Benefits and Challenges of Implementing Personal Health Records to Enhance Mental Healthcare Transparency

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Abstract. This study aims to synthesize the reported benefits and challenges of PHR implementation for patients with mental disorders, conducted through a *Narrative Review* approach. The relevant literature was retrieved from three major electronic databases: *Scopus, ScienceDirect*, and *PubMed*. The inclusion criteria for this study were scientific articles, published specifically between 2021 and 2025, full-text access, and relevance to the topic. A total of 923 articles were initially retrieved, and then narrowed down to 6 articles were selected for descriptive analysis. The systematized analysis revealed a variety of research methods: 3 quantitative (*Randomized Controlled Trial, Cross Sectional Survey*), 2 qualitative (*Delphi Study, interview study*), dan 1 mixed method. The substantial benefits of PHR include enhancing patient awareness towards their clinical condition, strengthening motivation for rehabilitation, improving transparency, encouraging active participation in treatment, and delivering t*herapeutic* function via *open notes*. PHRs also reinforce the bond between patients and healthcare staff, offers expert advice, and expand the patients opportunities for personal reflection beyond the scheduled session. However, the implementation challenges identified are limited ownership of digital devices; poor long-term engagement; potential added burden on health staff; data security and privacy issues; the frequent use of stigmatizing medical terminology; and the necessity for stronger regulation and staff training. Thus, PHR has the potential to be vital instrument for mental disorder patient empowerment and quality service improvement. However, its effective implementation requires comprehensive and systemic supports, regulations, and strategies to overcome both technical and ethical barriers.

Keywords: Personal Health Record, Psychiatric Patient, Benefits, Challenges, Narrative Review

1 Introduction

Mental disorders continue to be a significant global health issue, posing significant social, economic, and health burdens. The global prevalence is estimated at 450 million

H. Saptaningtyas et al. (eds.), *Proceedings of the 4th International Conference on Multidisciplinary Studies 2025 (ICOMSI 2025)*, Advances in Social Science, Education and Humanities Research 1012,
https://doi.org/10.2991/978-2-38476-571-3_21

individuals with a psychiatric diagnosis, with Bipolar disorder being a leading condition (WHO, 2020). Stigma against mental health prevents people from seeking help, necessitating a proactive approach including early identification, clinical intervention, and primary prevention (Adler & Van Brunt, 2025). Information transparency within the mental health context is a crucial aspect of improving the quality and outcomes of clinical care.

Patient involvement in the staged management of their health is recognized as a determinant factor in achieving optimal healthcare service delivery and high-quality care (Niazkhani et al., 2020). Patients with mental disorders often face limitations in receiving continuous care due to a lack of involvement from both patients and healthcare providers in monitoring their medical history comprehensively. This is relevant to Muchtarul (2022), who noted that psychiatric patients have difficulty communicating their medical history. The utilization of electronic medical records offers a solution to overcome these limitations, as patients can use a Personal Health Record (PHR) to manage their health information and even schedule treatments.

Amidst the digital transformation in healthcare, the Personal Health Record (PHR) has emerged as a novel innovation. A PHR contains a controlled repository of an individual's health information and clinical data (Mandels, 2021). Research by Price et al., (2015) emphasizes that PHRs are designed to involve patients so they can control, share, or manage the data themselves, thereby supporting patient-centered care model. Robotham et al., (2015) found that the electronic Personal Health Record (ePHR) is very useful for patients to monitor their own health, which significantly helps them manage their mental condition. This utility extends beyond psychiatric populations to encompass health monitoring, general welfare enhancement, and improved patient-healthcare provider communication.

The adoption of PHR offers strategic opportunities for patients with psychiatric diagnoses. Research indicates that 46.7% of patients showed interest in using a PHR, influenced by factors such as performance expectancy, effort expectancy, social influence, and facilitating conditions(Abebe et al., 2024). PHR usage can increase therapeutic engagement, as access to notes helps patients recall discussions during therapy, access patient information, increase satisfaction with care, improve medication adherence, enhance patient-focused care, and strengthen the continuity of care through more integrated access to medical information (Falconer et al., 2018; Gagnon et al., 2016; Blease et al., 2020). Furthermore, PHR potentially serves as a tool for patient empowerment in mitigating stigma by providing greater control over their health information.

However, the implementation of PHR for psychiatric patients also presents a number of systemic challenges. Varying levels of digital literacy, concerns regarding data privacy and security, and limited healthcare infrastructure support can hinder the adoption of this system. Moreover, questions remain about the extent to which psychiatric patients can optimally utilize PHR, considering potential cognitive or psychosocial impairments that may be present.

Regarding these potential benefits and barriers, a dedicated study on personal health records in psychiatric patients is important. A more comprehensive understanding of the opportunities and challenges associated with PHR implementation is intended to

provide a foundation for developing policy strategies and clinical practices that are more inclusive, secure and focused on patient empowerment.

2 Method

This article employed Narrative Review approach to synthesize research findings related to Personal Health Records (PHR) within psychiatric patient population. This approach was chosen due to the suitability with the objective of identifying and synthesizing heterogeneous research results. The literature retrieval process is illustrated in the diagram below:

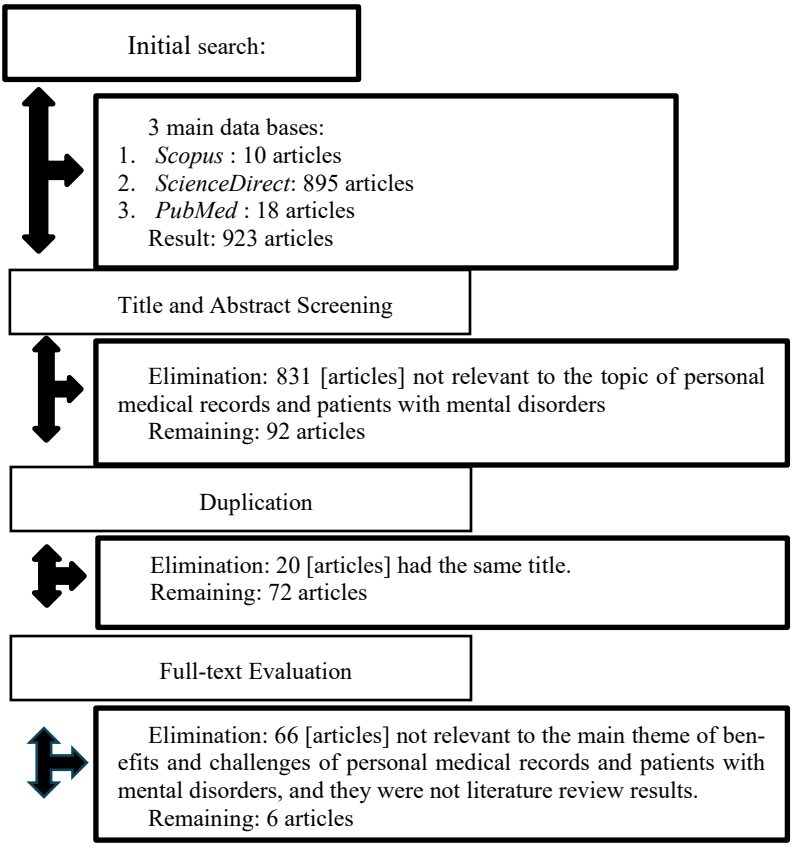

Fig. 1. Article search flow diagram

The systematic literature search was conducted utilizing three distinct databases: Scopus, ScienceDirect, and PubMed, with the majority of articles originating from ScienceDirect. In formulating the literature search, Boolean operators (AND, OR) were used to combine, filter, and define alternative keywords. The keywords used were: *mental illness* OR *psychiatric patients* OR *mental health* AND *personal health record* OR

ePHR OR *patient access.* Inclusion criteria included articles published within the last 5 years (2021-2025), classified as scholarly journal articles, and available for full-text access without charge.

The initial search yielded 923 articles (Scopus: 10, ScienceDirect: 895, PubMed: 18). The initial selection based on titles and abstracts relevance to PHR and psychiatric patients resulted in 92 articles. Duplicate articles were eliminated, leaving 72 articles. The final selection stage involved full-text evaluation, resulting in 6 core articles aligned with the central theme of PHR benefits and challenges in the psychiatric population. The articles were descriptively analyzed in accordance with the principles of a Narrative Review, focusing relevance, methodological quality, and their contribution to health informatics in mental healthcare.

3 Result and Discussion

3.1 Psychiatric Medical Records in Specialized Hospital and Primary Care

Psychiatric medical records, whether maintained in both Hospital (specialized) and Non-Hospital (primary care) settings, play a vital role in diagnosis, clinical management, and epidemiological research. The main distinctions are detailed below:

Table 1. Differences between Hospital and Non-Hospital Psychiatric Medical Records

Aspect	Specialized Hospital	Primary Care	Reference
Primary function	For diagnosis, intensive care, and clinical follow-up for Severe Mental Illness (e.g., Schizophrenia, Bipolar, Major Depression).	For screening, early detection, and initial follow-up for common psychiatric conditions (e.g., Depression, Anxiety) in the community.	(Davis et al., 2018; Talebi et al., 2024)
Data Type	Includes comprehensive data: ICD-10 diagnosis, lab results, clinical progress notes, and psychotropic medications.	Data is more concise, focusing on screening results, primary complaint, and basic social/medical history.	(Davis et al., 2018; McCombe et al., 2018)
EMR System Used	Internal electronic hospital system with high validity (PPV diagnosis 73–90%).	Simple general practice EMR; not yet nationally standardized.	(Davis et al., 2018; Talebi et al., 2024)
Complexity and Users	Managed by a multidisciplinary team: psychiatrists, psychologists, nurses, and pharmacists.	Managed by general practitioners and community nurses, with limited psychiatric supervision.	(Hashemi et al., 2019; Talebi et al., 2024)
Data Quality and Validity	High, verified, and suitable for clinical research and quality assurance audits.	Variable and inconsistent; high variation between different practices.	(Davis et al., 2018; McCombe et al., 2018)

Aspect	Specialized Hospital	Primary Care	Reference
Data Element Coverage	Demographic, administrative, historical, clinical, therapeutic, and financial elements.	Limited to patient identity data, screening results, and basic service notes.	(Hashemi et al., 2019; Talebi et al., 2024)
Ultimate Goal	Diagnostic confirmation, treatment, research, quality audit, and national reporting.	For prevention, mental health promotion, and referral to specialist facilities.	(Hashemi et al., 2019; Talebi et al., 2024)
Main Obstacles	Systemic complexity, high development costs, and need for specialist training.	Limited screening tools, untrained general healthcare staff, and poor data integration across levels.	(Talebi et al., 2024; McCombe et al., 2018)

The main difference between psychiatric medical records in specialized hospitals and in non-hospital (primary care) facilities lay on their purpose, the granularity of data, and the technology employed. Specialized Hospital records are comprehensive, serving for diagnoses, intensive care and clinical research for severe psychiatric diagnoses, using highly validated, integrated electronic systems such as Hospital Episode Statistics (HES) (Davis et al., 2018). The recorded data includes up to 140 elements, covering demographic, clinical, medication, and financial aspects, and is managed by a multidisciplinary team (Hashemi et al., 2019).

In contrast, medical records in primary care function for screening and early detection of less severe disorders, using simplified systems like SINA in Iran, limited to recording primary complaints and screening results (Talebi et al., 2024). The validity and completeness of data at the primary level are still variable, depending on the capabilities of healthcare staff and system standardization (McCombe et al., 2018). Consequently, integration between specialized hospital and primary care medical record systems is necessary to ensure the longitudinal tracking of patient data, spanning from initial detection to follow-up treatment.

3.2 Trends in Personal Health Records for Mental Illness

The stigma associated with mental disorders remains strong and influences the trends in documentation and willingness to utilize PHR features. Concerns about privacy and discrimination cause patients and medical staff to limit documentation and disclosure. Educational efforts and cultural change are needed to reduce stigma and improve the quality of care and patient data security.

The key trends are as follow:

Privacy Concerns: Many patients and clinicians are reluctant to record details of mental illness in electronic medical records for fear of data leakage or use for discrimination (Soni, 2019; Salomon et al., 2010).

Patient Preference: Patients consider mental health information to be the most sensitive data, more so than physical or genetic data, leading them to restrict access or sharing of that data (Soni, 2019).
Professional Disclosure: In the medical environment, stigma causes medical students and residents to refrain from disclosing personal psychiatric history for fear of being viewed as impaired or detrimental to their career progression (Kassam et al., 2024; Hoes et al., 2022).

3.3 Benefits and Challenges

The search yielded 6 core articles related to personal health records in psychiatric patients, specifically focusing on the benefits and challenges encountered in implementing personal health records for these patients. The literature results indicate a variety of research methods used: 3 quantitative approaches (Randomized Controlled Trial and Cross Sectional Survey), 2 qualitative approaches (Delphi Study and qualitative), and 1 mixed method (Quantitative and Qualitative). The synthesized articles are presented in Table 2 below:

Table 2. Synthesis of 6 Core Articles

Author, Year	Method, Population	Benefits	Challenges
Gumley et al., 2022	Randomized controlled trial, 73 with schizophrenia/related disorders divided into 2: 42 using a smartphone application (intervention group), 31 usual care (control group)	Intervention increased illness awareness, reduced anxiety over relapse prevention; feeling calmer about their clinical status.	Low long-term patient engagement, patients rarely share data with healthcare from the application professionals and family; need for large-scale trial.
Luther et al., 2020	Randomized controlled trial, 56 with schizophrenia divided into 2: 27 using MEMS (intervention group), 29 control group	Intervention helped increase motivation, anticipatory pleasure, and achievement of recovery-oriented goals.	Limited ownership of digital devices (handphones). Social interaction acted as a barrier to participant progress; need for large-scale trial.
Nielsen et al., 2024	Delphi Study, 84 authors/experts (27 participated in the first round, 21 in the second). Follow-up testing in 4 child and adolescent mental health clinics involving 41 respondents.	Increase information access and patient involvement, and provided guidance professional for health Expert consensus recommendations in 4 main themes: digital	Confidentiality concerns; ambiguity regarding patient competence/age for access; critical need for staff professional development

Author, Year	Method, Population	Benefits	Challenges
		access to health notes, writing health notes, support/training for health staff, and conditions for withholding notes.	
Meier-Diedrich et al., 2025	Quantitative and Qualitative, 876 clinical notes (453 pre and 423 post open notes) for quantitative method. 10 healthcare professionals for qualitative method.	Open notes as a therapeutic tool helping patients recall consultation content, review, and reflect (memory function). Provided validation, allowing for corrections. Expanded therapy sessions beyond face-to-face meetings.	Increased workload for health professionals, system integration issues, risk of losing detailed information due to simplifying notes, time support, and training needed.
Wang et al., 2023	Cross Sectional Survey, 9094 respondents divided into 2: 2,008 receiving mental health services, 7,086 receiving somatic services.	70% of mental health patients felt more trust in doctors/nurses after seeing their medical notes. Patients felt more valued due to transparency. Enhanced health literacy and encouraged active participation in care.	Medical language that feels offensive and stigmatizing. Additional burden for medical staff.
Van Rijt et al., 2021	Qualitative, 11 mental health professionals and 10 group discussion participants.	Increased patient involvement in care, patients were better prepared for consultations, provided opportunities for a therapeutic relationship through collaborative correction of medical notes.	Security of sensitive and subjective patient information, risk of patient relapse due to medical record content, need for organizational support, regulation, and training for health staff.

Author, Year	Method, Population	Benefits	Challenges
Gumley et al., 2022	Randomized controlled trial, 73 with schizophrenia/related disorders divided into 2: 42 using a smartphone application (intervention group), 31 usual care (control group)	Intervention increased illness awareness, reduced anxiety over relapse prevention; feeling calmer about their clinical status.	Low long-term patient engagement, patients rarely share data with healthcare from the application professionals and family; need for large-scale trial.

The synthesis of the 6 selected articles indicates that personal health records or open notes in psychiatric patients have benefits for both the individual and the healthcare system, although their implementation faces various challenges. The benefits derived from the use of PHR or open notes are classified into 2 categories:

Clinical Benefits for Patients: Experimental research involving intervention and control groups shows a positive impact on patients. Gumley et al., (2022) reported that psychiatric patients (with schizophrenia) receiving intervention using a smartphone application felt calmer and less afraid of relapse. Patients also became more aware of their condition. This finding is reinforced by Luther et al., (2020), who showed that digital intervention helps increase motivation, anticipatory pleasure, and recovery goal achievement. Nevertheless, both studies need to be conducted on a larger scale to confirm whether digital intervention can prevent relapse in patients with mental disorders.

Wang et al., (2023) confirmed that the transparency of medical notes increases the patient's trust in healthcare professionals, making patients feel more valued and encouraging them to be more active in their care. The benefit of active patient involvement in care after PHR use is also demonstrated in the findings of Nielsen et al., (2024) and Van Rijt et al., (2021). Increased active patient involvement can enhance understanding of their health condition, especially if accompanied by clear guidance on how to share information, thereby reducing confusion and increasing trust.

Systemic and Therapeutic Benefits: The utilization of PHR is also crucial in the healthcare system. The Delphi Study by Nielsen et al., (2024) yielded 17 practical recommendations summarized in 4 main themes:

Introducing Digital Access to Health Records: During the session, the sensitive nature of notes, the risk of sharing on social networking platforms, and the possibility of parents accessing notes must be explained. Adolescents should be encouraged to ask questions.

Writing Health Notes: Notes must be written using polite and respectful language. However, the study noted two differing opinions on documentation: notes written primarily for the patient using simple language, or for professionals using medical terminology.

Support and Training for Healthcare Staff: Staffs need training on how to write accessible notes, legal rules, how to share notes digitally, and procedures for withholding

notes when necessary. Staffs also need specific time for discussions on note-sharing practices.

Conditions for Withholding Notes: This is done if there is a risk of serious harm to the life or health of the adolescent patient or a family member, and after case-by-case assessment with clear criteria and review by other parties.

Open notes also have a benefit as a therapeutic tool between the patient and the healthcare professional. Meier-Diedrich et al., (2025) stated that open notes function not only as documentation but also as a therapeutic tool. Their use helps patients recall consultation content, review, and reflect by utilizing memory function, and allows for corrections if there are errors in the documentation. Open notes also expand the therapeutic function outside of face-to-face sessions, even serving as homework for patients, while increasing the validation of the patient's experience. Van Rijt et al., (2021) also confirmed that the use of open notes strengthens the therapeutic relationship, helps patients better prepare for consultations, and allows for collaborative correction of medical notes.

The challenges in implementing PHR or open notes are divided into Technical, Psychosocial, and Ethical challenges:

Technical Challenges: PHR implementation also faces significant technical constraints. Luther et al., (2020) noted the limited ownership of digital devices, specifically hand phones, among patients, which means not all patients who need it can benefit from technology-based intervention. Nielsen et al., (2024) highlighted the need for training and support for healthcare professionals in writing accessible notes and understanding related regulations. Meier-Diedrich et al., (2025) added that system integration limitations and an additional workload for health professionals are barriers, driven by the need to adapt documentation to be more patient-friendly, requiring extra time to create open notes.

Psychosocial and Ethical Challenges: Psychosocial barriers are also present in PHR implementation. Gumley et al., (2022) observed low long-term patient engagement, including rare sharing of information from the application with healthcare professionals or family.

From an ethical standpoint, Wang et al., (2023) identified that the use of medical language in documentation can be perceived as offensive or stigmatizing, potentially causing psychological distress for patients and reducing the intended benefits of information transparency. Van Rijt et al., (2021) emphasized the risk of patients experiencing stress or relapse due to sensitive medical information. This study also mentioned the importance of regulatory support, organizational policy, and privacy protection in PHR utilization due to concerns about patient safety, for example, if a patient learns about involuntary commitment beforehand.

The limited literature on personal health records for psychiatric patients offers a significant opportunity for further research in this field. This theme also opens the way to investigate the impact of technology use in medical record management, which can

increase patient engagement and strengthen their relationship with healthcare providers. Thus, this research contributes to public literacy and the improvement of quality care and reduction of stigma around mental health.

4 Conclusion

The implementation of Personal Health Records (PHR) for patients with mental disorders improves the quality of care and patient empowerment through increased self-awareness, active involvement, greater trust in healthcare professionals, and better therapeutic relationships. PHR functions not only as a documentation tool but also as a therapeutic and communication medium that strengthens patient-centered care.

However, its implementation still faces various technical, psychosocial, and ethical challenges, such as limited digital device ownership, lack of system integration, additional workload for healthcare professionals, concerns about privacy and data security, and the risk of stress from sensitive medical information. Therefore, policy support, regulation, training for healthcare professionals, and an increase in patient digital literacy are needed to ensure that PHR utilization is safe, effective, and sustainable. Overall, the adoption of PHR for psychiatric patients has the potential to be a strategic instrument in patient empowerment and stigma reduction, moving towards mental healthcare services that are more inclusive, transparent, and recovery-oriented.

Acknowledgments. We extend our gratitude to STIKes Mitra Husada Karanganyar and Sebelas Maret University for their support, enabling the authors to complete this narrative review.

References

Abebe, S. A., Endehabtu, B. F., Walle, A. D., Hailu, D. T., Yeshaneh, A. T., Dres, E. A., Yimmam, M. T., & Gashu, K. D. (2024). Intention to use personal health record system and its predictors among chronic patients enrolled at public hospitals in Bahir Dar city, northwest Ethiopia: using modified UTAUT2 model. *Frontiers in Medicine*, *11*(September), 1–17. https://doi.org/10.3389/fmed.2024.1421559

Adler, J., & Van Brunt, D. (2025). It is Time to Realize the Promise of the Digital Mental Health Transformation: Application for Population Mental Health. *Journal of Medical Internet Research*, *27*. https://doi.org/10.2196/63791

Blease, C. R., Walker, J., Torous, J., & O'Neill, S. (2020). Sharing Clinical Notes in Psychotherapy: A New Tool to Strengthen Patient Autonomy. *Frontiers in Psychiatry*, *11*(October), 1–4. https://doi.org/10.3389/fpsyt.2020.527872

Davis, K. A. S., Bashford, O., Jewell, A., Shetty, H., Stewart, R. J., Sudlow, C. L. M., & Hotopf, M. H. (2018). Using data linkage to electronic patient records to assess the validity of selected mental health diagnoses in English Hospital Episode Statistics (HES). *PLoS ONE*, *13*(3), 1–15. https://doi.org/10.1371/journal.pone.0195002

Falconer, E., Kho, D., & Docherty, J. P. (2018). Use of technology for care coordination

initiatives for patients with mental health issues: A systematic literature review. *Neuropsychiatric Disease and Treatment*, *14*, 2337–2349. https://doi.org/10.2147/NDT.S172810

Gagnon, M. P., Payne-Gagnon, J., Breton, E., Fortin, J. P., Khoury, L., Dolovich, L., Price, D., Wiljer, D., Bartlett, G., & Archer, N. (2016). Adoption of electronic personal health records in Canada: Perceptions of stakeholders. *International Journal of Health Policy and Management*, *5*(7), 425–433. https://doi.org/10.15171/ijhpm.2016.36

Gumley, A. I., Bradstreet, S., Ainsworth, J., Allan, S., Alvarez-Jimenez, M., Aucott, L., Birchwood, M., Briggs, A., Bucci, S., Cotton, S. M., Engel, L., French, P., Lederman, R., Lewis, S., Machin, M., MacLennan, G., McLeod, H., McMeekin, N., Mihalopoulos, C., … Gleeson, J. (2022). The EMPOWER blended digital intervention for relapse prevention in schizophrenia: a feasibility cluster randomised controlled trial in Scotland and Australia. *The Lancet Psychiatry*, *9*(6), 477–486. https://doi.org/10.1016/S2215-0366(22)00103-1

Hashemi, N., Sheikhtaheri, A., Hashemi, N. sadat, & Rawassizadeh, R. (2019). Electronic medical records for mental disorders: What data elements should these systems contain? *Studies in Health Technology and Informatics*, *260*, 25–32. https://doi.org/10.3233/978-1-61499-971-3-25

Hoes, C., Yellman, T., & Murray, T. (2022). Medical Student Perspective of Disclosing Personal Mental Health History and Stigma Surrounding Mental Illness. *Journal of System Safety*, *57*(2), 4–8. https://doi.org/10.56094/jss.v57i2.188

Kassam, A., Antepim, B., & Sukhera, J. (2024). A Mixed Methods Study of Perceptions of Mental Illness and Self-Disclosure of Mental Illness Among Medical Learners. *Perspectives on Medical Education*, *13*(1), 336–348. https://doi.org/10.5334/pme.1152

Luther, L., Fischer, M. W., Johnson-Kwochka, A. V., Minor, K. S., Holden, R., Lapish, C. L., McCormick, B., & Salyers, M. P. (2020). Mobile Enhancement of Motivation in Schizophrenia: A Pilot Randomized Controlled Trial of a Personalized Text Message Intervention for Motivation Deficits. *Journal of Consulting and Clinical Psychology*, *88*(10), 923–936. https://doi.org/10.1037/ccp0000599

Mandels, R. . (2021). Meningkatkan Literasi Kesehatan melalui Inovasi Personal Healt Record. *Jurnal Cakrawala Ilmiah*, *1*(17), 733–746.

McCombe, G., Fogarty, F., Swan, D., Hannigan, A., Fealy, G. M., Kyne, L., Meagher, D., & Cullen, W. (2018). Identified mental disorders in older adults in primary care: A cross-sectional database study. *European Journal of General Practice*, *24*(1), 84–91. https://doi.org/10.1080/13814788.2017.1402884

Meier-Diedrich, E., Blease, C., Heinze, M., Wördemann, J., & Schwarz, J. (2025). Changes in Documentation After Implementing Open Notes in Mental Health Care: Pre-Post Mixed Methods Study (Preprint). *Journal of Medical Internet Research*, *27*, 1–19. https://doi.org/10.2196/72667

Muchtarul, F. (2022). Penggunaan Electronic Health Record (EHR) Dalam Keperawatan Jiwa : Literature Review. *Ji*, *5*(2), 113–124. http://jurnalilmiah.stikescitradelima.ac.id/index.php/

Niazkhani, Z., Toni, E., Cheshmekaboodi, M., Georgiou, A., & Pirnejad, H. (2020). Barriers to patient, provider, and caregiver adoption and use of electronic personal health records in chronic care: A systematic review. In *BMC Medical Informatics and Decision Making* (Vol. 20, Issue 1). BMC Medical Informatics and Decision Making.

https://doi.org/10.1186/s12911-020-01159-1

Nielsen, M. S., Steinsbekk, & Nøst, T. H. (2024). Development of Recommendations for the Digital Sharing of Notes With Adolescents in Mental Health Care: Delphi Study. *JMIR Mental Health*, *11*, 1–13. https://doi.org/10.2196/57965

Price, M., Bellwood, P., Kitson, N., Davies, I., Weber, J., & Lau, F. (2015). Conditions potentially sensitive to a Personal Health Record (PHR) intervention, a systematic review Healthcare Information Systems. *BMC Medical Informatics and Decision Making*, *15*(1). https://doi.org/10.1186/s12911-015-0159-1

Robotham, D., Mayhew, M., Rose, D., & Wykes, T. (2015). Electronic personal health records for people with severe mental illness; a feasibility study. *BMC Psychiatry*, *15*(1), 1–7. https://doi.org/10.1186/s12888-015-0558-y

Salomon, R. M., Blackford, J. U., Rosenbloom, S. T., Seidel, S., Clayton, E. W., Dilts, D. M., & Finder, S. G. (2010). Openness of patients' reporting with use of electronic records: Psychiatric clinicians' views. *Journal of the American Medical Informatics Association*, *17*(1), 54–60. https://doi.org/10.1197/jamia.M3341

Soni, H. ; A. G. A. M. S. D. (2019). State of the Art and a Mixed Methode Personalized Approach to Assess Patients Perceptions on Medical Recotd Sharing and Sensitivity. *J Biomed Inform*, *176*(1), 139–148. https://doi.org/10.1016/j.physbeh.2017.03.040

Talebi, M., Taghipour, A., Raouf-Rahmati, A., Farokhani, E. M., Ghaffariyan-Jam, S., Samarghandi, A., Nemati, M., & Nemati, A. (2024). Prevalence of mental disorders among middle-aged population of primary healthcare centers in Northeastern Iran. *BMC Public Health*, *24*(1), 4–11. https://doi.org/10.1186/s12889-023-17598-0

Van Rijt, A. M., Hulter, P., Weggelaar-Jansen, A. M., Ahaus, K., & Pluut, B. (2021). Mental health care professionals' appraisal of patients' use of web-based access to their electronic health record: Qualitative study. *Journal of Medical Internet Research*, *23*(8). https://doi.org/10.2196/28045

Wang, B., Kristiansen, E., Fagerlund, A. J., Zanaboni, P., Hägglund, M., Bärkås, A., Kujala, S., Cajander, Å., Blease, C., Kharko, A., Huvila, I., Kane, B., & Johansen, M. A. (2023). Users' Experiences With Online Access to Electronic Health Records in Mental and Somatic Health Care: Cross-Sectional Study. *Journal of Medical Internet Research*, *25*(1). https://doi.org/10.2196/47840

WHO. (2020). *Mental health and psychosocial considerations during the. Mental Health and*.