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Oyster Care for persons experiencing severe persistent mental illness in residential mental health care: a pilot implementation study

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Abstract

Introduction: People experiencing severe and persistent mental illness often have complex needs that are not adequately addressed within existing healthcare systems. The Oyster Care model represents a context-specific application of palliative psychiatry that emphasises holistic, relational and creative care to support autonomy, dignity and well-being among this population. To translate the conceptual foundation of Oyster Care into residential mental health practice and to support its consistent implementation in day-to-day use, an Oyster Care monitoring tool was developed, along with a peer review process based on audit and feedback principles. This pilot study explores the experiences of mental health professionals with these strategies to inform the future embedding of Oyster Care into Flemish residential mental health care.

Methods: This study was conducted in four mental health facilities in Flanders. A procedure was developed to integrate the Oyster Care monitoring tool and the peer review process into clinical practice. A qualitative research design was used to explore mental health professionals' experiences with these strategies, in order to gauge their feasibility and acceptability. Data were collected through non-participant observations, focus groups and individual interviews.

Results: The integration of Oyster Care monitoring and the peer review process acts as a catalyst for the implementation of the care model in routine use, guiding and reflecting on care practices while promoting critical reflection, dialogue and knowledge exchange. This study highlights the value of Oyster Care as both a conceptual framework and a broader practice movement, enabling professionals to deliver high-quality care to people experiencing SPMI with renewed motivation and a shared sense of purpose.

Conclusion: Oyster Care embodies a bottom-up approach in which healthcare professionals take responsibility for reflective practices and continuous improvement, while top-down support remains essential to assure progress and coherence. Supportive policy measures are needed to strengthen professional identity and enable teams to advocate for the needs of this vulnerable population. Furthermore, it is crucial to align implementation strategies with the operational realities of clinical settings to ensure the sustainable implementation of Oyster Care and maximise the impact on care delivery and patient outcomes.

Introduction

People experiencing severe and persistent mental illness (SPMI) often have complex needs that span multiple aspects of their lives and are inadequately addressed by existing healthcare systems (1, 2). SPMI refers to long-lasting and profoundly disabling mental health conditions, such as refractory schizophrenia, treatment-resistant depression and severe bipolar disorder. For many people who experience SPMI, symptoms persist despite repeated courses of evidence-based treatment, often leaving them to cope with significant functional limitations, deep psychosocial distress and a markedly reduced quality of life (3, 4). In recent years, palliative psychiatry has gained increasing scholarly and

clinical attention as a new clinical approach within mental health care, developed to respond to the often unmet needs of this population (5). Palliative psychiatry represents a paradigmatic shift from a purely cure-oriented model of care, which emphasises symptom remission and functional restoration, toward an approach that places the person, their well-being and their lived experience at the centre. The focus is on alleviating suffering, minimizing harm and supporting quality of life, even when psychiatric symptoms persist (2, 5, 6). This approach reflects the principles of palliative medicine, recognising that for some, the pursuit of full remission may not be realistic or may even be counterproductive when weighed against the potential burden and harm of treatment.

Within this evolving field, the Oyster Care model, developed in Belgium, has been recognised as an innovative and context-specific application of palliative psychiatry for people experiencing SPMI. Oyster Care adopts a holistic approach in caring for this group of people on the basis of four pillars: physical care addresses somatic conditions, psychological care focuses on comfort and well-being, social care provides structure through activities and connections and existential care promotes a sense of meaningful living. This model focuses on creating a dynamic ‘protective shell’ around a person, one that can temporarily close when symptoms pose a risk to themselves or others, yet remains as open as possible to allow for maximum autonomy. This shell serves as a metaphor for the external environmental support required to experience quality of life, acknowledging that full recovery may not always be attainable. Rooted in the philosophy of palliative care, Oyster Care places quality of life at the heart of clinical decision-making and employs a deeply holistic, relational and creative approach to address the distressing and potentially harmful manifestations of SPMI. It seeks to support people in reclaiming autonomy, dignity and well-being, while fostering an environment that values personal meaning and existential comfort alongside symptom management (7). At present, the principles of Oyster Care are being applied by twelve units within the Flemish residential mental healthcare system. Approximately half of these units have been applying the approach for several years, while others are still in the early stages of implementation. Additionally, an increasing number of other facilities are exploring the concept for potential integration into their services. Interest in Oyster Care is also expanding beyond residential mental healthcare to nursing homes and community-based psychiatric teams.

As interest in Oyster Care has increased, between 2021 and 2023, a mixed-methods study was conducted to develop ‘the Oyster Care monitor’, a structured framework comprising 24 themes central to the care model. This tool translates the conceptual foundations of Oyster Care into daily practice, providing healthcare professionals with clear and practical guidelines on its core principles (8). The Oyster Care monitor also enables systematic monitoring of adherence to the model and can be used for both self-evaluations and external evaluations using a four-point Likert scale per theme. The external evaluation method was operationalised by the researchers through an audit and feedback-based peer review process, whereby summaries of clinical performance over a given period are compiled, with recommendations for improvement (9). Both monitoring and audit-and-feedback approaches are well-documented in the literature as effective strategies for supporting the consistent implementation of complex care models into routine use and enhancing care practices (10, 11, 12).

Following the theoretical and technical development of the Oyster Care monitor and the peer review process, the next logical step is to introduce it into clinical practice as a means of supporting the implementation of Oyster Care. This process should begin with a pilot study in a small number of representative settings, designed as a feasibility and acceptability exercise, to optimize both the instrument and the peer review process before it is used on a larger scale (13). The aim of this study is to explore mental health professionals' perceptions and experiences with the monitoring tool and the peer review process, in order to gauge their feasibility and acceptability in supporting the implementation of Oyster Care in Flemish mental health settings.

Methods

Design: A qualitative study design was used to explore mental health professionals' perceptions and experiences with the Oyster Care monitor (see Table 1.) and the peer review process. Data were collected through non-participant observations, focus groups and individual interviews (14). Building on the collaborative development of the Oyster Care monitor, this pilot study engaged closely with end users on the work floor to ensure that the tool and peer review process were acceptable, feasible and aligned with the realities of everyday clinical practice. This approach aimed to increase the likelihood of a successful roll-out of the monitor and the peer review process, thereby supporting the sustainable embedding of Oyster Care into Flemish residential mental health care (15, 16).

Table 1
Oyster Care monitor, domains and themes

Domains of the monitoring tool	Themes of the monitoring tool
Domain 1. The care process	Theme 1. The acquaintance
	Theme 2. The personalized support plan
	Theme 3. The support meeting
	Theme 4. Upscaling and downscaling care intensity
Domain 2. The somatic pillar	Theme 5. Physical health
	Theme 6. The eating experience
	Theme 7. Contact with the body
	Theme 8. Medication
Domain 3. The psychological pillar	Theme 9. The care relationship
	Theme 10. Therapy and activities
	Theme 11. Dealing with symptoms
	Theme 12. Dealing with crisis and coercive measures
Domain 4. The social pillar	Theme 13. Family and significant others
	Theme 14. Activation
	Theme 15. Social participation and inclusion
Domain 5. The existential pillar	Theme 16. Connection, meaning and identity
	Theme 17. Spirituality, worldview and religion
Domain 6. End-of-Life care	Theme 18. Advance care planning
	Theme 19. End-of-life care
	Theme 20. Post-death care
Domain 7. Team vision, -culture and -development	Theme 21. Attitude
	Theme 22. Professionalization, innovation and quality of care
	Theme 23. Leadership
Domain 8. The place of residence	Theme 24. The home and living environment

Setting and sample: The study was conducted in four mental health facilities across Flanders, purposively selecting two psychiatric nursing homes and two psychiatric hospitals, the types of facilities for which the monitoring instrument was specifically designed and validated (8). In both psychiatric

hospitals, this includes one Oyster Care unit with all 25 to 30 residents experiencing SPMI. One psychiatric nursing home provides care to 21 residents, 8 of whom experience SPMI. The other psychiatric nursing home provides care to 60 residents, 15 of whom experience SPMI. Residents with SPMI are offered Oyster Care, while other residents with milder mental health problems are offered recovery-oriented care. Psychiatric nursing homes have a lower staff-to-resident ratio than psychiatric hospitals do. Three of the four facilities had already been implementing the Oyster Care philosophy for several years, whereas one facility had only recently initiated its implementation (approximately six months prior to the study). In each facility, all healthcare professionals involved in Oyster Care were invited by the local contact person to participate in the study and in multiple data collection sessions.

Procedure: 'Integration of the monitoring tool and the peer review process into clinical practice': The monitoring tool can be used to systematically observe whether implementation (in this case: Oyster Care) is proceeding as intended. The peer review process, based on audit and feedback, involves providing summaries of clinical performance over a specified period. Together, these strategies guide the implementation of the care model and allow it to be refined based on empirical data (10). In the procedure, each team's Oyster Care implementation is evaluated by external peers using the monitoring tool. The evaluation assesses performance against the 24 themes of the monitor on a four-point scale. This scale ranges from 'not visible' to 'in development,' 'embedded,' and 'pearl'. The latter draws upon the shell metaphor, which serves as the central metaphor of the Oyster Care model. 'Pearl' can be interpreted as 'exemplary' or representing excellence in implementation. The quantitative scores are underpinned by qualitative feedback and recommendations for improving clinical practice. The findings are communicated back to the team and jointly reflected upon, with the aim of driving performance improvement (12, 17). The evaluations are conducted by external peers, professionals with similar backgrounds and expertise from other pilot sites, which promotes mutual understanding, credibility of performance results and constructive dialogue (18). Within this context, the commonly used term 'audit' is therefore replaced by 'peer review'.

The researchers developed both the monitoring tool and the peer review process in co-creation with experts from ART (19) and FACT (20), two treatment methods in the Netherlands for people experiencing severe mental illness, using proven methods for quality assessment, including monitoring and auditing. FACT supports people in their own environment with flexible care, while ART focuses on recovery for people who have been treated clinically for long periods of time. In addition, the progress of the study was repeatedly communicated to members of the Oyster Care Forum for feedback. The forum is a digital meeting where professionals, academics and educational partners within Oyster Care meet several times a year to further grow, refine and evaluate the concept and related initiatives.

At each facility, the local contact person was asked to recruit two healthcare professionals, preferably from different disciplines, for the role of peer reviewer. In one psychiatric nursing home, this number was reduced from two to one peer reviewer to increase feasibility within the staffing schedule. The seven reviewers conducted a peer review in pairs or trios. The distribution of peer reviews was determined based on several factors: the personal preferences of the peer reviewers (e.g., feasibility related to travel

time, interest in visiting a specific facility), the aim of having each reviewer conduct at least two peer reviews to increase the learning effect, and the regulation that the pairs or trios could not include two members from the same facility, to minimise potential bias. The peer reviewers received a one-day training course on how to conduct a peer review, in an appreciative rather than a judgmental manner and on how to use the monitoring tool. This training was organised in collaboration with the Centrum Certificering ACT en FACT (CCAF), a Dutch foundation with expertise in auditing and auditor training. The CCAF certifies teams that provide model-fidelity care to people experiencing severe mental illness, such as those working in FACT teams.

The procedure of monitoring and peer review was repeated at each participating facility, it consists of the following components:

1) An educational session for the team

on the use of the monitor and the peer review process

2) A site visit: A site visit was conducted during which the peer reviewers spent a full day with the team to gain a thorough understanding of how the team operates, based on 24 themes from the monitor. The site visit was prepared by the host team, who bundled information about their operations using a standardised template and drew up a daily schedule for the peer reviewers. The daily schedule included the following components: a guided tour of the facility, an interview with the team (in which peer reviewers took an active role), attendance at team meetings (in which peer reviewers took an observational role), file audits, informal interactions with residents and optionally, participation in a family meeting, therapy session or other activities. This information was sent to the peer reviewers and researchers two weeks in advance. The timing of each site visit was determined in consultation with the ward manager, taking into account feasibility (e.g., preparation time for the visit) and the opportunity to observe specific activities or meetings considered particularly relevant. A peer reviewer from the host team moderated the site visit.

3) Consensus assessment process

After the site visit, the peer reviewers individually assessed the teams' performance on 24 themes from the monitoring tool. They then met (online) to discuss the similarities and differences between their individual scores and to formulate a consensus score for each of the 24 themes. During the assessment process, the peer reviewers completed both the four-point scale for each theme and qualitative information to support their scores, as well as suggestions for improving a teams' current practice.

4) Researcher-led *feedback of the scores* to the team: Two weeks after each site visit, the scores on the monitoring instrument were fed back to the team by the researchers. During this feedback session, the team had the opportunity to ask questions, challenge scores, share concerns and jointly reflect on potential areas for improvement.

Data collection: To obtain a comprehensive understanding of both the use of the monitor and the peer review process, data was collected at multiple points throughout the study. Non-participatory observation was conducted during the training day for peer reviewers and during each of the four site visits. Two weeks after each site visit, the peer reviewers who conducted the visit and those who were visited participated together in a focus group with the researchers to explore their experiences with the site visit, the assessment process and monitor use. After another two weeks, a focus group was held with the visited team, in which their scores on the monitor, their perception of the use of the monitor and the peer review method, and additional reflections were discussed. All sessions lasted two to three hours and used a semi-structured interview guide (see supplementary file 1) that was developed for this study and was refined iteratively. Individual interviews were held with ward managers to explore their perspectives on the peer review process and the use of the monitor. At the end of the study, a final focus group with all seven peer reviewers served as a member check, as they had also participated in the focus groups with their own teams. This enabled validation of findings and collective reflection on the process and shared learning (14). Data collection closely aligned with the monitoring and peer review procedure and is supplemented by additional collection points (see Table 1).

Table 1
Data collection methods and time points

Monitoring and peer review procedure	**Data collection method**
One-day training for peer reviewers	Non-participant observation
Components of monitoring and peer review procedure repeated in each facility	
Site visit	Non-participant observation
Consensus assessment process	Focus group with involved peer reviewers
Reporting performance scores back to the team	Focus group with healthcare professionals Individual interview with ward manager
End of study	
/	Focus group with all peer reviewers (member check)

Furthermore, to assess the feasibility and acceptability of the peer review process, the inter-rater agreement between peer reviewers was examined. This was calculated using percent agreement, which reflects the proportion of cases in which reviewers assigned the same scores across the 24 monitoring themes. Percent agreement was used as a pragmatic and transparent measure to gauge the feasibility and acceptability of the monitoring tool (21).

Data analysis: All the observations and interviews were audiotaped and transcribed using artificial intelligence software (Turboscribe®), with the security and privacy of the transcripts and media files verified and safeguarded. The transcripts were reviewed, listening to the audio recordings and corrected

where necessary. The transcripts were independently coded by at least two researchers using NVivo 13, following the principles of thematic analysis (22). The independence of the research team to both the study and the developers of the monitor was ensured by engaging analysts who had not been directly involved in the monitor's development. Differences in interpretation were discussed and resolved within the research team. The researchers' observation reports and field notes were also included in the analysis to increase the validity of the interpretations.

Percent agreement was calculated by dividing the number of agreements between the raters by the total number of ratings and multiplying by 100 (21). Missing data were excluded from the analysis (e.g., when a rater was unable to provide a score). In cases where a rater expressed doubt between two possible scores, the lower score was systematically used in the calculation to ensure a conservative estimation of agreement. Values from 75% to 90% demonstrate an acceptable level of agreement (23).

Ethical considerations The study adhered to the Declaration of Helsinki and European General Data Protection Regulation rules, and was approved by the Medical Ethics Committee of UZ Gent (approval no. THE-2024-0208). Informed consent to participate was obtained from all the participants in the study.

Results

This study aimed to explore mental healthcare professionals' perceptions and experiences with the monitoring instrument and peer review, to gauge their feasibility and acceptability for implementing Oyster Care in Flemish residential mental health settings. The findings are presented according to three overarching themes: (1) guidance and reflection in implementing Oyster Care, (2) meaningful change through collective learning and (3) after the peer review: continuing the Oyster Care journey. A total of 33 individuals participated in the study, with some involved in multiple data collection sessions. Post-visit focus group participation among peer reviewers was as follows: site visit 1 (n = 5), site visit 2 (n = 5), site visit 3 (n = 4), and site visit 4 (n = 5). Team focus group participation was as follows: setting 1 (n = 9), setting 2 (n = 7), setting 3 (n = 7), and setting 4 (n = 10). One ward manager per facility (n = 4) participated in an individual interview. The member check was conducted with all the peer reviewers (n = 7).

Guidance and reflection in implementing Oyster Care

The participants perceived the monitoring tool both as a practical guide to clarifying the principles of the Oyster Care philosophy and as a reflective tool for evaluating and improving a team's performance, thereby facilitating the implementation of the Oyster Care principles into practice.

The monitoring tool as guide

The participants described the monitor as a valuable tool that enhances understanding of the Oyster Care concept by identifying patient needs and providing concrete guidance for care delivery through a structured, thematic design. For the team that had only recently begun implementing the model, the tool

provided guidance for structuring care practices in line with the philosophy. Team members in leadership positions in particular considered it a useful tool for guiding team discussions as the tool provides them with a shared language to articulate their practices. Several participants also emphasised the potential of using the monitor at patient level, where it can serve as a guiding framework for an in-depth exploration of themes particularly relevant to individual situations.

“The monitor actually puts into words what we do and what the patients truly need (…) Now we also have a framework in which we can anchor all of this: this is how we do it, and this is why.'" (ward manager)

Overall, with its introduction, healthcare professionals described feeling more empowered and experiencing a stronger sense of pride in their work, as previously intuitive practices were now explicitly described and clarified through a shared framework that guides complex decisions. This was important, as working according to the Oyster Care model, which often requires non-conventional, individualized approaches and previously lacked concrete, day-to-day guidance, can lead to feelings of uncertainty about whether the right choices are being made. In addition, all ward managers reported that the monitor is a powerful means of defining the unit's identity in relation to broader organizational policy. This clarification was considered essential, as their teams were often perceived as outliers within the facility and constantly felt the need to justify their practices, some more than others, to be able to provide care according to the model. One ward manager also expressed the aspiration that the Oyster Care model would further strengthen its identity and gain a stronger position within the broader mental healthcare landscape.

"Reading the monitor gave me more confidence in my work, especially in thinking outside the box. For example, I ordered fries and cycled with patients, even though that’s not a typical nursing task. Now I’m more confident that it can actually be part of my role. It encourages me to do it more often and gives me something to refer to in team discussions” (nurse)

The monitoring tool as a mirror

A second function attributed to the monitor is its role as an evaluative framework. The participants described the monitor as “a mirror” through which they can critically examine their own practices and assess their alignment with the Oyster Care principles. During the focus groups, teams recognised themselves in both the strengths identified and the areas highlighted for further development. While a few participants felt that some scores were rated too stringently, and some participants questioned when “excellence” could realistically be achieved, overall participants indicated that there were no major surprises in the feedback. Teams reported experiencing this feedback as a stimulus for improvement, while also emphasizing the importance of maintaining what is already working well. Furthermore, in each facility, the feedback session triggered team reflection on strategies to address specific themes and the informal exchange of best practices as inspiration. Ward managers mentioned the intention to integrate the monitoring scores into their broader policy planning. For some participants, the monitor offered an

opportunity for personal growth, as it encouraged them to reflect on their own strengths and areas for improvement in daily practice.

"I find the monitor very accessible. It quickly presents the evidence, the philosophy, and the vision behind a theme, while also offering practical insights and actionable points. (…) It feels very validating and appreciative. At the same time, I took away many insights that we can actively work with. It is very practical material that inspires action. I am enthusiastic about it. It offers a valuable mirror for reflection. We want to do well for the people in our care, for their families, and for ourselves." (psychiatrist)

Each theme was considered relevant to Oyster Care, still the participants appreciated the monitor's flexibility to act as a mirror for their unique context and to support the selection of their own priorities, as they agreed that Oyster Care cannot be implemented as a one-size-fits-all model. For example, one facility focused on individuals aged 60 and over, emphasizing somatic care and end-of-life support. Another facility prioritized social participation and inclusion, as these opportunities are more readily available in their urban context, supported by strong local social policies. These priorities, rooted in daily practice, were reflected in site visit observations and positive monitoring scores. The teams appreciated that their "DNA" was observed and validated through the feedback. Strong scores were experienced as motivating, reinforcing commitment to valued areas. One ward manager noted that this recognition could reduce resistance to further engagement, while another described how acknowledgement of their efforts in end-of-life care can help the team move from uncertainty to greater confidence. Themes rated as 'in development' were sometimes deliberately de-emphasised to focus on areas more relevant to their operational context, yet participants stressed the importance of remaining responsive to all the themes.

"We've noticed that some themes are less of a priority for us. For example, the social domain is more challenging, we work with an older audience, less mobile, so you notice they tend to stay more easily in their little cocoon... so we focus more on other areas. (…) When we reflect on our work, we see those themes do come up, but not all are equally relevant. We align the framework with our population's needs, some themes naturally stand out more than others." (peer reviewer)

Integrating the monitor ('s guidelines) into practice

Half of the participants had thoroughly engaged with the monitor individually, primarily the peer reviewers, members of the leadership team and a few proactive professionals, whereas others had only partially read it or consulted the theme summaries. For the latter group, the focus group in which their scores were fed back by the researchers was the first occasion for them to become familiar with the complete monitor. Some participants noted that the monitor is a substantial document requiring dedicated time to read, which is difficult during working hours because of daily care demands. Given the complexity and emotional intensity of their work, many also found it difficult to study material outside working hours. Some have suggested alternative initiatives to strengthen the uptake of knowledge from the monitor. These included embedding monitor themes into team discussions, assigning specific themes for peer education, visiting other Oyster Care teams and developing visual aids to enhance

understanding. In one facility, a small working group began studying the themes in greater depth to support their translation into daily practice. Additionally, team members became more familiar with the monitor by naturally relying on their own peer reviewers to share monitor-related knowledge and insights gained from other facilities.

“The monitor for Oyster Care ‘…’ I do remember certain things… Sometimes you just get so much handed to you, at different meetings, this, that and that. It’s not like I’m going through all of that again every week, sorry.” (nurse)

Additionally, throughout the study participants identified several important factors that promote the implementation of Oyster Care in practice: adequate (trained) staff and resources, sufficient time for improvement efforts, support from the organisation, contact with other Oyster Care partners, and strong links with educational institutions, academia and participation in research initiatives. Furthermore, an engaged leadership team that acts as ambassadors for the Oyster Care model, as outlined in Theme 23 of the monitor, was identified as crucial for implementing the care model as intended.

Meaningful change through collective learning

It was through the peer review process that the monitor truly reached its potential in daily practice, supporting the implementation of Oyster Care. The participants indicated that the monitor was primarily consulted, and questions about the review process were asked, in preparation for the site visit. They valued an external perspective, acknowledging that they might overlook certain aspects when relying solely on self-assessment. At the same time, peer reviewers reported that it is only through organising and participating in a review that one fully grasps how to apply the instrument. The core principles of the peer review process focus on the exchange of ideas and practices, as well as an appreciative approach to substantive work.

Harnessing collective wisdom through emerging networks

Focus group discussions revealed strong interest among teams in visiting peers to observe and learn from each other’s best practices. This interest stems from the relatively solitary position that teams working with the SPMI population and the Oyster Care model often occupy within their facilities. Peer exchange is therefore considered particularly valuable for fostering the cross-pollination of ideas and sharing best practices to shape specific themes in daily practice. The participants emphasised how encouraging it is to hear that peers face similar challenges and to learn how they address them, fostering solidarity and shared learning. These exchanges are already partly supported through inter-facility reflection groups, the Forum Oyster Care and symposia. However, some participants indicated that they had not yet had the opportunity to take part in such activities, despite raising this with management. For peer reviewers, the opportunity to gather ideas and bring them back to their own team was a strong incentive to volunteer for the role. During initial site visits, peer reviewers sometimes found it challenging to balance their role as objective evaluators with that of facilitators of cross-pollination.

They expressed concern that a strong sense of admiration for the behind-the-scenes view of another Oyster Care unit might occasionally inhibit a more critical appraisal of its operations, but this feeling was mitigated by conducting site visits in trios.

“It’s good to be able to collaborate and exchange ideas, because I think it’s different in every place. I’d love to see how things are done elsewhere. It’s also nice to be able to take in all those ideas. (…) Also, to hear how others approach something, they can say: try it this way. For example exchanging difficult situations, the things you struggle with. We’re still very much finding our way, while others have already been working with Oyster Care for longer” (care assistant)

The peer reviewers mentioned already sharing reflections and best practices observed at other units with their own teams, thereby initiating internal discussions and improvement efforts. Likewise, during feedback sessions, teams expressed curiosity about how other units approached specific themes, particularly those marked as ‘excellence’. Participants described this network as valuable for exchanging ideas, but also for other joint initiatives, such as coordinating shared care trajectories that allow patients to transition between Oyster Care units according to their needs. In the final focus group with the peer reviewers, they shared that over the course of the study, they had built a bond with each another in which trust and a sense of psychological safety had grown naturally. They now regard each other as a mini-network where they can confidently turn to each other for consultation, advice and knowledge sharing.

Shaping change by valuing what matters

All the participants experienced the peer review process as one focused on genuine curiosity, collaboration, reflection and mutual learning, rather than an interrogation or a process involving formal judgements. Although some initial tension was observed at the start of the site visits, this gradually gave way to a relaxed and collegial atmosphere. Team members reported that peer reviewers did not act primarily as assessors, but rather as active listeners who facilitated constructive dialogue. The notion of "being in the same boat" and "learning from each other rather than judging" was highlighted as a key departure from traditional inspection models, promoting a sense of shared purpose and alignment. The participants emphasised that conventional inspections usually focus on procedural aspects, such as registrations and checklists, whereas these site visits concentrated substantive aspects and the learning potential inherent in the process. This distinction was further underscored by the absence of negative consequences typically associated with audits (e.g. accreditation programs), such as the risk of failing to meet prescribed standards. This evaluation was experienced more as an open inquiry: “What are we doing and how are we doing it?" rather than a binary judgement of right or wrong. This approach enabled participants to speak candidly and critically about how their unit operates, supported by mutual understanding and authentic engagement between peer reviewers and teams.

“Here it’s also a kind of evaluation, but more like: what can we still learn? What can we still improve? It’s not like when the care inspectorate comes by, then it’s: this isn’t right and that isn’t right.” (ward manager)

"I think colleagues genuinely experience it as a form of recognition, like, ‘Wow, we’re really being seen, we’re doing something meaningful and others are noticing.’ It creates a sense of pride and drive, a feeling that we’re on the right track and want to build further on that." (peer reviewer)

The evolving expertise of peer reviewers

Peer reviewers indicated that their knowledge of the monitor and peer review process evolved gradually through repeated contact with the researchers, training and mutual reflection. Initially, distinguishing between themes required some effort, but consensus discussions helped align interpretations. No suggestions were made to modify the themes. As reviewers became more familiar with the monitor, they learned to probe more effectively during site visits, enabling them to provide well-substantiated scores and targeted feedback. Mixed professional backgrounds were considered particularly beneficial, enabling more directed questioning and observations. Moreover, this approach reinforced peer reviewers' confidence that the assessment of a unit's functioning was grounded in collectively validated observations. They reported feeling more confident when site visits were conducted in trios rather than in pairs. However, this subjective perception was not confirmed by the percent agreement analysis. This analysis revealed variation across settings: setting 1 (three reviewers) 79%; setting 2 (three reviewers) 70.83%; setting 3 (three reviewers) 48%; and setting 4 (two reviewers) 87.5%. The lower agreement in setting 3 was attributed to procedural deviations, including delays in certain parts of the visit, the cancellation of other components, and reviewers becoming separated, which meant that they spoke to different staff, observed different activities and were unable to locate personnel at key moments. For peer reviewers the interpretation of the highest category 'pearl' evolved over time. Defined as an exceptional level of implementation, it was not awarded during the first site visit due to a lack of reference points. Retrospectively, the reviewers indicated that they would have done so in hindsight. From the second site visit onward, ‘pearl’ was more readily accepted, leading to more nuanced scoring. In some cases, awarding a ‘pearl’ also reflected the recognition that, given the specific context, it was unrealistic to expect a better performance. Peer reviewers observed that their input in daily practice tends to carry more weight, as they are seen as representatives of the monitor. Consequently, they are perceived as speaking from an objective perspective rather than from a personal preference.

After peer review: continuing the Oyster Care journey

The participants emphasised the importance of ensuring that the monitor remains an active tool, rather than becoming just another document on the shelf, and that the peer review process does not turn into a one-off exercise. Following the site visit, each unit was offered the opportunity to contact the researcher for additional coaching to support improvement efforts. Despite concerns that the buzz for change driven by the monitoring and peer review process might dissipate after the site visit, none of the participating teams made use of this offer. In practice, teams appeared to rely primarily on their peer reviewers, who were viewed as valuable sources of expertise. Nevertheless, some concrete changes were reported to the researchers. Two units have been involved in a hospital-wide initiative to adapt the structure of the electronic patient record. A third unit is in the midst of this process. The monitor was

used to determine which structural elements should be included to enable documentation aligned with Oyster Care principles, encouraging more purposeful use of recorded observations in guiding treatment. Two ward managers reported that insights from the monitor were being integrated into organizational policy plans for the coming year, although it remains unclear whether this has yet led to tangible improvement initiatives.

During the final focus group with peer reviewers, half expressed willingness to participate in future peer reviews. Those who were less inclined were mainly ward managers who had joined the project to deepen their understanding of Oyster Care. They stressed the importance of involving 24/7 care staff in future cycles to ensure that multiple “vision carriers” are present within a team. Pairing new peer reviewers with experienced ones was suggested to support mutual learning and mentorship. Several key conditions for successful peer reviews were identified: awareness of the required level of commitment, intrinsic motivation, managerial support to free up time and thorough preparation. A spirit of curiosity, self-critical awareness, strong interpersonal skills and a willingness to learn from one another were viewed as core drivers of meaningful participation. Despite the considerable effort required by the peer review process, strong motivators remain: the opportunity to learn from best practices, deepen Oyster Care knowledge and ultimately contribute to providing high-quality care for people experiencing SPMI.

Discussion

The findings from our pilot study demonstrate that the implementation of Oyster Care is feasible, and that the strategies employed, including use of the monitor and the peer review process, are acceptable and supportable within the clinical context. The findings indicate that the Oyster Care monitor and the peer review process each fulfill distinct yet complementary roles in the implementation of Oyster Care. The monitor provides a structured framework that guides the application of Oyster Care practices and serves as a mirror to systematically assess current performance. Meanwhile, the peer review process provides a platform for external feedback, the exchange of ideas and collective learning. Together, they foster a culture of collaboration, critical reflection and continuous quality improvement.

The findings of this study show that there was a need to familiarise teams with the identification of Oyster Care practices and to validate and guide them in their work, as teams providing long-term care are often seen as outliers within their organisation and the broader mental healthcare system. This peripheral position reflects the dominant orientation of psychiatric services toward acute, short-term interventions and measurable clinical outcomes (24, 25). Consequently, teams working with people experiencing SPMI and providing long-term care face ongoing pressure to justify their practices. This position can evoke feelings of uncertainty, especially since Oyster Care is a continuous process of creative, trial-and-error approaches to alleviate suffering and improve quality of life, often requiring individualised, non-conventional interventions that do not follow standard procedures. The introduction of the Oyster Care monitor has helped make explicit the values, principles and expertise that underpin this work. In doing so, the process of guiding and mirroring practice has strengthened professionals’ sense of identity. As the literature indicates, a stronger professional identity is closely intertwined with

gaining recognition and establishing a more legitimate position within the institutional context (26). It is also associated with greater personal accomplishment, reduced risk of burnout and increased staff retention (27, 28). Furthermore, our findings suggest that this heightened sense of identity has increased professionals' confidence that they are acting appropriately and that they will be even more inclined to act in accordance with the care model and advocate for practices that respond to the needs of people who do not fit into standard treatment models.

The teams consistently recognised themselves in the feedback, which was perceived as affirming and consistent with their values, context and priorities. Awarded 'pearls' accurately reflected setting-specific strengths, whereas lower scores were often acknowledged as consistent with intentional choices to deprioritize certain areas. These findings suggest that the monitor effectively captures both the visible practices and the underlying logic guiding team decisions. It also reinforces the value of combining structured scoring with context-sensitive, narrative feedback to ensure a nuanced and credible monitoring process (17, 29). This is in line with the monitor's deliberate design, which features an open and flexible structure, enabling professionals to develop innovative and context-specific initiatives within the monitor's established themes. This openness promotes local innovation and professional engagement, as teams create new working methods and solutions tailored to their unique settings and organisational cultures, which in turn can inspire other teams and generate ideas for improvement efforts (20). Interestingly, even the newly implementing team achieved some high implementation scores. This can be explained by a frequently cited motivation for joining the Oyster Care movement, namely: *"We already work according to the Oyster Care principles, now it finally has a name."* In this sense, for some, the monitor does not necessarily introduce entirely new practices, but rather offer a shared language and framework for recognising, structuring and guiding care delivery.

Gaining insight into performance through monitoring encouraged teams to modify their practices (12), still participants strongly valued *how* this was achieved through the peer review process. Having an external perspective on a unit's performance was considered valuable, and the true strength of the process lies in its tone and approach. Rather than being experienced as a top-down control mechanism, the peer review process was perceived by teams as a supportive and reflective practice. This aligns with a current paradigm shift from a deficit-based perspective to a strength-based perspective on care practices, in line with the principles of Appreciative Inquiry (30). It facilitated collective sense-making and open dialogue, rather than external judgement or inspection. An emphasis on the substantive aspects of care, reframing problems into possibilities and threats into opportunities, and seeing the strengths and successes, may further enhance this dynamic by fostering sincere curiosity and positive engagement, which in turn can improve both clinical care and organisational outcomes (30, 31). Importantly, the monitoring and peer review process leaves responsibility with each team to determine where to place emphasis, set priorities, and translate insights into meaningful, context-sensitive actions. Because this process is not externally imposed, it supports professional autonomy and reinforces team ownership, both of which are essential for sustainable change in complex care environments (29, 32, 33).

Strengths and limitations

While the study has several notable strengths, including piloting in four different settings, extensive multiple and longitudinal data collection, and the close and continued involvement of end users on the work floor, it is also subject to several limitations. One potential limitation of this study concerns the measurement of fidelity. Relying on healthcare professionals to accurately report and discuss their actual Oyster Care activities may make the data vulnerable to social desirability bias, potentially resulting in overly optimistic assessments (34, 35). However, the findings also illustrate a key strength of the peer review process: unlike inspections, it is not perceived as controlling or punitive. This more supportive and collegial atmosphere encourages teams to present their practices more openly and accurately, thereby reducing some of the social desirability pressures often associated with external audits (30). At the same time, it is important to maintain existing strengths, such as conducting peer reviews in interdisciplinary duos or trios and using multiple data sources, including direct observation and file audits, as these strategies already contribute to more consistent and accurate evaluations.

Inter-rater reliability showed acceptable, although variable, levels of agreement. Clearer and more detailed scoring guidelines during training could enhance both the reliability and transparency of the scoring process (35). In one of the four settings, the level of inter-rater percent agreement did not reach an acceptable threshold. This may have been due to deviations from the planned schedule and the separation of peer reviewers during the site visit. Such fragmentation likely contributed to divergent impressions and, consequently, lower agreement. Based on these insights, it is recommended that reviewers stay together to foster a more coherent and in-depth understanding of the context instead of splitting up to broaden observational coverage. However, focus group discussions with the teams indicated that participants recognised themselves in the identified strengths, growth areas, and chosen priorities, which supports the acceptability of the monitoring tool and suggests that it provides a credible and meaningful reflection of practice.

Another limitation of this study is the possible bias in recruitment and data collection, which may have contributed to leadership being strongly perceived as a key facilitator for effectively implementing the treatment model in practice. For example, three of the seven peer reviewers held managerial positions, and the 23rd theme on the monitor, ‘leadership’, received a pearl in three of the four facilities, potentially influencing their positive assessment. Additionally, all individual interviews were conducted with managers, which may have further reinforced the emphasis on leadership as a critical facilitator (e.g., through organizing training, allocating resources, and embedding the vision into daily operations). Nevertheless, the literature supports the notion that strong leadership is indeed essential for the successful implementation of treatment models and for prioritizing them within routine practice (36).

Recommendations for practice and policy

A key concern expressed by participants in this study was the need to maintain a rhythm of continuous quality improvement, rather than treating the use of the monitor and peer review as a one-off exercise. Engagement typically peaks during a site visit, but declines again in the following months. As Pedersen (37) alerts, one should be aware that even when improvement actions are discussed, such as during focus groups with teams, there is a risk that they will fizzle out over time. To counter the challenges of

decline and discontinuity, the literature recommends organising multiple cycles of the peer review process, alongside complementary implementation strategies such as setting specific, challenging yet achievable goals, appointing champions, establishing implementation teams, and providing reminders and additional training. Together, these approaches can foster long-term embedding, adaptive learning, and the sustainability of change efforts (10, 12, 17).

The following recommendations are suggested to strengthen and sustain the role of peer reviewers: (1) institutionalize the role as a formally recognised task with dedicated time and organizational support; (2) implement a mentorship structure in which new reviewers accompany experienced reviewers for at least one site visit before taking the lead in the consensus assessment process; (3) provide systematic coaching and debriefing after each site visit to support learning, ensure calibration and maintain intersubjective consistency; (4) establish a rotation schedule that distributes reviewer participation evenly throughout the year, taking workload, personal preferences and work context into account; and (5) appoint peer reviewers as ‘champions’ within their teams to increase motivation and promote role modeling in daily practice.

Recommendations for future research

Given the presence of an implementation momentum and the risks associated with inaction in addressing the needs of the SPMI population, it may be time to undertake a process and effect evaluation (38). While this study provides indications of beneficial outcomes, predominantly at the level of caregivers and teams, these effects warrant more formal evaluation, including their impact on other stakeholders, not least the patients themselves. In the case of Oyster Care, such outcomes might include improved quality of life, enhanced feelings of dignity and inclusion, or reduced distress and isolation (7). Simultaneously, achieving meaningful outcomes in complex care settings requires not only strong interventions but also high-quality implementation (10). To this end, effectiveness-implementation hybrid designs offer a valuable methodological approach (39).

Conclusion

The integration of Oyster Care monitoring and the peer review process acts as a catalyst for the implementation of the care model in routine use, guiding and reflecting on care practices while promoting critical reflection, dialogue and knowledge exchange. This study highlights the value of Oyster Care as both a conceptual framework and as a broader movement, enabling professionals to deliver high-quality care to people experiencing SPMI with renewed motivation and a shared sense of purpose. Oyster Care embodies a bottom-up approach in which healthcare professionals take responsibility for reflective practices and continuous improvement, while top-down support remains essential to assure progress and coherence. Supportive policy measures are needed to strengthen professional identity and enable teams to advocate for the needs of this vulnerable population. Furthermore, aligning implementation strategies with the operational realities of clinical settings to ensure the sustainable implementation of Oyster Care and maximise the impact on care delivery and patient outcomes.

Abbreviations

SPMI
Severe and persistent mental illness

Declarations

- **Ethics approval and consent to participate**

The study adhered to the Declaration of Helsinki and European General Data Protection Regulation rules, and was approved by the Medical Ethics Committee of UZ Gent (approval no. THE-2024-0208). Informed consent to participate was obtained from all the participants in the study.

- **Consent for publication**

Not applicable

- **Availability of data and materials**

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request

- **Competing interests**

The authors declare that they have no competing interests

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- **Authors' contributions**

(anonymized)

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