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Increased Mental Illness and the Challenges This Brings for District Nurses in Primary Care Settings

Annica Bjorkman, PhD, RN\textsuperscript{a,b}, Kajsa Andersson, RN, MSc\textsuperscript{b}, Jenny Bergström, RN, MSc\textsuperscript{b}, and Martin Salzmann-Erikson, RN, PhD\textsuperscript{b}

\textsuperscript{a}Department of Public Health and Caring Sciences, Uppsala University, Uppsala, Sweden; \textsuperscript{b}Faculty of Health and Occupational Studies, University of Gavle, Gavle, Sweden

ABSTRACT

Patients with mental illness generally make their initial healthcare contact via a registered nurse. Although studies show that encountering and providing care to care-seekers with mental illness might be a challenge, little research exists regarding Primary Care Nurses’ (PCN) view of the challenges they face. The aim of this study was to qualitatively explore PCNs’ reflections on encountering care-seekers with mental illness in primary healthcare settings. The results consist of three themes: constantly experiencing patients falling through the cracks, being restricted by lack of knowledge and resources, and establishing a trustful relationship to overcome taboo, shame, and guilt.

Introduction

Mental illness is common within all countries and cultures, and almost 20% of all cases of illness are related to mental illness (Aczon-Armstrong, Inouye, & Reyes-Salvail, 2013; World Health Organization, 2016). The term “mental illness” is an umbrella term including a wide range of diseases from minor symptoms of anxiety to complex diseases such as psychosis, bipolar disorder, and major depression. The prevalence of mental illness is increasing in all age groups and among both women and men. Mental illness is more frequent among younger, female, and unemployed persons (Alonso et al., 2004; Koochaksaraei, Mirghafourvand, Hasanpoor, & Bani, 2016). The prevalence of anxiety in Sweden has grown during the last 25 years, and ~25% of the population is affected by a psychiatric illness at some point (Calling, Midlöv, Johansson, Sundquist, & Sundquist, 2017). There is a vast amount of unmet needs regarding mental health problems among all ages, placing great demands on the healthcare system and its organization (Abel, 2018). Patients suffering from mental illness are at risk of long-term illness and at greater risk of relapse and deterioration of their functional ability if they do not receive proper treatment at an early stage (Hunter & Storat, 1994; Jansson & Fridlund, 2016). Early detection of mental illness is crucial, as it enables early treatment and better prognosis (Allison, Nativio, Mitchell, Ren, & Yuhasz, 2014). Nurses play an important role in this, as they are often a patient’s first contact with the healthcare system.

Background

In Sweden and many other Western countries, the care of patients with psychiatric illness is provided by a number of professions such as physicians, sociologists, psychologists, and registered nurses (RNs)/PCNs. Many patients with psychiatric illness will initially contact their primary healthcare (PHC) provider for help. These contacts are commonly made via telephone, and the calls are answered by RNs. PHC providers are regarded as the proper provider of mental healthcare (Cleary et al., 2014; Luoma, Martin, & Pearson, 2002). However, patients with depressive problems have expressed concern about PHC providers’ ability to meet their mental health needs (Kravitz et al., 2011). Studies have shown how patients with mental illness experience a number of obstacles when seeking care (Ali et al., 2017; Barney, Griffiths, Jorm, & Christensen, 2006; Gulliver, Griffiths, & Christensen, 2010; Kravitz et al., 2011). They perceive problems related to mental illness to be stigmatized or even taboo, and are afraid of the reaction they will have from the healthcare provider when seeking care for mental illness. Some patients state that they would have preferred to have a somatic disease, as this would have made it less embarrassing to seek care (Kravitz et al., 2011).

Several studies have shown how both healthcare professionals and patients perceive mental illness as stigmatizing, taboo, and difficult to talk about (Björkman, Angelman, & Jönsson, 2008; Dardas, Bailey, & Simmons, 2016; Natan, Drori, & Hochman, 2015; Oates, Drey, & Jones, 2017; Tharaldsen, Stallard, Cuijpers, Bru, & Bjaastad, 2017). Both healthcare professionals and patients with mental illness...
report negative attitudes towards mental illness (Hansson, Jormfeldt, Svedberg, & Svensson, 2013; Mittal et al., 2014). These negative attitudes are related to a low degree of faith in the opportunities that people with mental illness have within society, such as possibilities to have a job and a social life. Healthcare professionals working within somatic care experience patients with mental illness as being unpredictable, frightening, and more demanding than other patients (Björkman et al., 2008). A lack of knowledge can result in nurses working within somatic care being afraid of patients suffering from mental illness (Mavundla, 2000). Studies have shown how nurses with a specialist degree in psychiatric nursing have a more positive attitude towards patients with mental illness compared to nurses with no specialist degree (Björkman et al., 2008; Natan et al., 2015), and also perceive mental illness as less stigmatizing. Nurses, as the largest proportion of healthcare personnel, play an important role as they are uniquely situated to facilitate care for care-seekers with depression, and are able to restore, maintain, and/or promote mental health and wellbeing (Dardas, Bailey, & Simmons, 2016). A majority of RNs working in PHC are Primary Care Nurses (PCN); that is, RNs with an advanced specialist university education in public health (The Association of Swedish District Nurses [DSF], 2008; Leppänen, 2010). In Sweden, the specialist nursing program in PHC nursing is an advanced academic degree including a Master of Science in Nursing and entails 75 credits at the advanced level. To become a PCN, aspirants must be a RN and have a Bachelor’s degree in Nursing before entering the specialist education program (The Association of Swedish District Nurses, 2008). The 75 credit education consists of courses in public health diseases, pharmacology and pathophysiology, nursing science with focus on prevention and health promoting among elderly, children and adolescents.

In Sweden, nurse education comprises approximately 2 weeks of theoretical education in mental illness and 5 weeks of clinical education in psychiatric wards. However, nursing students report lacking theoretical knowledge during clinical practice, especially within psychiatric care (Löfmark & Wikblad, 2001), and there is a gap between theory and practice (Jonsén, Melender, & Hilli, 2013). The specialist education program for PCN in Sweden does not have specific courses on psychiatric illness; the subject of psychiatric illness is included in public health diseases. Haddad et al. (2005) reported that PCNs found their training in encountering patients with mental issues limited. Even though the participants expressed an ambition to develop their skills, three-quarters had not received any training during the past five years. Nurses’ lack of knowledge regarding how to communicate with, encounter, and care for patients with mental illness might mean that patients risk receiving inappropriate or inadequate care (Kerrison & Chapman, 2007). Following their specialist education, PCN are supposed to be responsible for leading and developing care within their PHC. PCN report that ~16% of their patients suffer from mental health problems (Haddad et al., 2005).

Mental illness is a common problem in today’s society, and its incidence is increasing, especially among adolescents and women (Calling et al., 2017). It leads to many and lengthy periods of sick leave (World Health Organization, 2013). In Sweden, mental illness accounts for ~44% of all sick leave across genders, but women are overrepresented, with 48% of all sick leave due to mental illness compared to 36% among men (Swedish Council on Technology Assessment in Health Care, 2004). Early treatment is important for successful treatment, and continuity is important for a caring relationship (Kane et al., 2015). Encountering and providing care to care-seekers with mental illness problems is not easy, and knowledge of PCNs/RNs’ experiences and reflections regarding this demanding work is scarce.

**Aim**

The aim of this study was to explore PCNs’ reflections on encountering care-seekers with mental illness in primary healthcare settings.

**Method**

A descriptive qualitative study design was chosen to address the aim and research questions.

**Participants**

Five health centres in the close geographical surrounding were selected based on a purposive sample (Creswell, 2002; Polit & Beck, 2008). A written request for permission to conduct the study was sent to the section manager for approval. The healthcare managers at each health centre assisted with recruitment by identifying potential participants who met the eligibility criteria. The PCNs who were interested in participating then contacted the researchers by email or telephone to agree a time and place for the interview. Inclusion criteria for participation were being a specialist PCN, having worked at the health center for at least 6 months, and having experience of meeting patients with mental health problems in their work at the health center. Recruitment of participants was based on a purposeful sample selection aimed at targeting interviewees with long-term and in-depth insights from their experience in the area of investigation (Creswell, 2002). Eight PCN, all of whom were women, agreed to participate. They worked at five different health centres in the selected municipality, and their ages ranged from 27 to 62 years (mean = 46.6 years). The background variables are further presented in Table 1.

**Table 1. Description of participants’ background variables.**

<table>
<thead>
<tr>
<th>Age</th>
<th>Time worked as undergraduate nurses (years)</th>
<th>Time worked as district nurse</th>
<th>Time worked at the health center</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>5</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>37</td>
<td>12</td>
<td>0.5</td>
<td>3.0</td>
</tr>
<tr>
<td>37</td>
<td>10</td>
<td>3.0</td>
<td>3.0</td>
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<td>40</td>
<td>18</td>
<td>6.0</td>
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<td>49</td>
<td>27</td>
<td>10.0</td>
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<tr>
<td>60</td>
<td>40</td>
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<td>61</td>
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<tr>
<td>62</td>
<td>30</td>
<td>27.0</td>
<td>23.0</td>
</tr>
<tr>
<td>Mean</td>
<td>46.6</td>
<td>9.2</td>
<td>7.5</td>
</tr>
</tbody>
</table>
Data collection

Data were collected from individual semi-structured interviews based on an interview guide designed according to the purpose of the study. The guide was used to ensure that all participants were asked the same core questions, while leaving the interviewer the option of posing additional probing questions based on the interviewees’ answers. The interview guide included open questions addressing the participants’ experiences of encountering patients with mental health problems in telephone counselling, reception desk encounters, and personal visits. All interviews ended with the question “Do you have something more you want to add?” to allow the participants to provide further information and develop their experiences and reflections (Polit & Beck, 2008). During the interviews, a number of follow-up questions were asked with the aim of getting as comprehensive answers as possible, such as “Can you tell me more?” and “How do you think and feel about it?” A number of background variables concerning among other things the sex, age, and occupational experience of the participants were also obtained.

Data analysis

Conventional (inductive) content analysis was used for data analysis. In conventional content analysis, coding themes are derived directly from the text data (Hsieh & Shannon, 2005). Transcripts of interviews were read and reread several times, with and without the audio, to become familiar with the content. Following this, each interview was coded line-by-line to identify meaning units that corresponded to the purpose of the study. The meaning units were then condensed by shortening the text, and each condensed meaning unit was given a code; that is, a descriptive label for its content. All codes were sorted into themes based on similarities and differences, as the purpose of creating themes was to describe the phenomena and to increase understanding. The themes were based on the researchers’ interpretation of the findings. Data analysis was conducted by all of the authors, and themes were re-read, reviewed, and discussed until consensus was reached.

Ethical considerations

Studies involving healthcare staff in their professional role do not require full ethics committee approval in Sweden. The ethical regulations and guidelines according to Swedish Law 2003:460 (CODEX, 2004) were followed. The nurses gave their informed consent to participate after receiving both written and verbal information about the study. They were informed about their rights to withdraw from the study at any time without giving an explanation, and assured that they as individuals would not be identifiable in quotations.

Results

The narratives of the nurses were interpreted as describing their being exposed to impossible demands. The results consist of three themes: “constantly experiencing patients falling through the cracks, being restricted by lack of knowledge and resources, and establishing a trusting relationship to overcome taboo, shame, and guilt.” These themes illustrate the PCNs’ reflections on encountering care-seekers with mental illness in primary healthcare settings. The participants described a number of challenges they faced when encountering such patients and these challenges led to difficulties in their daily work with this patient group. They shared their reflections on the underlying causes, and described the thoughts and feelings arising from these challenges.

Constantly experiencing patients falling through the cracks

The participants spoke about the need for collegial cooperation, including both internal and external cooperation, when encountering patients with mental illness. They described both positive and negative experiences of this type of cooperation, and emphasized the importance of referring mental health patients to the right care provider. External cooperation with other care providers was sometimes problematic and inadequate. The participants noted that patients risked falling through the cracks as they were referred back and forth among different caregivers.

“They… very often they fall through the cracks … and they’re referred to the social services – they’re referred here, they’re referred there, but it’s like they… it doesn’t work… somebody needs to take charge.” (Nurse 1)

The participants stated that no care provider had the overall responsibility for these patients, which led to frustration among the PCN. Their experiences of cooperation with psychiatric healthcare had been problematic, as rules and regulations hindered the patients’ reaching the most appropriate and competent care provider. The participants had found support among colleagues at the district medical center, and cooperation with colleagues from other professions such as physicians, psychologists, and social workers had been helpful to support them. Even so, they said that the lack of routines regarding patient follow-ups was a problem.

“…there’s no good system right now for case follow-up ... so we’re left with a completely full appointment book and no idea where to send the patient, so it’s a big problem for us.” (Nurse 7)

The participants also said that they were able to consult a psychosocial team at the health center for advice on how to approach mental illness and the patient’s needs.

As PCNs, the participants were the ones who initially encountered the patients via the telephone or at drop-in appointments. While a nurse might not be the most appropriate profession to initiate care and treatment, it was their responsibility to gather a complete anamnesis and general picture of the situation, to be able to refer the patient
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expressed the difficulty of defining mental illness. That mental illness among patients could manifest as complex and divergent nature of mental illness. They said caused a sense of frustration. Patients were put on long waiting lists. This knowledge soon as possible, but their restricted time meant that the nurses often felt that they wanted to help the patient as time before seeking help. Due to their awareness of this, the mental illness had struggled with their problems for a long time. Providing nursing care for patients with mental illness was vital for the forthcoming encounter.

Being restricted by lack of knowledge and resources

All the nurses said that mental illness was a very common reason for people to make contact with the health center, and that they encountered these patients several times a day. There was a general opinion among the participants that mental ill health was a cause of contact that had grown greatly, especially among children and young adults.

“As I mentioned, if I compare the situation with what it was like before, I do think we're getting more and more of these patients, and especially the young ones, who are often extremely sick.” (Nurse 8)

Nevertheless, mental illness was not only restricted to younger patients; the participants confirmed that they saw it in all age groups. When they reflected upon the causes of this development, based on their experience, one suggestion was the general strain that patients are experiencing from the societal pressure to be successful and able to perform.

The nurses believed that the enlarged number of patients contacting the health center due to mental illness risked a decreased quality of care due to long waiting lists. They also described how visits due to mental illness were time consuming and did not fit into the restricted time they had available for each visit. This posed challenges, and resulted in a stressful work situation.

“At the same time we’re working under time constraints, so we don’t always have time to do exactly what we might want to … because I've got my twenty minutes, and I'm supposed to … meet with the patient, take some action, and document it, so that …” (Nurse 7)

The participants said that many of their patients with mental illness had struggled with their problems for a long time before seeking help. Due to their awareness of this, the nurses often felt that they wanted to help the patient as soon as possible, but their restricted time meant that the patients were put on long waiting lists. This knowledge caused a sense of frustration.

“Plus, it’s appalling that people who are so sick have to wait eight weeks before they can be seen at a district medical centre … it’s just crazy …” (Nurse 5)

During the nurses’ narrations of their experiences, they expressed the difficulty of defining mental illness.

“It’s hard to define it … it’s about what the patient experiences … if they say they’re not feeling well then that’s a mental health issue … because I can’t judge … actually.” (Nurse 3)

Another challenge described by the nurses was the highly complex and divergent nature of mental illness. They said that mental illness among patients could manifest as anything from mild symptoms to a long-term psychiatric diagnosis.

“I see that as possibly being anything from … anxiety to depression to bipolar to, so … a huge range … OCD, and just this thing about being down … it can of course be ordinary physically healthy people who have just had too much to deal with in life, or … we have, you know … it’s extremely broad.” (Nurse 6)

As exemplified in the quotation above, mental illness was seen as divergent since it stemmed from numerous causes, such as divorce, psychiatric conditions, or other severe diseases. Mental illness was also described as complex, since it sometimes originated from physical ill health. The nurses said that there were times when patients contacted the health center for a physical disorder, but during the visit the mental illness became more prominently in focus. Mental illness was described to be a highly individual experience from the patient perspective. This affected the nurses’ care strategies, in that they could not decide on specific advice, methods, or treatments in advance, but had to provide advice that was more individually and situationally created. Most of the participants said that they lacked knowledge about mental health, and that this restricted them when encountering patients with mental illness. They said that they had not had any educational programs training them to encounter patients with mental illness. Most of them described how their skills had been developed from clinical and private experiences, and said that they used these experiences when encountering future patients.

“I had a patient once … he was having a really rough time, and he actually opened up to me, and afterwards he said he was really glad he had made that call and was very grateful to me for the way I talked to him … and you know, that’s an experience I can use next time … that I must have done something right.” (Nurse 5)

The participants believed that there was a need for further competence at the health centers regarding mental illness. One of the health centers had developed a flowchart for these patients, which the nurses described as a good supporting tool, which facilitated their work.

Establishing a trustful relationship to overcome taboo, shame, and guilt

Providing nursing care for patients with mental illness was described in terms of challenges that were exclusive to these patients. The participants said that many of the patients had difficulty opening up and talking about their issues, as the problems were of a sensitive nature. It was the nurses’ perception that these patients felt that mental illness was associated with shame and guilt, grounded in the idea that mental illness is more taboo than physical illnesses. Hence, they believed nursing care should normalize mental illness to guide patients to improve their mental health. Based on their experiences with this patient group, there was full agreement among the participants that initially establishing a confident and trustful relationship between them and the patients was vital for the forthcoming encounter.
“You have to listen more, too, and you have to… always… we’re always empathic, but in these cases you have to be even more empathic and more understanding, because otherwise the patients can lose their trust in you if you don’t give them a good initial reception… you mustn’t rush, because then they’ll lose their trust.” (Nurse 4)

As shown in the quotation above, being responsive to the patient’s narrative was spoken of as a strategy for creating a trustful relationship. Responsiveness meant not interrupting the patient, giving them time, and conveying a sense of being present for them by taking a respectful and gentle approach. However, the nurses were concerned by their lack of time to spend on each patient.

“So I think it’s extremely important that you yourself stay fairly calm, that you don’t start to push it, even if you’re under stress and are in a hurry… it’s incredibly important and… the patient feels that there’s time here… because otherwise you’re deceiving them in a way, if you start a conversation and then start checking the clock or doing something else… then it’s like, then you’ve… you’ve lost that patient.” (Nurse 1)

During these encounters, the nurses found it necessary to pose concrete questions to the patients even though the questions might be of a sensitive nature, for example, questions about self-harm and/or suicidal thoughts.

“Any concrete plans, if they’ve thought about how they’d do it, if they’ve made any previous attempt, and so on… you might think that would be provocative at first, but it’s not provocative when you talk about it with them, because you’re showing them you’re familiar with the problem, you understand, and you care.” (Nurse 6)

Another strategy that the nurses shared was to be flexible and make individual adjustments based on the patients’ needs. For example, since the patients were in need of more time, they took the time needed. This need for extended time was explained partly by the complexity of the patients’ life situations, but also by their need for more extensive information or more detailed advice.

“Um, but as I said before, it’s more that… that you might have to explain in a little more detail and maybe you’d decide to write it down as well – ‘This is what you need to do’ – or draw a picture… I’ve done that sometimes because… it was hard to… sort of remember and understand.” (Nurse 7)

Discussion

The PCNs participating in this study encountered patients with mental illness on a daily basis, but perceived themselves as lacking the competence to provide proper care to this group. This poses a number of challenges for PCNs, as the number of citizens with mental illness is rising. The participating PCNs reflected on how mental illness problems had increased within the younger population. They described both positive and negative experiences of internal and external collegial cooperation when working with care-seekers with mental illness. They stressed their responsibility for obtaining a proper anamnesis of the care-seeker’s problems, to facilitate a correct assessment regarding need of care and thus be able to refer the care-seeker to the proper healthcare provider. They also stressed the importance of being perceptive, daring to ask questions, and trying to have a patient-centered approach.

PCNs are often a care-seeker’s first contact with the healthcare system, and are responsible for triaging the need of care and referring to the appropriate healthcare provider when necessary. However, encountering care-seekers has been shown to be a challenge for nurses (Koekkoek, van Meijel, & Hutschemaekers, 2006). As described by the participants in this study, many care-seekers with mental illness are “high consumers” of healthcare, and research has shown how they are at risk of not receiving proper care based on their care-seeking habits (Hansagi, Edhag, & Allebeck, 1991). Another challenge described by the nurses in our study is the limited availability of resources for this group of care-seekers. Studies (Björkman et al., 2008) have shown how healthcare personnel within somatic care experience care-seekers with mental illness as unpredictable, frightening, and more demanding than other care-seekers. The participants in this study did not describe feelings of being frightened by care-seekers with mental illness, but did describe the group as more demanding than other care-seekers. Several previous studies (Ali et al., 2017; Barney et al., 2006; Björkman et al., 2008; Bluhm, Covin, Chow, Wrath, & Osuch, 2014; Bristow et al., 2011; Hansson et al., 2013; Kravitz et al., 2011; Natan et al., 2015; Pagura, Fotti, Katz, & Sareen, 2009; Rao et al., 2009; Shattell, McAllister, Hogan, & Thomas, 2006; Svedberg, Jormfeldt, & Arvidsson, 2003) have shown how care-seekers with mental illness are often subjected to stigma, and are discriminated against and not provided with the care they are entitled to since they are perceived as frightening and unpredictable by healthcare professionals. The most negative attitudes among healthcare professionals are directed against care-seekers with drug addiction, alcohol addiction, and schizophrenia; and care-seekers with drug addiction are regarded as particularly dangerous. The nurses in the present study reflected on how stigma and shame contributed to individuals with mental illness avoiding seeking care, and they also perceived that this group had difficulty talking about their thoughts and feelings. According to Lester, Tritter, and Sorohan (2005) and Eriksen, Arman, Davidson, Sundfor, and Karlsson (2014), it is easier for care-seekers with mental illness to talk about their problems if they have trust in the caregiver, and continuity in their contacts with the healthcare system facilitates trust between the care-seeker and caregiver.

Primary healthcare has been shown to be of greatest importance for care-seekers with mental illness, and the challenge for healthcare is to provide easily accessible care. However, nurses express insecurity, lack of training, and lack of expertise with this group of care-seekers (Lester et al., 2005). This insecurity and perceived lack of competence was also described by the nurses in this study, and it was clear that they desired more competence and education regarding mental illness, as they believed they did not have the proper education to attend to these patients and provide sufficient care. They also described how a major part of their competence was based on previous clinical experiences. Hence, personal life experiences were described as valuable...
when encountering care-seekers with mental illness. Shattell et al. (2006) found that patients with mental illness appreciated it when nurses used their own personal experiences of life and showed their personality in the meeting, and these strategies contributed to care-seekers’ experiences of a good caring relationship. According to Reed and Fitzgerald (2005), knowledge regarding mental illness is essential for nurses to feel secure in encountering care-seekers with mental illness. Lack of proper knowledge led to insecurity and fear of asking the wrong question or saying something that could be regarded as offensive by the care-seeker with mental illness. However, support contributed to nurses feeling both more enthusiasm and increased security in their work (Reed & Fitzgerald, 2005).

It is worth noting that care-seekers with mental illness report preferring healthcare providers’ continuity and good listening skills over expertise and knowledge within the subject (Lester et al., 2005). This shows a discrepancy between what healthcare professionals believe care-seekers desire and what care-seekers actually desire. The participants in this study reported having a lack of competence to provide care for care-seekers with mental illness, but according to care-seekers themselves this knowledge is of less importance (Lester et al., 2005). Patients with mental illness desire trust, reciprocation, and to be acknowledged and seen. They want nurses to be available, engaged, affirmative, and hopeful (Svedberg et al., 2003). The PCNs in this study described how they tried to create a feeling of trust by listening and showing empathy. Other studies have shown how patients with mental illness desire treatment to be initiated without delay when they seek care, and wish that healthcare was more easily accessible (Bristow et al., 2011; Lester et al., 2005; Oud et al., 2009). These patients also prefer to come into contact with the person responsible for their treatment at an early stage. Their preferred type of care is counselling, which as shown in the present study is also considered important by PCNs. This places a great demand on the PCN, who have limited possibilities to refer care-seekers to counselling. The participants in this study said that care-seekers with mental illness often also have physical illnesses, and hence mental illness is regarded as complex. Roberts, Roalfe, Wilson, and Lester (2007) showed that doctors tend to focus too much on the mental illness, and eventually physical issues will be at risk of not being properly addressed. The PCNs in our study stressed the importance of a holistic perspective when encountering care-seekers with mental illness. They said they tried to facilitate good care for care-seekers with mental illness, but felt insufficient as they believed they did not have the proper education and knowledge. However, when comparing this to what care-seekers with mental illness desire from nurses—that is, empathy and good listening skills—perhaps these nurses contribute more than they are aware of.

**Methodological considerations**

Conventional content analysis poses a number of issues regarding trustworthiness (Creswell, 2002; Hsieh & Shannon, 2005). To facilitate credibility, the data analysis was performed by two of the authors and recurrent discussions took place among all four authors until consensus was reached. Quotations are presented in the findings section to elucidate the content of the themes. All interviews were performed by two of the authors (blinded for review) together using a semi-structured interview guide. In order to strengthen dependability, we chose participants who varied in aspects such as size of health center, geographic location, and form of management. Finally, to help the reader decide the transferability of the results, we have described the participants’ demographics, the data collection, and the analysis.

**Conclusion**

PCNs encounter care-seekers with mental illness on a daily basis. This poses challenges for these nurses, as they perceive that they lack the competence and resources to provide accurate care for this vulnerable group of care-seekers. This study found that the nurses used their own personal experiences of life and made use of their personalities when encountering the patients in order to establish a caring relationship. To facilitate a patient-centred approach, it is important that PCNs are perceptive of care-seekers’ needs and dare to ask questions, even though the questions might be of a sensitive nature.

**Implications for clinical practice**

Mental illness is rapidly increasing, and primary healthcare providers are often the first points of contact for care-seekers with mental illness. The PCNs in this study felt insufficient, believing that they did not have the education and experience to facilitate good care for these care-seekers. However, according to previous research, there is an incongruence between what nurses believe that care-seekers desire and what care-seekers really desire. It is therefore important for PCNs to be provided with sufficient support and opportunity for coaching sessions, to strengthen them in their demanding and exposed position.

**Ethical approval**

According to Swedish legislation this study this kind of non-intervention study do not require ethical approval. However, guidelines of the Helsinki declaration was followed; participation was voluntary and all participants provided written informed consent.

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**Disclosure statement**

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the article.
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