstrated robust psychometric properties across multiple languages and health care contexts, including long-term, acute care and psychiatric care [15, 16]. Recent systematic reviews have confirmed the instrument's overall reliability and construct validity, with Cronbach's alpha values typically ranging between 0.80 and 0.90 [15, 16]. The P-CAT consists of 13 items rated on a five-point Likert scale ranging from 1 (*"disagree completely")* to 5 (*"agree completely").* The instrument is designed to capture both individual and organisational dimensions of PCC and typically comprises two underlying subscales: *Extent of Personalising Care (*items 1–8) and *Amount of Organisational and Environmental Support* (items 9–13) [17].

In addition to the 13 P-CAT items, the survey included five background questions with optional open-text responses. The questions were informed by a systematic literature review providing contextual information and enabling exploration of how perceived safety, security and communication climates relate to staff-rated PCC measured by the P-CAT (Author, 2024). Using a four-point categorical scale (*No, Partly, Yes, Don't know*), staff rated: (1) their wish to work with patient participation at all, (2) perceived personal safety while working on the ward, (3) satisfaction with overall hospital security, (4) perceived possibilities to discuss all topics, including difficult ones, with patients without risk of violence and (5) perceptions of whether patients can discuss all topics without fear of negative consequences.

The optional open-text fields allowed participants to elaborate on and provide FMHS-specific contextual reflections. Demographic variables were also collected to describe the study population and explore potential group differences.

The questionnaire was pilot tested with five staff members representing different professional groups to assess clarity and contextual relevance. Feedback indicated that some items were challenging to interpret within the FMHS context; however, no modifications were made to the P-CAT to preserve comparability with previous studies. Background variables were recoded into categorical groups to

facilitate subgroup analyses. Age, years of experience, and professional roles were collapsed into three categories. Gender was analysed as a binary variable (*male*, *female*), due to small numbers in other categories.

Procedure

Data were collected over two years (2022–2024). The initial online administration had a low response, so the survey was converted to paper format, resulting in substantially higher participation. All forensic psychiatric care providers in Sweden were invited by email to participate. The invitation included study information and a request for institutional approval. The invitation included study information and a request for institutional approval. Reminders were issued periodically during the data collection period. Institutional approval was obtained through the Chief Medical Officer (CMO) at each site. Upon receiving consent, each hospital nominated a local liaison who coordinated logistics and served as the main contact with the first author. For administrative and analytical purposes, participating hospitals were assigned study-specific codes to enable classification as regional or non-regional hospitals, monitoring of hospital-level response rates and quality control during data entry and cleaning. These codes contained no information that could identify individual respondents.

A total of 1835 paper-based questionnaires were distributed to participating hospitals, together with written guidance for local coordinators regarding inclusion criteria, handling procedures and confidentiality. Surveys, the official information sheet and a pre-addressed envelope were distributed directly to staff working on eligible wards. The study was approved by the Swedish Ethical Review Authority. The overall response rate was based on the number of returned questionnaires and the estimated number of eligible staff at each hospital, as reported by the local liaison responsible for coordinating data collection. The survey was voluntary and completed anonymously during regular working hours.

Sample and Participants

A total of 718 staff members working in Swedish inpatient forensic psychiatric hospitals (security level 2 and 3) participated in the survey. In Sweden, FMHS is administratively organised under 25 healthcare providers; however, clinical inpatient care is delivered across 19 forensic psychiatric hospitals. This distinction reflects that several healthcare providers purchase forensic psychiatric inpatient care from specialised hospitals rather than operating their own FHMS. All 25 healthcare providers were invited to participate in the study. Of the 19 hospitals delivering inpatient FMHS, 13 granted consent to participate, and 12 hospitals ultimately participated by returning completed staff surveys. All five national regional forensic psychiatric hospitals participated (representing 56% of the sample). These regional hospitals have a formally designated mandate to treat patients with more complex clinical needs and higher levels of risk. Therefore, their inclusion ensured representation from highly specialised regional hospitals to smaller local forensic psychiatric hospitals. The participating hospitals were geographically dispersed,

supporting national representativeness. The largest regional forensic hospital in Växjö, accounted for approximately 20% of the total sample, whereas the remaining hospitals each contributed smaller proportions, around 10% of the total sample.

Participants were evenly distributed by gender and spanned a wide age range, with a larger proportion aged 46 years or older. Years of professional experience varied, and the sample was predominantly composed of assistant psychiatric nurses. This accurately reflects the national staffing structures in Swedish FMHS.

Reliability

The internal reliability of the P-CAT, examined using Cronbach's alpha, was α = .76 for the full 13-item scale, indicating an acceptable internal consistency among the items. However, item 13 *("Residents are able to access outside space as they wish")* was subsequently excluded because previous validation studies have suggested potential conceptual limitations [17] and outside access may be inherently restricted in secure settings. When item 13 was removed Cronbach's alpha increased slightly to .77. Both coefficients fell within the acceptable range (α ≥ .70), supporting the reliability of the P-CAT in inpatient forensic psychiatric care. All 13 items were retained in the main analysis to preserve comparability with previous studies.

Subscale-level reliability analyses further supported internal consistency of the instrument. The *Personalising Care* subscale (Cronbach's α = .70) and the *Organisational and Environmental Support* subscale (Cronbach's α = .73) demonstrated acceptable internal consistency. Both analyses were based on 677 cases (94.3%), indicating a low level of missing data and supporting the robustness of the findings.

Data and Statistical Analyses

Statistical analyses were conducted using IBM SPSS Statistics [18] and structured around the four objectives of the study. The summed P-CAT total score (range 13–65), mean item score (range 1–5), and subscale mean scores were calculated and reported to facilitate comparison with previous studies using different reporting formats. In line with prior psychometric studies, item scores were treated as continuous variables, where higher scores indicated a higher perceived degree of PCC [14, 17]. When fewer than 10% of item responses were missing, missing values were replaced with the corresponding item mean across the sample, following Edvardsson et al. (2010). Medians and interquartile ranges were calculated to determine score distributions, which were visually presented in a boxplot (Fig. 1). Subscale means were calculated separately for *Personalising Care* and *Organisational and Environmental Support* to explore differences between relational and structural PCC dimensions. Individual item-level means and standard deviations were reviewed to identify the specific aspects of PCC that were rated highest and lowest by staff.

The potential differences in P-CAT scores across demographic subgroups were examined using independent-samples *t*-tests for dichotomous variables (gender and hospital type) and one-way ANOVAs for variables with more than two categories (age, profession and years of clinical experience). Although the P-CAT items were measured on a Likert scale, the total and subscale scores were treated as continuous variables, in line with previous studies using the instrument. The use of parametric tests was considered appropriate given the validated composite nature of the scale, the large sample size and the approximate normal distribution of summed scores, consistent with the central limit theorem. Descriptive statistics were calculated for each subgroup. Statistical significance was set at $p < .05$. Where relevant, the Holm–Bonferroni method was applied to adjust for multiple comparisons.

Pearson's correlation coefficients were used to examine associations between P-CAT total scores and the background questions assessing contextual factors within FMHS.

Open-text responses linked to the background questions were also analysed using summative content analysis. The analysis involved identifying frequently occurring expressions or meaning units, quantifying their frequency and grouping them into descriptive categories that reflected manifest content. This provided a richer understanding of how staff perceived the organisational conditions that shaped their ability to provide PCC.

Studies for comparison were identified through systematic reviews and key original publications and were included if they reported descriptive P-CAT scores reflecting staff-rated levels of PCC. Subscale scores and Cronbach's alpha coefficients were included where available to support comparison across settings.

FINDINGS

The results are presented as four sections: overall P-CAT scores, subgroup comparisons, associations with contextual factors and findings from the content analysis and comparison with other healthcare settings.

Staffs' Ratings of Provided Care as Person-centred

The total P-CAT score was 50.2 (SD = 7.17) (Fig. 1), corresponding to a mean item score of 3.86 (SD = 0.55). Total P-CAT scores were distributed across a wide range, with a median of ~ 51 and an interquartile range of mid-40s–mid-50s. Most scores were concentrated above the midpoint of the scale, within the higher range. The total score for the subscale *Personalising Care* was 31.4, corresponding to a mean item score of 3.92, whereas *Organisational and Environmental Support* had a total score of 18.8, corresponding to a mean item score of 3.75.

The lowest item means were observed for item 13 (*Patients are able to access outside space as they wish*), item 5 (*Freedom to alter work routines*) and item 9 (*Work completion prioritised over homelike*

environment), (Table 1).

Table 1
Descriptive statistics for individual P-CAT items among staff in FMHS

Item	n	Mean (SD)
1. We often discuss how to give person-centred care	712	4.42 (0.80)
2. We have formal team meetings to discuss patients' care	713	4.55 (0.84)
3. The life history of the patients is formally used in the care plans	718	4.34 (0.78)
4. The quality of the interaction between staff and patients is more important than getting the tasks done	711	3.72 (0.96)
5. We are free to alter work routines based on patients' preferences	709	3.26 (1.11)
6. Patients are offered the opportunity to be involved in individualised everyday activities	716	4.25 (0.89)
7. I simply do not have the time to provide person-centred care	711	3.92 (1.10)
8. The environment feels chaotic	710	3.89 (1.28)
9. We must get the work done before we can worry about a homelike environment	706	3.26 (1.26)
10. The organisation prevents me from providing person-centred care	711	3.74 (1.21)
11. Assessment of patients' needs is undertaken on a daily basis	710	3.89 (1.27)
12. It is hard for patients in the facility to find their way around	703	4.23 (1.05)
13. Patients are able to access outside space as they wish	709	2.95 (1.48)

Examining Differences in P-CAT Scores Across Background Characteristics

ANOVA data showed no statistically significant differences in total scores across age groups ($F(2, 700) = 1.46$, $p = .232$), professional categories ($F(2, 715) = 0.53$, $p = .587$), or clinical experience in FMHS ($F(2, 715) = 2.94$, $p = .054$). A t-test showed no significant differences for hospital type ($t(633.5) = 1.23$, $p = .219$) or gender differences ($t(699) = 1.87$, $p = .062$), although men reported slightly higher scores.

Table 2 shows the mean P-CAT scores and standard deviations across demographic and professional backgrounds.

Table 2
Descriptive statistics of the P-CAT mean by background characteristics

Background variable	Group	% (n = 718)	Mean (SD)
Gender	Male	51	3.91 (0.54)
	Female	49	3.83 (0.53)
Age	18–29 years	20	3.82 (0.55)
	30–45 years	36	3.86 (0.53)
	46 + years	45	3.88 (0.56)
Experience	≤ 3 years	31	3.90 (0.53)
	3–10 years	37	3.80 (0.57)
	> 10 years	32	3.90 (0.55)
Education	Assistant staff	74	3.86 (0.54)
	Registered nurses	10	3.83 (0.59)
	Specialist or academic professionals	16	3.91 (0.55)
Hospital type	Regional hospital	53	3.29 (0.38)
	Non-Regional hospital	47	3.25 (0.43)

Contextual Factors Influencing Person-Centred Care: Associations and Summative Content Analysis

Associations between staff responses on contextual factors and the P-CAT total score were analysed using Pearson's correlation (Table 3).

Table 3
Staff-reported perceptions of work with patient participation, safety, security and communication in FMHS

Background Question	N	No %	Partly %	Yes %	Negative % (No + Partly)
Like to work more with participation	712	15	27	59	41
Feel safe at work	713	1	17	82	18
Satisfied with security	712	9	31	61	39
Can discuss everything without risk of violence	709	10	50	40	60
Patients can talk freely without fear of consequences	709	9	33	58	42

All contextual factors showed significant positive associations with P-CAT total and subscale scores ($p < .001$) (Table 4). The strongest correlations related to the P-CAT total score were perceived safety on the ward ($r = .36$) and satisfaction with security ($r = .32$). Similar patterns were observed across both subscales, *Personalising Care* ($r = .23$ and .21) and *Organisational and Environmental Support* ($r = .35$ and .30).

Table 4
Correlations between contextual factors and P-CAT total and subscale scores.

Contextual factor	P-CAT Total score	*Personalising Care*	*Organisation & Environmental Support*
Feel safe on ward	.36***	.23***	.35***
Satisfied with security	.32***	.21***	.30***
Talk about everything without risk of violence	.22***	.16***	.20***
Patients can talk freely without punishment	.26***	.18***	.23***

**Note.* Pearson's r between staff's perceptions of ward safety, security, and communication climate and P-CAT total and subscale scores. ****p < .001*.

Perceptions of the communication climate were also positively related to PCC. Staff who reported the possibility of discussing all topics with patients without risk of violence ($r = .22$, $p < .001$) and treating patients who were able to speak freely without fear of punishment ($r = .26$, $p < .001$) reported higher levels of PCC (Table 4).

The correlation analyses were complemented by a summative content analysis of 526 open-text responses. Staff identified organizational factors, particularly limited time and staffing, as the main barriers to further developing patient participation. Several respondents expressed that participation was already sufficient in current practice. Perceived safety was primarily associated with adequate staffing, staff competence, and consistent security routines, while communication was described as requiring continuous risk assessment and strong relational competence. Some respondents perceived that fear of negative consequences limited patients' willingness to discuss sensitive issues, whereas threats, violence, and coercive care were mentioned only occasionally (supplementary Table S1).

Comparison of P-CAT Ratings in Forensic Mental Health Services with Other Healthcare Settings

The mean P-CAT score in the present study (M = 3.86) is comparable to levels reported in previous staff survey studies (approximately 3.6 to 3.9) conducted in long-term and institutional care settings (supplementary Table S2). Similarly, the total P-CAT score was consistent with findings from studies reporting summed scores [19, 20]. Notably, our mean score, derived from a nationwide sample, falls within the upper range of scores reported in long-term, geriatric and palliative care settings and is higher than the score reported in the only Swedish forensic psychiatric P-CAT study (M = 3.63) [21] .

Cronbach's alpha analysis of internal consistency of the *Organisational and Environmental Support* subscale demonstrated acceptable reliability (α = .68), comparable to values reported in previous psychometric evaluations across general healthcare and institutional care settings. In contrast, the *Personalised Care* subscale showed consistently lower internal consistency (α = .59), as also reported by Degl' Innocenti et al. 2020. This suggests a sensitivity of items related to individualised care to contextual and organisational constraints present in FMHS. Variability in subscale reliability has been noted in previous studies across different care contexts, with subscales typically showing lower and more heterogeneous estimates compared to the total scale [14, 22–24].

Reporting formats also showed variation in previous studies. The original development study reported P-CAT results as mean item scores on a 1–5 scale [14], whereas later studies have reported either summed total scores or both formats. Nevertheless, the overall level of staff-rated PCC observed in the present FMHS sample trends towards the upper range of levels reported in other healthcare contexts.

DISCUSSION

This nationwide study of staff-reported levels of PCC in Swedish forensic psychiatric hospitals revealed a relatively high perception of PCC. Compared to other health care settings, PCC levels from FMHS trended towards the upper end of previously reported ranges. This is notable, given the restrictive and security-oriented nature of forensic psychiatric care, where patients are hospitalised involuntarily and opportunities for autonomy and participation are structurally constrained. Furthermore, the consistency between the observed PCC levels and the international meta-analytic mean item scores across 25 samples involving more than 15,000 participants [16] suggests that FMHS staff do not necessarily have

a low perception of the person-centredness of their practice. One possible interpretation is that staff perceptions of PCC in FMHS are more strongly influenced by relational aspects of care than by patients' actual opportunities for autonomy and shared decision-making This interpretation aligns with a recent systematic review that identified relational facilitators amid structural barriers in FMHS and underscored a potential disconnect between staff views and substantive PCC (Author, 2024).

These considerations highlight the importance of critically examining how PCC is understood and operationalised in coercive contexts and whether staff-rated measures reflect patients' perspective of PCC. In the following sections, we compare findings between the present study and existing literature, explore implications for PCC in FMHS practices, address limitations and propose directions for future research.

Person-centred Care Dimensions: Relational Strengths and Organisational Constraints

The item means revealed the following areas where staff perceived lower degrees of person-centredness: *limited access to outdoor spaces* (item 13), *restricted flexibility to adapt work routines based on patients' preferences* (item 5), and *prioritisation of task completion over creating a homelike environmen*t (item 9). These items all belong to the *Organisational and Environmental Support* subscale and highlight areas for improvement. Similar patterns have been reported in other highly specialised and restrictive care contexts. Healthcare professionals in allogeneic stem cell transplantation settings reported relatively high overall PCC levels (total score 45), while organisational and environmental aspects, such as time constraints and care environments, were consistently rated lower [25]. This consistent pattern across contexts suggests that organisational conditions represent a common challenge for PCC implementation [26], even in settings with strong relational care practices. These findings can be understood further by looking at previous studies identifying the details of structural and environmental barriers within FMHS, such as rigid routines, physical restrictions and high security demands [27]. However, these constraints are not solely organisational but also reflect the broader ethical and value-based complexities inherent in FMHS, where care practices are shaped by competing goals and context-dependent interpretations of what constitutes "good care" [7]. The results emphasise the need to strengthen organisational flexibility, enhance environmental conditions and create safe yet more humane living environments in long-term care settings.

Further analysis of the two P-CAT subscales showed slightly higher mean scores for *Personalising Care* than for *Organisational and Environmental Support*. In line with previous studies, this pattern suggests that staff perceive a more consistent presence of relational and interpersonal aspects of PCC than of organisational conditions that support PCC in daily practice. Similar patterns have been reported in a Swedish forensic psychiatric hospital where relational components of PCC appeared more stable over time than structural conditions, even following relocation to purpose-built facilities [22]. More broadly, this finding aligns with research from non-forensic contexts indicating an often easier integration of relational aspects of PCC than organisational or environmental changes into clinical practice, as the

latter require systemic support and managerial prioritisation. Collectively, these findings challenge assumptions that PCC is uniquely constrained within FMHS. Instead, they suggest that FMHS and other healthcare sectors share core challenges, particularly those related to organisational routines, environmental conditions and structural flexibility.

Consistency of Person-Centred Care Perceptions Across Groups

PCC perceptions did not differ significantly by staff subgroup or hospital type, indicating a consistent view across FMHS staff. These results differ from findings in other settings, where individual staff traits often influence PCC ratings. Older staff, higher education and those who had received PCC-specific training have also been reported to give higher PCC scores [25, 28]. Likewise, organisational factors (e.g. culture, teamwork) explained far more of the variation in nurses' PCC perceptions than by personal traits (e.g. compassion, self-leadership) [28]. These results imply that PCC in FMHS is shaped less by individual characteristics and more by shared contextual conditions.

Safety, Communication Climate and the Conditions for Person-Centred Care

The strong positive association between staff perceptions of safety, security and communication climate and their P-CAT total scores was a central finding. Staff who felt safe at work, were satisfied with ward security and perceived communication as psychologically safe and open also reported higher PCC levels.

These findings underscore that PCC in FMHS cannot be understood independently of safety and organisational context. A work environment characterised by physical and psychological safety appears to be a prerequisite for relational PCC practices. This aligns with previous forensic psychiatry research indicating that staff perceptions of safety and trust are closely intertwined with care quality and therapeutic relationships [20]. Notably, the lack of correlation between the *wish to work more on patient participation* and P-CAT ratings suggests that motivation alone may not translate into practice without supportive environmental conditions. Instead, other factors (e.g. staffing levels, routines, communication climate) may play a more decisive role in shaping PCC practice. This is consistent with previous research identifying time constraints and organisational barriers as key limitations to PCC despite otherwise high staff ratings [25]. Together, these findings reinforce the view that PCC does not solely depend on individual attitudes or relational competence but is shaped by structural and organisational conditions that influence its enactment in practice.

The summative content analysis provided additional context to the quantitative findings by highlighting how staff describe the influence of everyday conditions on participation, safety and communication. Staff frequently referred to organisational factors (e.g. staffing levels, staff competence, routines) as central to relational aspects of PCC. Communication was described as influenced by continuous risk assessment, relational competence and perceived consequences for patients who express concerns or

disagreement. Few comments explicitly referred to threats, violence or coercive care; when mentioned, these were typically not framed as exceptional events but as inherent features of the forensic context.

Together, these findings suggest that improving PCC in FMHS requires more than strengthening individual staff competencies or promoting person-centred values alone. Rather, implementation efforts should focus on embedding PCC within organisational routines, communication practices and working conditions that enable staff to consistently translate PCC principles into everyday practice.

Strength and limitations

This study has some limitations. The cross-sectional design precludes conclusions about causality, and the findings are based on staff self-reports, which may be influenced by social desirability bias. Although the P-CAT was originally developed for long-term care settings, previous validation studies and the acceptable reliability observed in the present study support its application in FMHS.

CLINICAL IMPLICATIONS

The results highlight safety as a prerequisite for staff to operationalize PCC. Forensic psychiatric care emerges here as a relationally strong yet structurally constrained practice. Staff demonstrate a capacity to uphold PCC values at the interpersonal level, but their ability to fully realise PCC is shaped by organisational and contextual conditions. This reflects a common pattern across care contexts, wherein the relational aspect of PCC is often easier to achieve than implementing broad organisational changes. Despite these constraints, PCC levels reported in this study trended towards the higher end compared to other healthcare settings, suggesting that person-centred frameworks are both relevant and applicable to FMHS.

Overall, the study findings imply that interventions developed for general healthcare contexts could be transferable to FMHS, provided they are adapted to account for security demands, risk management structures and legal oversight. PCC appears possible, and even sustainable, when relational practices are supported by organisational structures that promote safety-focused frameworks, providing a viable pathway for enhancing PCC in FMHS. The lack of differences in PCC perceptions between staff subgroups or hospital types in our study emphasises that systemic factors hinder full enactment of PCC in FMHS.

Declarations

Competing interests

The authors have no competing interests to report.

Funding statement

This research received no specific grant from any funding agency or commercial or not-for-profit sectors.

Authorship Statement

VVA conceived and designed the study, coordinated data collection, performed data entry, statistical analyses, and wrote the majority of the manuscript. SO contributed to study design, data analysis, interpretation of findings, and manuscript writing. EA, AW, and TN contributed to study design, guided and supported data analysis, and critically reviewed and revised the manuscript. All authors approved the final version of the manuscript.

Ethical approval and consent to participate

The study was conducted in accordance with the Declaration of Helsinki and was approved by the Swedish Ethical Review Authority (reference number [2022-02148-01]). All participants received written information about the study, including its purpose, the voluntary nature of participation, confidentiality, and their right to decline participation. Completion and return of the anonymous questionnaire were considered to constitute informed consent.

Data availability statement

De-identified data may be made available from the corresponding author on reasonable request, subject to approval by the relevant ethics committee and institutional data protection requirements.

Author Contribution

VVA conceived and designed the study, coordinated data collection, performed data entry, statistical analyses, and wrote the majority of the manuscript. SO contributed to study design, data analysis, interpretation of findings, and manuscript writing. EA, AW, and TN contributed to study design, guided and supported data analysis, and critically reviewed and revised the manuscript. All authors approved the final version of the manuscript.

Acknowledgement

The authors would like to thank Magnus Pettersson, Biostatistician (fil. lic., PStat®, AEUStat), Akademistatistik, University of Gothenburg, for his valuable support with the data analyses and manuscript feedback.

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De-identified data may be made available from the corresponding author on reasonable request, subject to approval by the relevant ethics committee and institutional data protection requirements.

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Figures

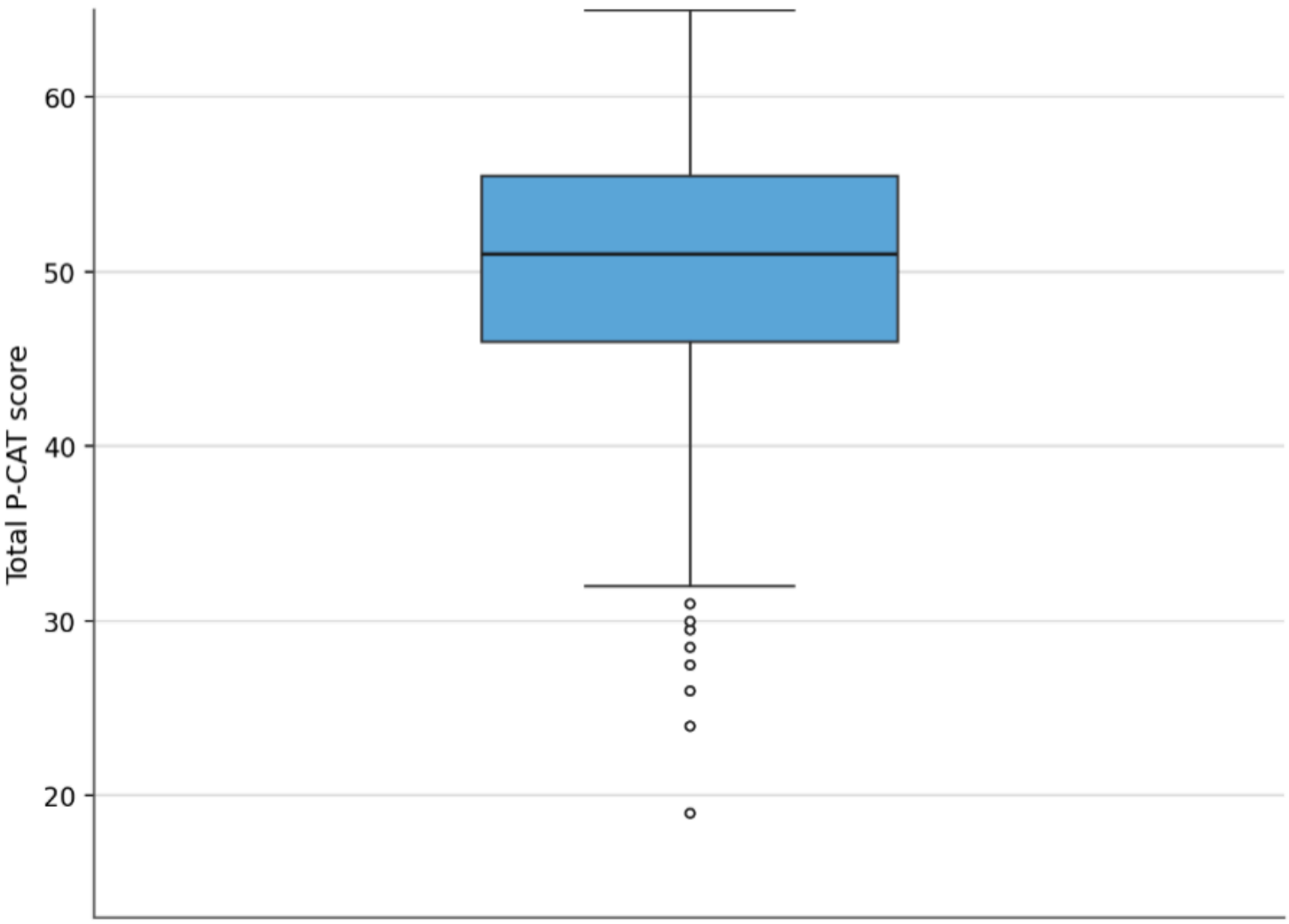


Figure 1

Distribution of the P-CAT total scores among Swedish FMH staff

Supplementary Files

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- TableS1Summativecontentanalysisofopentextcommentstobackgroundquestions..docx
- TableS2ComparisonofPCATscoresacrosshealthcaresettings.docx