

# Mental ill-health among adult patients at healthcare centres in Sweden: district nurses experiences

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## Mental ill-health among adult patients at health care centres in Sweden: district nurses experiences

**Background:** Mental ill-health among the general population is increasing in Sweden. Primary Health Care (PHC) and Healthcare Centres (HCC), where district nurses (DNs) work, bear the basic responsibility for treatment of mental ill-health, while severe mental ill-health fall under the responsibility of psychiatric specialist care. The increased prevalence of mental ill-health in the community means that DNs increasingly encounter people with mental health problems – not least as a comorbidity. How well DNs are equipped to deal with mental ill-health is currently unclear.

**Aim:** The purpose of this study was to explore district nurses' experience of encountering and dealing with mental ill-health among adult patients at healthcare centres.

**Design:** A qualitative explorative approach was used to capture the experiences of the phenomena under study.

**Methods:** Individual interviews were conducted with 10 DNs working at six HCCs. The interviews were transcribed and analysed by qualitative content analysis.

**Results:** The result emerged as several subcategories captured by three categories: (i) having competence – a prerequisite for feeling confident; (ii) nursing mental ill-health requires time and commitment; and (iii) working in an organisation without preparedness, encompassed by the synthesising theme; nursing mental ill-health requires specific competence and organisational support.

**Conclusion:** Working as a DN requires formal and informal competence when encountering patients with complex health needs. The findings revealed that the DNs could feel insecure regarding how to deal with patients with mental ill-health due to lack of knowledge. Assessment of patients with mental ill-health is time- and energy-consuming and calls for improved teamwork at HCCs as well as effective collaboration with psychiatric specialist care and other care givers. The DNs responsibility to fulfil their work considering the increasing number of mental ill-health among people that seeks help at HCCs needs to be acknowledged and met by the PHC organisation.

**Keywords:** district nurses, experiences, encounter, mental ill-health, adults, primary health care, healthcare centres.

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## Introduction

An increasing amount of people are suffering from mental ill-health and are diagnosed with mental disorders in Sweden. According to the World Health Organization [WHO] (1), depression is currently the fourth leading cause of disability or ill-health in the Western world. The trend is still increasing, and depression is expected to be ranked as high as second place in the Western World by 2020 (2). Mental ill-health has become the leading cause of sick leave among people of working age in Sweden

(3). The more mental suffering, the more patients will be the responsibility of the primary health care (PHC) system. The increase in patients with mental ill-health – either alone or in terms of comorbidity – means that the district nurse (DN) encounters these patients with increasing frequency (4). As DNs who work in healthcare centres (HCC) often are the first contact for patients seeking care, it is prudent to explore their experience of mental ill-health when encountering patients.

Mental ill-health can be described as the opposite of mental health (5). The term mental ill-health is an umbrella term that includes a variety of problems such as headaches, anxiety, worry, anxiety, fatigue, stress, sleep disorders, reduced mental well-being, depression and suicidal ideation (6). In this study, mental ill-health is used in a wide sense to include all mental health problems

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that make it harder for someone to function well and develop normally. As a result, the term mental ill-health encompasses both the various psychiatric problems for which there are clinical diagnoses, as well as minor and moderate mental afflictions that, while falling short of diagnostic criteria, still can have a negative impact on the individual. Symptoms listed as minor and moderate mental ill-health are usually treated in HCC. People with severe psychiatric problems and diagnoses are the responsibility of specialised care (3, 5) but are living in the community with access to somatic care (7).

A study by Östman and Björkman (2014) showed that more than 50% of people with severe mental ill-health also need somatic care (7) which could lead to contact with a HCC.

Several studies show that patients experience a stigma about their mental health problems when they sought care in primary health care (8–10). There are also indications from the Ministry of Health and Social Affairs (3) that patients with mental ill-health do not receive equal treatment of physical illnesses as other patients when they seek care. Björkman et al. showed that when encountering patients with schizophrenia, nursing staff in somatic care more frequently reported more negative attitudes compared to nursing staff in mental health (11). Also, failure to provide appropriate care to young people with suicidal problems seeking care in PHC has been shown (12). Feelings of incompetence, lack of time, insufficiently trained professionals and inadequate communication skills were some of the barriers identified. The stigma of mental ill-health can result in the patient's care needs not being met when patients seek first-line primary care (13). The gap between the need for care and provision of care for patients with mental ill-health is large. Today, 50% of the mentally ill in developed countries receive no help, and in developing countries the number is as high as 85% (1). Some of these people need care provided by HCCs. Furthermore, some patients do not realise they can get help for their mental ill-health through a HCC. This uncertainty in where to seek care for mental ill-health was reflected in an Australian study by Boyd et al. (14). This demonstrates a general unawareness in the patient community, and the level of unawareness may be similar in Sweden. This is the kind of patients the DNs may face (15).

Detecting underlying mental health problems often requires a durable and solid contact with the patient, and knowledge about mental ill-health. A DN often meets with the patient at regular intervals and has the opportunity to develop trustful relationships. A trustful relationship means that a patient feels safe to open up and talk about their feelings (16, 17). The DN can provide early identification of need for care in patients who lack the ability to seek care for themselves (16). The way in which communication is carried out may also influence

the relationship. Today, many contacts with patients are made by telephone which, in comparison with in-person meetings, makes a holistic approach more difficult. Mental ill-health may be more difficult to identify and thereby assess (18).

Mental ill-health is a specific field of competence, and dealing with mentally ill patients is considered part of the key responsibility areas (KRAs) for district nurses (19). The DN role is complex and involves contact with patients who have both physical and mental health problems. Several previous studies show that DNs feel uncertain and express a lack of adequate knowledge or training when encountering patients with mental ill-health (16, 20, 21). In order to increase the DNs confidence when encountering mental health problems and to ensure that patients receive appropriate care, it seems important to understand the DNs experiences. What knowledge and skills do the DNs lack? How well are the DNs equipped to deal with the mental health problems they encounter? Which support and training efforts are needed within the organisation? To our knowledge, there are few current studies made on the topic, and therefore, it seems worthwhile to further explore.

## Aim

The purpose of this study was to explore district nurses' experiences of encountering and dealing with mental ill-health among adult patients at healthcare centres.

## Method

### Design

A qualitative explorative study design with individual interviews was chosen to obtain DNs experiences of the focus of the study. Such a design is considered appropriate to describe variations within an area by finding patterns, similarities and differences (22).

### Setting

The study was conducted in southern Sweden at HCCs, located in either rural ( $n = 4$ ) and urban ( $n = 2$ ) municipalities, with population varying between 4,000 and 64,000 inhabitants. The HCCs were run either privately ( $n = 2$ ) or by the County Councils ( $n = 4$ ). Initially, site managers at eleven HCCs gave permission to conduct the study. However, DNs (comparable to those who *did* participate) at five HCCs declined participation, citing a lack of knowledge about mental ill-health. Ultimately, the study was conducted at six HCCs, with the DNs' work spread across public health issues and lifestyle-related disease on various levels.

### Informants

A purposeful sample was used as using subjects with experience of the study focus enriches the study (22). Inclusion criteria were DNs with more than 3 years' experience of working at a health centre. A contact person at each HCC contacted DNs interested in participation, gave them oral and written information about the study and notified the authors. The DNs received further information via phone, signed an informed consent, and scheduled the time and place for their respective interview. Ten DNs agreed to participate (HCC/DNs = 1/1, 2/2, 3/1, 4/3, 5/2, 6/1), all female between 46 and 65 years of age. Their professional experience ranged between 8 and 35 years (mean 16). In addition to primary health care Specialist Nursing Education, several nurses were educated in for example asthma/chronic obstructive pulmonary disease, diabetes and psychiatry. One DN had experience of management at the HCC.

### Data collection

Individual interviews were conducted (by LJ) in conversational form (23) to achieve a shared understanding of meaning. An interview guide (Table 1) was tested in a pilot interview (22) and proved to work well. At the time of the interview, information about the study was repeated. The actual interview started with overarching questions like 'What does mental ill-health mean to you?' and 'Can you talk about encountering mental health problems among patients in your work?' The interviews lasted between 40 and 60 minutes, and were digitally recorded and transcribed verbatim into text. The interviews were conducted between October and December 2013 at the DNs workplaces.

### Analysis

The interviews were analysed by qualitative content analysis which is considered an appropriate approach for analysing interview data and interpreting its meaning in a systematic way by focusing relevant data, following certain steps along the analysis, coding consistently, and preferably using a coding frame for categorisation (24, 25). During the analysis process, we mainly followed steps in a qualitative content analysis often used in nursing research (26) which the authors describe in terms of analysing different levels of interpretations: manifest (the more obvious content of the text) and latent (the underlying meaning of the text). Further characteristics of the analysis process are as follows: identifying content areas and meaning units, condensing the units, abstracting the condensed meaning units into codes, sorting codes by their commonality into categories (a descriptive/manifest level) and sorting similar codes in a category into

**Table 1** Interview guide

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- Can you talk about what mental ill-health means to you?
  - Can you talk about encountering mental health problems among patients in your work?
  - Physical ill-health and disorder is a common part of your work, but can you talk about in what way you come into contact with mental ill-health among adult patients?
  - What kind of mental ill-health do you encounter?
  - Do patients always seek help specifically for mental health problems?
  - Can you give an example of how you deal with mental ill-health?
  - Can you talk about some common professional challenges that you experience when encountering patients with mental ill-health?
  - What about emotional challenges?
  - Do you feel you have adequate competence for dealing with patients' mental ill-health?
  - What support do you have with handling encounters with patients' mental ill-health and distress?
  - Can you talk about whether or not patients are aware of their mental ill-health?
  - What is your experience of stigma in relation to patients with mental health problems?
  - What observations have you made regarding the care and service of this group of patients?
  - Based on your observations, do you have any suggestions for improving care and service to people with mental ill-health?
- 

subcategories. Theme/s can when possible be created, which link the underlying meaning of the categories together (26). The analysis started with the first and second author individually reading and rereading the transcripts, and using the previous described research questions to determine what issues to focus on. Subsequently, the authors met and reached agreement on five preliminary content areas related to the DNs experiences: (i) encountering the patients, (ii) description of the mental health problems DNs encounter, (iii) knowledge and training in mental ill-health, (iv) how to deal with mental health problems and (v) organisational circumstances. These content areas were used as a preliminary coding frame (25), which was 'tested' by individually working through three transcripts, identifying meaning units, condensing and coding. These codes were then sorted by similarities and differences in content into categories within each content area. When comparing and discussing the two individual analyses, different perspectives seemed to emerge, requiring us to reorganise the codes into the following content areas: (i) professional prerequisites, (ii) the actual professional encounter and (iii) organisational circumstances. These revised content areas were settled upon as the coding frame to be used. At this point, to gain an additional perspective, the third author

joined to review and reflect over the analysis process and the coding frame, which was subsequently agreed upon and approved. The three authors continued to meet periodically to improve the credibility of the analysis process including the categorisation process within the decided content areas (Table 2), and to choose citations to validate the categories. Finally, a theme was formulated based on the text, the content of the categories and our interpretation of the latent meaning of the DNs experiences. During the analysis process, continuous discussions among the authors took place until consensus was reached concerning the result. The analysis was mainly data-driven (inductive), which allowed patterns of content that emerged from the text to be further categorised on a manifest level of interpretation, and to finally be synthesised into a latent interpretation by a theme.

### Ethical considerations

Ethical approval and permission to conduct the study was given by Kristianstad University (Dnr.2016-232-408), all according to national standards and procedures. Ethical principles were adhered to in terms of information requirement, requirement of consent, confidentiality requirement and utilisation requirement (27). The subjects gave informed consent after being informed orally and in writing that the study was voluntary, that participants had the freedom to withdraw any time and that all data were considered confidential.

### Results

When talking to their adult patients, the DNs did not find it as natural to discuss mental ill-health as they did

psychical ill-health. A shared sentiment was that the types of mental ill-health among patients seeking help at the HCC could range from mild mental ill-health to more severe mental ill-health. Factors potentially causing mental problems were reviewed. Peoples' lifestyles were perceived as either contributing to or buffering mental ill-health. Abuse of alcohol and drugs was described as sometimes used by patients as self-medication to alleviate problems such as pain, anxiety or to prevent sleep problems. Demands of working life could be stressors just as demands related to unemployment. The review revealed differences between groups of people. Seeking help for mental health problems was viewed as more common among women than men, and more common among young adults than other groups. A noted cause of potential mental ill-health was changing residence due to studies or work. Mental ill-health among older people appeared to be related to loneliness. Mental ill-health among immigrants and refugees was recognised as an increasing problem to handle. Refugees who had been involved in war experiences or torture could be difficult to get close to. This was something the DNs had to take into account in their care of patients with a foreign background. The DNs' experiences of encountering and dealing with mental ill-health are captured by three main categories and several related subcategories. The three main categories are as follows: (i) having competence – a prerequisite for feeling confident; (ii) nursing mental ill-health requires time and commitment; and (iii) working in an organisation without preparedness. The categories were finally interpreted with a theme as meaning; nursing mental ill-health requires specific competence and organisational support (Table 3).

**Table 2** Example of the analysing procedure; meaning unit, condensed unit, code, subcategory and category

Meaning unit	Condensed unit	Code	Subcategory	Category
'I feel confident in my knowledge of mental ill-health but that's probably because I have my training' (nurse 10)	Feeling confident because of knowledge in mental ill-health	Feeling confident	Formal competence	Having competence – a prerequisite for feeling confident
'We typically [only] measure [blood pressure] once a year, maybe... but patients don't want to hear that. Then you begin to think that there is something else behind [their visit]' (nurse 1)	Thinking there is something else behind the visit other than wanting to have blood pressure measured	Something else behind	Responsive to the unspoken	Nursing mental ill-health requires time and commitment
'It's not easy to get patients into psychiatry care. There are many patients who fall between the cracks. Sometimes I have been disappointed by psychiatry care, thinking that they've taken too lightly' (nurse 8)	I have been disappointed by psychiatry care, which takes patients problems to lightly and many fall between the cracks	Collaboration	Lack of collaboration with specialist outside the healthcare centres	Working in an organisation without preparedness

**Table 3** The structure of the theme, categories and subcategories

<i>Theme: Nursing mental ill-health requires specific competence and organisational support</i>	
Categories	Subcategories
Having competence – a prerequisite for feeling confident	Formal competence Informal competence
Nursing mental ill-health requires time and commitment	Planned and unplanned visits Responsive to the unspoken
Working in an Organisation without preparedness	Lack of cooperation inside healthcare centres (HCC) Lack of collaboration with specialists outside the HCC

*Having competence – a prerequisite for feeling confident*

Both formal competence, such as education, and informal competence, achieved through work experience within the psychiatric field, was said to offer confidence when encountering and dealing with patients with mental ill-health. Competence – or lack of it – could influence the patient encounter.

*Formal competence.* The DNs described their specialist education as lacking in the area of mental ill-health in general. Their employers neither asked for such knowledge and skills nor offered skill improvement courses in this area. In addition, the professional shortcoming was also said to derive from personal lack of interest.

It is enough if you have interest. If you want to do something. I don't think such training is something that you want. I mean, if I wanted to work with such patients I would work in psychiatry and not as a DN (7).

As DNs had limited expertise in mental ill-health, uncertainty about how to behave in the care of these patients was pervasive. This uncertainty leads to fear of encountering patients with mental issues or diagnosis and to ask deeper questions. *Some [DNs] are reluctant to meet with them, while some embrace them and can handle it. It is as if the fear is due to ignorance; the fear of not feeling safe with them* (8). Managing patients with mental health problems was a skill DNs had to develop themselves. Those who were trained in mental health/psychiatric nursing felt more comfortable. *'I feel confident in my knowledge of mental ill-health but that's probably because I have my training'* (10).

*Informal competence.* The interviewees described that limited competence also could be achieved through work experience. Still, having insufficient knowledge about mental ill-health in general created uncertainty about providing adequate care. Development of informal

competence relies on learning from live on-the-job experiences, despite fears of something serious happening if they interacted with these patients in the wrong way.

Most [patients] call us by telephone. Then you must ask the right questions and think of your voice. It is this tacit knowledge ... It's hard to describe but you hear whether it is serious [or not]. And sometimes, this can probably take a bit [of time] ... what you base this on, guess it must be enough experience (4).

The DNs experienced that if they, through ignorance, said something inappropriate, the patient would withdraw. As a result, DNs were afraid to ask questions if they felt they were not equipped to handle the response. On the other hand, if these patients did not feel validated and satisfied, they would simply come back again.

*Nursing mental ill-health requires time and commitment*

As a DN, an important part of meeting with patients suffering from mental health problems was to listen to and validate them, which could be time- and energy-consuming.

*Planned and unplanned visits.* The DNs described most consultations as short. As time was set aside for practical interventions like pharmaceutical delivery, blood pressure measurement or dressing wounds, there was no time to deal with mental ill-health.

The DNs stated that patients could make an appointment for physical complaints and unexpectedly disclose mental health problems, but patients could also turn up in the waiting room without having booked an appointment. Patients with all forms mental ill-health were considered stressful to deal with due to being more time-consuming, and it was at times necessary to ignore the patient's need to talk by ending the conversation prematurely. On the other hand, it was important to take advantage of the moment when a patient opened up to talk.

They want to talk more and more and we have to find a way to end the conversation... like, 'sit down on the balcony at home with a cup of coffee and get back to us again if you need' (9). Some patients could talk for ages and took plenty of time ...//give someone an inch and they take a mile (3).

*Responsive to the unspoken.* The DN described it necessary to be good at reading people to identify mental ill-health. It was important to show engagement to make the patient feel heard and validated. The DNs scanned for both verbal and nonverbal signals as patients were described as emotionally cautious and guarded during their first visit to the HC. It was necessary to endear themselves to the patient through empathy in order to

understand the actual problem. Gut instinct was relied upon to sense how each individual should be handled. There was no universal approach that worked for all individuals. Some patients needed validation, while other patients needed more empowerment. However, based on patients' insistence on coming back, these conversations were most valuable for the patients.

They can ask to come back [for blood pressure measurement] about every month or so. And there is really no basis for it, especially as resources has gotten tighter. One typically measures it once a year, maybe... but this patients do not want to hear. Then maybe you can think that there is something else behind [their visit] (1).

#### *Working in an organisation without preparedness*

Mental ill-health among patients seeking help at HCCs was described to have increased. The PHC organisation seemed unprepared for this increase. The resource shortcomings that characterised the organisation manifested as a lack of professionals with adequate competence, a lack of cooperation inside the HCC, a lack of collaboration with specialists outside the HCC and a lack of time for these patients.

*Lack of cooperation inside the HCC.* Cooperation between DNs and other professionals regarding patients with mental ill-health was said to not function well. There was a shortage of specialists in HCCs such as counsellors, psychologists and general practitioners (GPs). The latter replaced by contract physicians when in shortage. The lack of specialists working with DNs and GPs as a team under the same roof was emphasised. This lack of cooperation could sometimes result in time-consuming detours for the delivery of patient care. These patients did not always get the help they needed because it was impractical, and therefore frowned upon by colleagues and management, to spend more time on a patient than allocated by schedule.

The problem is that the HCC are not really equipped. We do not have time for these [mental/psychiatric] patients. They are very time consuming patients (6).

The DNs expressed a need for counselling or psychotherapy for patients. However, there were often queues for therapy, and patients had to wait so long that they would end up on sick leave before getting an appointment.

It's more and more up to us in primary health care to take care of these patients with mental ill-health. It should of course be [counselors] who take care of them. It is not supposed to fall on the rest of us (6)

The GPs were also described to lack resources to delve deeper into the patient's problems. However, ordinary GPs were perceived to get more involved in patients

mental issues compared to contract physicians. DNs working with contract physicians ended up with increased workload and responsibility for patients. Contract physicians usually neglected mental ill-health in general and concentrated on physical illness. It was easier to prescribe medicine than to spend more time with patients. Some patients could also be very assertive in wanting a particular drug prescription. The physicians were not always able to resist these demands. Patients were therefore described to receive prescriptions for drugs they did not need. If patients met with different physicians at each visit, but with the same DN, it was quite normal for patients to open up more with DNs. *'If it's just a contract physician, the DN is the glue that holds the entire health care together'* (1).

*Lack of collaboration with specialists outside the HCC.* General practitioners in HCCs were expressed to have insufficient knowledge in mental ill-health and psychiatry and therefore needed additional support from specialists. DNs described how patients were referred to psychiatric specialists when they were considered to have more severe problems. But the referral assessments were time-consuming and did not always result in an actual referral. Instead, patients were often referred back to the HCC for continuing care and treatment.

Psychiatric care can't possibly take care of all these [patients], but they must take on the more severe cases. The physicians must naturally take some appointments, but they often simply prescribe antidepressants; fast and easy. But perhaps [the patient] only needs counselling or a talk (6).

After assessment and treatment by psychiatric care, the HCC was still responsible for the patient, despite lacking the adequate competence. *'It's not easy to get patients into psychiatry care. There are many patients who fall between the cracks. Sometimes I have been disappointed by psychiatry care, thinking that they've taken too lightly'* (8).

Improved collaboration between psychiatric care and PHC was desired in order to transfer psychiatric knowledge to PHC. The DNs emphasised a strong need for improved care of patients with mental ill-health. To optimise the care for these patients, HCCs were suggested to expand their interaction with other actors. As with for example occupational health services, which were considered to be in need of an expansion of their responsibilities, as a large part of mental ill-health is linked to employment. The DNs called for an additional form of care that would prevent patients from falling between the cracks and improve the collaboration between the care providers.

## **Discussion**

The findings indicate that the DNs work situation has changed in response to the increase in mental ill-health.

The risk of comorbidity among chronically ill people also seems rather high. Early identification and prevention of all forms of mental ill-health are within the scope of the DNs' responsibilities. When the DNs shared their experiences with mental ill-health among adults, some groups seemed to dominate. Their work at HCCs meant encountering older people and young adults with lifestyle problems – especially work-life stress and/or addiction. A growing population with mental ill-health was immigrants and refugees. This places even greater demands on both formal and informal skills among the DNs about how mental ill-health is expressed in different cultures as well as how the healthcare needs of these people and their families can be met. Working in an organisation without preparedness for the increase in mental ill-health seemed stressful for the DNs as mental nursing requires additional time, commitment and teamwork.

#### *Having competence – a prerequisite for feeling confident*

Having formal and informal competence was important when meeting with patient suffering from mental health problems. With regard to DNs, a lack of education in mental health/ill-health and disorder was reported as a reason for the deficiency of competence. The result is in line with the Waidman et al. study, featuring 17 nurses in 2012, which showed that nurses felt incapable due to the absence of educational training as well as uncomfortable feelings when attending the patients (28). Also Winer et al. describe an insufficient knowledge among primary care providers (29). A study (30) about nursing students' attitudes and preparedness to care for people with severe mental ill-health showed that the majority of the students felt uncertain while interacting with people with mental diagnoses and not confident in their ability to care for them. Considering the increasing mental ill-health and thereby the demand for competent health professionals education in all forms of mental ill-health needs to be a top priority. According to the Higher Education Act (31), the goal for the DN education is to be able to assess, plan, implement and evaluate the necessary measures to promote the physical, mental and social health of patients and prevention the onset of disease and disease complications. The education is on a master level which includes the ability to observe and assess patients' complex needs of care, habilitation and rehabilitation. The results from the present and former studies have to be taken into account among nursing education providers as well as caregiver's responsibility to train and maintain staff competency so they can meet the needs of the patients. This seems to be particularly important when caring for people with complex care needs and limited autonomy. To counteract the nurses' feelings of uncertainty and fear of saying something wrong professional supervision and guidance may be of importance

(32) as well as reduce stress and emotional exhaustion (33).

#### *Nursing mental ill-health requires time and commitment*

Meeting with patients suffering from mental ill-health during clinical appointments was expressed by the DNs as challenging. One of the reasons was because these patients could be very time-consuming. Our study showed how committed DNs told of observing and conciliating patients in order to identify mental health problems. However, the DNs patient approach appeared to range from being open, committed and giving patients time to express their worries to avoiding mental problems and issues altogether. The latter, a rather task-oriented approach, may be a strategy to guard against time pressure or the fear of not being able to handle what is expressed. A Swedish study focusing on DN (n = 27) encounters with general patients in PHC reported lack of time, stress, language barriers and poor patient moods as common obstacles to successful patient visits (34). Given such findings, it is reasonable to infer that if patients in general cause named difficulties, dealing with patients with mental ill-health must be even more challenging. Holopainen et al. (35) identified and listed four factors – presence, recognition, availability and mutuality – as required components for 'caring encounters' to take place. In the context of the previously mentioned obstacle 'lack of time', the authors discuss whether caring encounters can emerge in the time-constrained and technologically driven environments of modern nursing care. The authors argued that presence is not actually a matter of time and that a caring encounter can occur in a matter of moments (ibid.). The rationalisation of not having enough time is more likely a shield to hide behind when not having the courage to be open to the patients suffering.

That the DNs are negatively challenged by mental ill-health must be highlighted as DNs in particular are likely to encounter a high degree of mental and physical comorbidity among their patients (36). The authors of an English study believed the DNs (n = 218) to underestimate the prevalence of mental health problems among their patients and, consistent with other studies, found DNs expressing a lack of knowledge and training for this aspect of their work (ibid.). Limited knowledge was also expressed by DNs (n = 18) in England regarding delivering care to drug misuse patients with clinical care needs. The DNs described alcoholics and drug misusers as 'risky' and labelled themselves as 'vulnerable'. The DNs focus consequently regressed to simply getting the job (task) done, failing to commit in patient discussions in personal terms (37). These findings altogether indicate that further training and education in mental ill-health is needed in order for DNs to be able to commit themselves in caring

encounters, integrate mental as well as physical aspects of a patient in assessments, and deliver holistic person-centred nursing care.

#### *Working in an organisation with insufficient preparedness*

The findings illustrate that primary care lacked resources to provide acceptable care for patients mental ill-health due to a lack of specialist skills and insufficiently allocated time. Contract physicians, in particular, focused on physical conditions and left mental issues to the DNs. Not surprisingly, as HCC staff lacked mental health/ill-health competence – which is a structural prerequisite for holistic understanding of the patient – team meetings at the HCC often overlooked mental ill-health issues (38). Team collaboration can facilitate person-centred care by offering several professional perspectives and is a core competence in specialist nursing and education (*ibid.*). When establishing a HCC team, at least one team member should have the knowledge and skills to include the mental perspective of the patient and family. We suggest that DN Specialists with additional training in mental ill-health would make a great difference on a HCC team, being able to provide a more holistic picture of the patient and his/her life situation.

Considering the responsibility of PHC as first-line caregiver, the findings indicate an alarming lack of interest for patients with mental ill-health. Also, a Swedish study (39) of a large improvement programme aiming to improve the chain of care for people with psychiatric disability found similar shortcomings; staff from municipality-, county council- and primary care were invited to collaborate in teams, but primary care representatives chose not to attend.

The insufficient care for patients with severe mental ill-health was reported in a national evaluation (40) in which the need of improved collaboration between care and service providers across systems was emphasised. It was noted that seven of ten PHC directors placed the responsibility for mentally ill patients' physical health on psychiatric specialist care. As a consequence, HCCs were designated to establish routines for early discovery of mental ill-health as well as for discovery of physical ill-health among patients with mental conditions (*ibid.*). This points to an evident need for care and service which takes the patient as-a-whole into account. Several international studies highlight the mental and physical health interplay in people and thereby the need for collaborative care (41–43), or shared care (44). Some researchers emphasise that collaboration is not enough. Instead, integrative care systems must be

developed to replace the traditionally fragmented healthcare system historically organised to the advantage of care providers and not the patients (45, 46). DNs have an important role to play in the development of such integrative care.

#### *Limitations*

Measures were taken to ensure the trustworthiness (47) of the study. However, the following aspects needs to be taken into account: That DNs at five HCCs declined participation limited the planned size of the sample can be viewed as a weakness, but it can also strengthen the findings which revealed lack of knowledge regarding encountering and dealing with mental ill-health. Looking back, it is difficult to assess whether the choice of individual interviews was better than using focus group interviews. However, it seemed appropriate given that the study then could focus on weaknesses in the DNs' professional competence – a subject possibly too sensitive for a focus group approach.

#### **Conclusion**

Working as a DN requires both formal and informal competence when meeting with patients with complex health needs. The findings revealed that the DNs could feel uncertain when encountering and dealing with patients with mental health problems. In order to fulfil their responsibility and work in an appropriate way, their knowledge needs to be improved. Assessment of patients with mental ill-health is time- and energy-consuming and also calls for improved teamwork at HCCs as well as better collaboration with psychiatric specialist care and other caregivers. Considering the increasing prevalence of mental ill-health among patients that seek help at HCCs, the professional needs of DNs need to be acknowledged and better met by the PHC organisation.

#### **Author contributions**

A-C.J and LJ designed the study; LJ collected the data; A-C.J, LJ and EK.C involved in conducted the analysis of data; A-C.J, LJ and EK.C prepared the manuscript.

#### **Ethical approval**

Ethical approval and permission to conduct the study was given according to national standards and procedures by Kristianstad University; Dnr.2016-232-408

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