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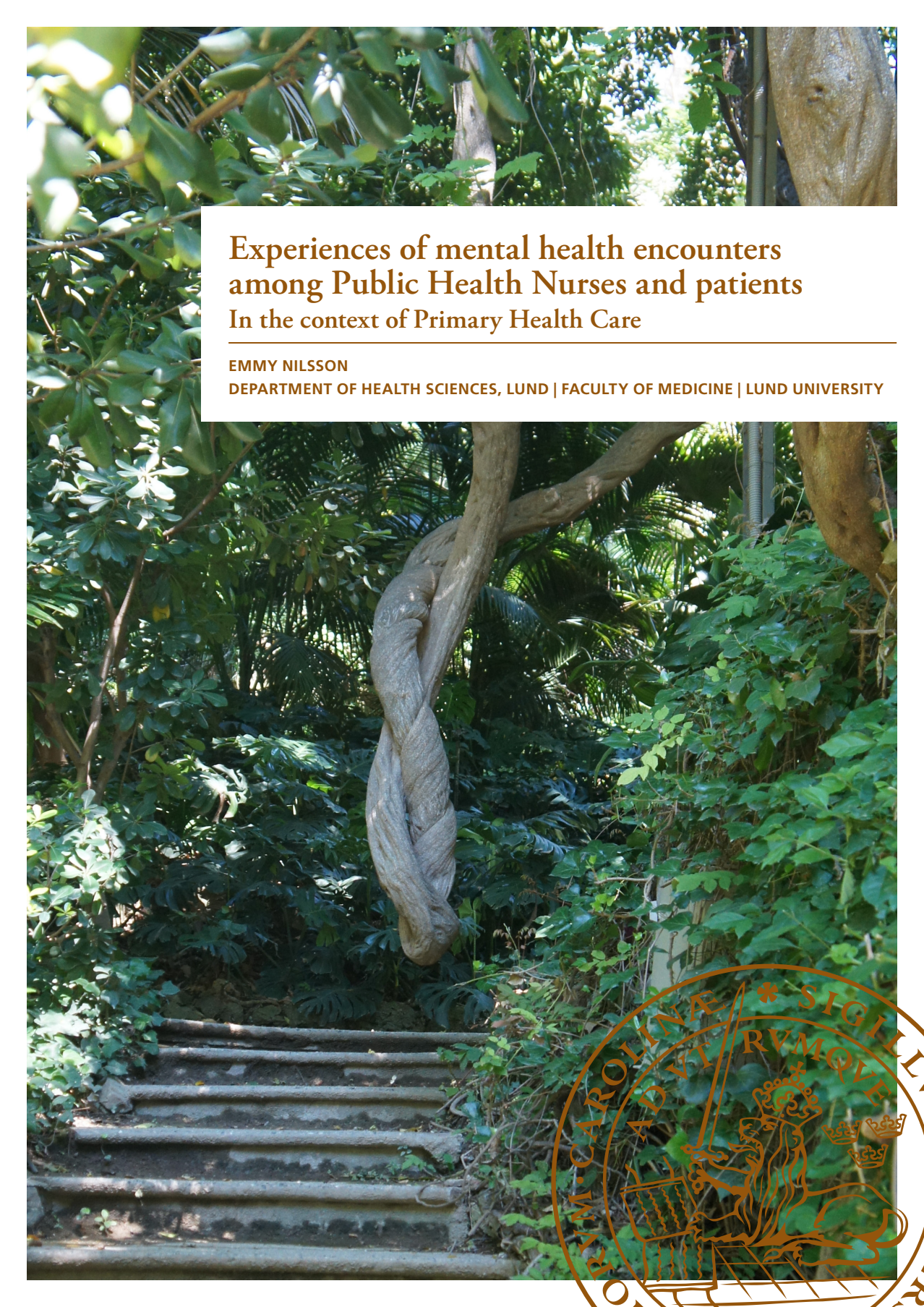
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The background of the cover is a photograph of a lush tropical garden. A large, thick, braided tree trunk is the central focus, surrounded by various green plants and trees. In the foreground, there are stone steps leading up through the foliage. The overall scene is bright and natural.

# Experiences of mental health encounters among Public Health Nurses and patients In the context of Primary Health Care

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DEPARTMENT OF HEALTH SCIENCES, LUND | FACULTY OF MEDICINE | LUND UNIVERSITY





Experiences of mental health encounters among Public Health Nurses and patients  
In the context of Primary Health Care



# Experiences of mental health encounters among Public Health Nurses and patients

In the context of Primary Health Care

Emmy Nilsson



**LUND**  
UNIVERSITY

LICENTIATE DISSERTATION

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**Abstract:**

Background: Mental Health Problems are increasing and there is a general lack of sufficient responses and adequate support from health care. In Sweden, Primary Health Care is the first in line Mental Health Service for patients with Mental Health Problems. The first health professional to encounter patients in need of Primary Health Care is often the Public Health Nurse. Previous research has described their lack of knowledge and low self-esteem, when encountering patients with Mental Health Problems. Research has described patients encounter mental health stigma when in contact with Primary Health Care.

Aim: To develop knowledge and an understanding of public health nurses' process and patients' experiences of mental health encounters within the context of Primary Health Care.

Method: To explain Public Health Nurse process a constructivist grounded theory was applied, and a descriptive phenomenology design was used to explore patients lived experience of mental health encounters.

Results: The grounded theory resulted in a core category explaining Public Health Nurses as a relationship builder – to initiate the dialogue. The process of Public Health Nurses builds upon three main categories and were decisive for initiating a dialogue, *“Being on your own”*, *“Being on top of things – knowing your limits”*, and *“Professional comfort zone”*. The preliminary results of patients' lived experience of searching, visiting and/or receiving Primary Health Care resulted in a general construction *“Health care is asking too much of them”* and builds upon four themes.

Conclusions: This licentiate thesis provided insights of the mental health encounter in the context of PHC. The result explains and describes the mental health encounter without the organisational capacity to deal with them. The experiences of Public Health Nurses and patients can be used for future research initiatives to improve mental health encounters.

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In the context of Primary Health Care

Emmy Nilsson



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## Abstract

**Background:** Mental Health Problems are increasing and there is a general lack of sufficient responses and adequate support from health care. In Sweden, Primary Health Care is the first in line Mental Health Service for patients with Mental Health Problems. The first health professional to encounter patients in need of Primary Health Care is often the Public Health Nurse. Previous research has described their lack of knowledge and low self-esteem, when encountering patients with Mental Health Problems. Research has described patients encounter mental health stigma when in contact with Primary Health Care.

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**Method:** To explain Public Health Nurse process a constructivist grounded theory was applied, and a descriptive phenomenology design was used to explore patients lived experience of mental health encounters.

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**Conclusions:** This licentiate thesis provided insights of the mental health encounter in the context of PHC. The result explains and describes the mental health encounter without the organisational capacity to deal with them. The experiences of Public Health Nurses and patients can be used for future research initiatives to improve mental health encounters.

## Populärvetenskaplig sammanfattning

Den självrapporterade psykisk ohälsan ökar i världen och i den svenska befolkningen, främst bland ungdomar (10-19år) och unga vuxna (16-29år) men förekommer i hela befolkningen. Primärvården utgör första-linjens vård för personer med psykisk ohälsa. Den psykisk ohälsa är idag en av de vanligaste sökorsakerna i primärvården och psykisk sjukdom utgör en av de vanligaste diagnoserna i primärvården. En tredje del (32%) av världens befolkning har levnadsår som går förlorade på grund av en psykisk funktionsnedsättning och en av tio (13%), förlorar hälsosamma levnadsår på grund av psykisk sjukdom. Idag möter människor i olika länder och samhällen utmaningar som påverkar deras psykisk hälsa och välbefinnande och som kan leda till psykisk sjukdom.

Världshälsoorganisationens definition av psykisk hälsa lyder; *"Psykisk hälsa är ett tillstånd av psykiskt välbefinnande där varje person kan förverkliga sina egna möjligheter, klara av vanliga påfrestningar, arbete produktivt och bidra till det samhälle vi lever i. Psykisk hälsa är inte detsamma som frånvaron av psykisk sjukdom"*.

Att få insatser från primärvården för sin psykiska hälsa är utmanande både för patienter och vårdgivare. Personer med psykisk ohälsa möter negativa attityder och uppfattningar om psykisk hälsa (stigma) i kontakt med vården, de beskriver en sårbarhet och förlorad kontroll över sig själva, i världen och i Sverige. De negativa attityderna bidrar till att unga vuxna (16-29år) drar sig för att ta kontakt med primärvården, en sjukvård de uppfattar är bättre på att hantera fysisk ohälsa än psykisk ohälsa. I reformen En God och nära vård beskrivs en primärvård som behöver inkludera och identifiera behov när det kommer till att kunna främja hälsa och arbeta sjukdomsförebyggande för personer med psykisk ohälsa. Att arbeta utifrån ett personcentrerat förhållningssätt är stommen i reformen En God och nära vård. Ett personcentrerat förhållningssätt är att se personen med en sjukdom i stället för sjukdomen hos en person. Att som hälso- och sjukvårdspersonal ta del av en persons berättelse om hur det är att leva med sina symptom och tecken på ohälsa, att betrakta personen som expert på sin egen hälsa och ohälsa, och att samskapa en vårdplan som sedan dokumenteras och utvärderas tillsammans, skapar förutsättningar för en personcentrerad vård. I en personcentrerad vård är en person kapabel att ta aktiva beslut som berör hens hälsa och vård. Inom primärvården beskrivs oftast distriktssköterskan vara den första professionen att möta en person med upplevd ohälsa. Distriktssköterskans erfarenheter beskriver att det är svårt att hantera möten med personer med psykisk ohälsa, de beskriver att de saknar kunskap om psykisk hälsa. Däremot beskriver distriktssköterskor att deras främsta arbetsuppgift är att arbeta hälsofrämjande och sjukdomsförebyggande i alla möten de har med personer med upplevd ohälsa. Det kan därför antas vara av vikt att ta vara på den kunskap som distriktssköterskor idag har vad gäller processer i möten med personer med psykisk ohälsa inom primärvården. Det är också av vikt i en personcentrerad vård att ta reda på patienters levda erfarenheter av att söka, besöka

eller få vård för sin psykiska ohälsa inom primärvården. Syftet med denna licentiatavhandling är att få kunskap om hur möten med personer med psykisk ohälsa idag hanteras och erfars inom primärvården, genom att förstå distriktssköterskors process och patienters levda erfarenhet av dessa möten. Förhoppningen är att kunskapen kan användas till framtida interventioner för att öka hälso- och sjukvårdspersonalens kunskap och därmed förbättra vården för personer med psykisk ohälsa.

Primärvård i denna licentiatavhandling utgör första linjens vård som är distriktssköterskans arbetsområde; barnhälsovård, vårdcentraler, den medicinska insatsen inom skolhälsovård samt kommunal hälso- och sjukvård. Metoderna som använts är kvalitativa metoder, med djupintervjuer som spelades in med ljudupptagning. I studie I användes en Grundad Teori av Charmaz, som är en forskningsmetod där forskarens kunskap och erfarenheter är en del av studiens data tillsammans med deltagarnas intervjuer. I studie II valdes en deskriptiv fenomenologi av Giorgi som är en forskningsmetod som används när forskaren behöver förstå ett fenomen, i vårt studie den levda erfarenheten av att söka, besöka eller få primärvård för sin psykiska hälsa. De valda forskningsmetoderna valdes utifrån att det finns lite kunskap inom området. Deltagarna i studie I var distriktssköterskor som rekryterades till en början med hjälp av bekvämlighets och därefter teoretiskt urval. Ett teoretiskt urval innebär att forskarna under hela datainsamlingsprocessen reflekterar och bearbetar insamlade data för att rikta specifika frågor till specifika deltagare som antas kunna besvara forskarnas frågor, frågorna kommer av pågående analyser av genomförda data. Totalt 13 deltagare inkluderades i studie I. I studie II rekryterades deltagarna via en informationsannons som gick att finna på sociala medier. Informationsannonsen skapades av forskargruppen med stöd av ungdomar, med syftet att göra annonsen lockande för just den målgruppen. Urvalet av deltagarna var ett bekvämlighetsurval där deltagarna visade intresse för att delta i studien via informationsannonsen på ”I dialog för psykisk hälsa” hemsida och anmälde sitt intresse. Totalt 11 deltagare inkluderades i studie II. I båda studierna har de etiska principerna vid Helsinkideklarationen följts, det vill säga med respekt för deltagarnas integritet och autonomi. Deltagarna fick skriftlig samt muntlig information om respektive studies syfte och genomförande, skriftligt medgivande inhämtades och deltagarna hade möjlighet att dra tillbaka sitt deltagande under hela processen. All data är avidentifierad och hanteras säkert för obehöriga. Etiskt godkännande finns för studie II, då det berör sådan data (frågor om hälsa) som enligt Lagen om etikprövning av forskning som avser människor behöver etik prövas. Diarienummer: 2022-02164-0.

Dataanalysen skiljer sig åt för de båda studierna. I studie I ses forskarnas kunskaper och erfarenheter av möten med personer med psykisk ohälsa som en styrka och inkluderas i processen när data analyserades. I studie II ska forskarnas förförståelse erkännas men ställas åt sidan under analysen av data. Förförståelsen används sedan för att ta reda på det naturliga fenomenet som beskrivs av deltagarna, fri från tolkning av forskarna.

Resultatet av studie I visar att processen som distriktssköterskan går igenom vid möten med personer med psykisk ohälsa är en komplicerad process som dels beror på vårdorganisationens resurser, strukturer för psykisk hälsa, dels på distriktssköterskans kunskap, attityder, synsätt och övertygelse om psykisk hälsa även kallat mental hälsolitteracitet. Distriktssköterskan har fått sin kunskap genom att möta personer med psykisk ohälsa i en vårdorganisation där psykisk hälsa inte får plats. Detta gör att distriktssköterskan känner sig ensam i mötet med en person med psykisk ohälsa och beroende på vilka egenskaper distriktssköterskan har, kan mötet med en person, hanteras på olika sätt. Att vara särskilt intresserad, positiv och nyfiken var egenskaper som beskrev en distriktssköterska som var villig att möta personer med psykisk ohälsa. Distriktssköterskans kunde variera beroende på var i organisationen distriktssköterskans arbetade, vilket förutom hens egenskaper och mentala hälsolitteracitet för psykisk hälsa skapade en konflikt hos distriktssköterskan. Distriktssköterskan agerade oftast som en mellanhand, vilket begränsade mötet genom att distriktssköterskan inte ställde så många frågor som hen hade kanske önskat och bokade oftast patienten till en annan profession såsom läkare, psykolog eller hälso- och sjukvårdscurator. När vårdorganisationen hade förutsättningar för psykisk hälsa kunde distriktssköterskan agera som en Care manager. En Care manager stod kvar vid patientens sida även om de blev remitterade vidare och de vågade ställa frågor. Resultatet av studie II är fortfarande under bearbetning och de preliminära fynden pekar mot att personer som sökt, besökt och fått primärvård, beskrev att hälso- och sjukvården krävde för mycket av dem. Denna beskrivning byggs upp av fyra identifierade teman; Jag har slut på strategier för att hantera min livssituation, jag behöver stöd av primärvården, Att söka stöd för sin psykiska hälsa är som att befinna sig i en karusell, Jag är lyckligt lottad om jag lyckas hitta stöd från en specialist i psykisk hälsa, Det är en kontinuerlig kamp av att hantera sina egna känslor, där jag ifrågasätter mig själv och om primärvården kan erbjuda stöd till sådana som jag.

Resultatet av studie I verifieras av andra studier genomförda inom samma område, distriktssköterskor och deras erfarenheter av att arbeta med psykisk hälsa. Denna licentiatavhandling bidrar till insikter om hur ett möte mellan distriktssköterskan och personer med psykisk ohälsa i primärvården kan se ut, vilken process och vilka faktorer som påverkar mötet distriktssköterskans men också utifrån den levda erfarenheten från personer med psykisk ohälsa. Förhoppningen är att kunskapen från studie I och studie II kan användas för framtida forskning och utveckling för att främja hälsa och arbeta sjukdomsförebyggande för personer med psykisk ohälsa i primärvården.



# List of Papers

## *Paper I*

Nilsson, E., Johanson, S., Behm, L., & Bejerholm, U. (2023). Public health nurses experience of mental health encounters in the context of primary health care: a *constructivist grounded theory study*. *BMC Nursing*, 22, 181 (2023).  
<https://doi.org/10.1186/s12912-023-01340-7>

## *Paper II*

Nilsson, E., Behm, L., Johanson, S., & Bejerholm, U. (In manuscript). Patients' lived experience of seeking, visiting, and receiving Primary Health Care for their Mental Health Problems – Descriptive Phenomenological Study. Purposed *Scandinavian Journal of Public Health*

## Author's contribution to the papers

### *Paper I*

All authors (E.N., S.J., L.B. and U.B.) made considerable contributions to the design, data analysis and interpretation of data; involved in process from manuscript to publication, revising it critically for important intellectual content. First author (E.N.) and third author (L.B.) gathered data and conducted the interviews. Each author has participated adequately in the work to take public responsibility for appropriate portions of the content; agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved

### *Paper II*

All authors (E.N., L.B., S.J., and U.B.) have made contributions to the design, data analysis and interpretation of data; involved in drafting the manuscript. First author (E.N) and third author (S.J.) has gathered data and conducted the interviews.

## Abbreviations

CCM	Collaboration Care Model
CEPI	Centre of Evidence-based Psychosocial Interventions
CM	Care Manager
COREQ	Consolidated criteria for Reporting Qualitative Research
DALY	Disability Adjusted Life Years
GUREGT	Guideline for Reporting and Evaluating Grounded Theory
ICN	International Council of Nurses
LU	Lund University
MHL	Mental Health Literacy
MHS	Mental Health Services
MHP	Mental Health Problem
NBHW	National Board of Health and Welfare
NSPH	Nationell Samverkan för Psykisk Hälsa [the Swedish Partnership for Mental Health]
PCC	Person-Centered Care
PHAS	Public Health Agency of Sweden
PHC	Primary Health Care
PHCC	Primary Health Care Centres
PHN	Public Health Nurse
SALAR	the Swedish Agency of Local Authorities and Regions
SAHCA	the Swedish Agency for Health and Care Analysis
SOU	Statens Offentliga Utredningar [the Swedish Government of Official Reports]
SSN	the Swedish Society of Nursing
YLD	Years Lived with Disability
WMA	World Medical Association
WHO	World Health Organisation

# Preface

As a newly graduate specialist Public Health Nurse (PHN), I soon discovered the structural difficulties of addressing the nursing needs of patients seeking health care in general and especially Mental Health Problems (MHP) in Primary Health Care (PHC). Being a PHN, a specialist in nursing in my professional role I am responsible for patients' health needs based on the International Council of Nurses (ICN) Code of ethics, *to promote health, to prevent illness, to restore health and to alleviate suffering and promote a dignified death* (ICN, 2021, p5). As a specialist nurse I would argue that I have a great responsibility of being active in the continuous development of the nursing profession and the nursing activities within my area of expertise, i.e., public health promotion and preventive activities from a holistic point of view. Therefore, some of the encounters with patients (newborn/patients/pupils/families) arose critical questions for me as a PHN, and I identified the need to understand, reflect upon my attitude and belief about mental health/ill-health from a professional point of view, but also from an organisational perspective. Furthermore, how Mental Health Services (MHS) are guided, structured, and planned is another concern, whether they employ a team-oriented person-centered approach, but also, where does the role of being a PHN fit in? By discussing these issues with my colleagues, my experience was that I was not alone with these concerns. Questions concerning how to best support mental health among patients within PHC became the starting point of this licentiate thesis

# Introduction

Since the declaration of Alma Ata in 1978, the agreed global understanding of PHC is that health is a fundamental human right (World Health Organisation [WHO], 2002). It highlighted a co-created health care that was acceptable, and accessible to people and affordable within the economic realities within each community and country. In Sweden the PHC is the first-in-line service also referred as first-level-of-service (Swedish Agency of Health Care analysis [SAHCA], 2017) in the Swedish healthcare system (Health and Medical Services act, SFS 2017:30; Swedish Government Official Reports [SOU] 2020:19). One of the most common reasons to visit the PHC is due to having MHPs (SAHCA, 2017). MHP are reported as symptoms of problematic concern, problematic sleeping habits and anxiety (Public Health Agency of Sweden [PHAS], 2022) in line with the definition of mental health by WHO (2003). With MHPs there is an increased risk of developing a mental health illness (Olafsdottir, 2019; PHAS, 2022) and being at risk for suicide (Lund et al., 2018). Today, the global burden of mental illness is estimated to 32% Years-Lived-with-Disability (YLD) and 13% of Disability-Adjusted-Life-Years (DAYLs) same rates as the disease burden of cardiovascular disease (Vigo et al., 2016). Mental health diagnoses are one of the most common diagnoses in PHC (Sundquist, 2017). Self-reported MHPs has increased over time and particularly in northern of Europe (Potrebny et al., 2017). In Sweden there is an increase of self-reported MHPs in the population, where adolescents (10-19 years) (Potrebny et al., 2017) and young adults (16-29 years) (Hagquist et al., 2019; PHAS, 2022) report higher prevalence of MHPs. Women in Sweden are more prone to self-report MHPs than men (Hagquist et al., 2019; PHAS, 2022) which is in line with the reports from a global perspective, were women report higher prevalence of depression, eating disorders while men report higher prevalence of substance abuse during their life stages (Lund et al., 2018). Globally, there is a discussion of underestimations of mental illness due to the direct or indirect link between physical and mental health (Vigo et al., 2016).

In Sweden today, the responsibility of providing MHS is divided between the first-in line PHC and the specialist MHS (SFS 2017:30). Within PHC, the PHN is often described as first in line of health professionals to encounter a person with perceived illness (Björkman et al., 2018; Falk-Rafael, 2005; Falk-Rafael & Betker, 2012 a-b; Kennedy, 2002; the Swedish Society of Nursing [SSN], 2019). The PHNs' experiences of encountering a person with MHPs is described as difficult and they experience a lack knowledge of how to deal with them (Björkman et al., 2018;

Janlöv et al., 2018; Löyttnynen et al., 2023.) Yet, PHNs have shown to prioritise health promoting care by building relationships with patients with perceived illness, based on a person-centered approach with emphasis on patients' lived experience (Lundin Gurné et al., 2023). It can be important to learn and benefit from their achieved knowledge and to study their understanding thoroughly, of the process and experience of PHNs and their mental health encounters. To address health professionals' knowledge, attitudes, views, and beliefs it is essential to meet the demands of an integrated and person-centered MHS (Ashcroft et al., 2021; Baxter et al., 2018; Raj, 2022). Likewise, it is of importance to include the patient's perspective of being a patient with MHPs, to study their lived experience of seeking, visiting, and or receiving PHC for the continuous development of MHS in PHC.

# Background

## Health from a whole-person point of view

In the declaration of Alma Ata (WHO, 2002), health is recognized as something more than only focusing on biomedical treatment and curative services. In the construction of health care social determinants and environmental factors should be a part of achieving health. PHC was assigned the first level of service for people in need of care in the health system and the declaration emphasized health promotion. Social determinants of health and health equity is affected by the psychosocial influences in at least four ways (Marmot, 2017). Firstly, early child development and education influence a person opportunities and choices, work, and social relationships through the rest of the life course. Secondly, behaviours influence health; the risk of illicit drug abuse (Grant et al., 2019; Marmot, 2017), diet and exercises (Marmot, 2017). Thirdly, stress factors are highly prevalent to cause physical disease. Fourthly, having a social disadvantage becomes a high risk and cause for developing mental illness. Furthermore, it is argued that there is a direct or an indirect link between a persons' physical and mental health (Orhnberger et al., 2017). Today there is also a general agreement within health care to have a whole - person approach (Ekman, 2022). The whole- person approach is often described as being holistic (Frisch & Rabinowitch, 2019), meaning that the health care/medicine becomes an integrated, interdisciplinary, and interprofessional approach. It has emerged from conventional health care environments where health professionals saw a need to include nonconventional care and alternative views of health/ disease into practice. Integrative health care focuses on the collaborative – shared practice nature and requirements needed to enable this in a health care organisation.

People across countries and societies face challenges that impact on their mental health and well-being and, in some cases, result in a diagnosis of mental illness (Olafsdottir, 2019; WHO, 2022). In the mental health definition of

The World health organizations' definition of mental health.

*“Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (WHO, 2003).*

WHO (2003), well-being is generally described as a “state” where the final goal is to realize their own abilities and strengths to be able to contribute to society. In the literature, however, there are different definitions of health and well-being (Pelters, 2021) which are described as confirming existing understandings and normative views. Based on the person-centered approach (Ekman et al., 2011), a person’s health and well-being are not separated, and the overall goal for encounters with people who seek and receive care is to create a meaningful life to promote health and well-being (Håkansson et al., 2021). Even though there is a general agreement to employ and deliver a person-centered PHC, the economic foundation and the organisational structure are still focusing on a more “traditional” patient-centered care (Swedish Association of Local Authorities and Regions [SALAR], 2023), This limits the opportunities for patients to receive a person-centered PHC (Rugkåsa, 2020) in which MHS is integrated (Baxter et al., 2018). Accordingly, there is an urgent need to explore mental health encounters, and their quality, in particular since there is a steady increase of patients suffering and seeking PHC for their MHPs in society today (PHAS, 2022; SAHCA, 2017; WHO, 2022).

## Mental Health Literacy

The concept of health literacy is argued to be a personal process and is an indicator for knowledge and an understanding of an individual’s own health and capacity for living a healthy life (Ringsberg et al., 2018). When health literacy is viewed as the capacity for living a healthy life, mental health is a key resource for the individual. The Mental Health Literacy (MHL) concept concerns the knowledge, attitude, views, and beliefs about mental health, which in turn affect individuals’ recognition, management, or prevention of mental health (Jorm et al., 1997). The concept of MHL is on the rising and has become more and more significant among researchers to explore and understand (Sweileh, 2021), especially since low MHL among health professionals may increase the service gap and thus decrease opportunities for care and support for patients with MHP (Lovén- Wickman & Schmidt, 2023). Low levels of MHL among health professionals can be targeted through mental health educational initiatives and results indicate an increase of MHL over time with improved attitudes towards patients with MHPs (Lexén et al., 2021; Raj, 2022).

MHL may also relate to other concepts such as mental health stigma, different signs and symptoms of mental health, and interventions such as Mental Health First Aid (Sweileh, 2021). Mental health stigma, i.e., negative attitudes and beliefs about MHP, and discrimination are highly prevalent and have not diminished during the last decades (Angermeyer & Dietrich, 2006; Clement et al., 2015; Phelan et al., 2023; Schomerus et al., 2012; Vistorte et al., 2018). Young adults’ perceived mental health stigma contributes to the lack of trust towards health professionals of dealing with mental health in PHC (Lovén-Wickman & Schmidt, 2023; Phelan et al., 2023).



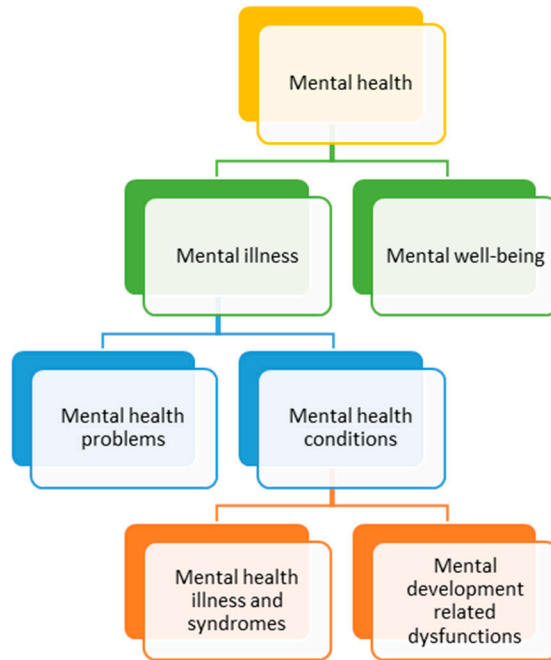
Public stigma and negative held attitudes against people with MHPs are the largest psychosocial environmental barriers of today (Hanisch et al., 2016). Research has shown that sufficient MHL is related to lower levels of mental health stigma (Lexén et al., 2021; Svensson & Hansson, 2016), and that stigma may differ across mental health illnesses and conditions (Sadler et al., 2012; Svensson & Hansson, 2016).

In PHC, mental health stigma among health professionals is common (Phelan et al., 2023; Raj, 2022; Vistorte et al., 2018). Older literature has shown that a person with MHPs were treated as less competent and were provided with few opportunities for personal recovery (Sirey et al., 2001). Stigma is viewed as a barrier for patients' with MHPs of receiving health care they are entitled to (Raj, 2022; Vistorte et al., 2018). Patients' with MHPs often have a devalued view of themselves (Yanos et al., 2008). Their self-stigma becomes part of the MHP and affects their life situation. It becomes an obstacle for seeking help and for successful treatment and recovery (Gulliver et al., 2010; Raj, 2022; Vistorte et al., 2018).

In Sweden, health professionals' attitudes and beliefs about mental health derive from their overall workplace culture (Mårtensson et al., 2014). Their knowledge is also based on if they have personal experiences of MHPs, health professionals had a positive attitude if their mental health knowledge was less stigmatized and if they had own experience of a significant other with MHPs. This indicates that MHL can be addressed thru initiatives of empowering health professionals thru anti-stigma educational activities (Lexén et al., 2021) along with strategies which can be used in practice (Raj, 2022) and by exposing health professionals to patients' with MHPs (Mårtensson et al., 2014). With regard to PHNs' knowledge, it has been shown to be based on their own special interest of mental health (Janlöv et al., 2018; Löyttynen et al., 2023).

## The integration of Mental Health Services into Swedish Primary Health Care

To access and maintain MHS across PHC are perceived as challenging for both a person seeking, visiting and/or receiving health care, as well as for the health care providers (Ross et al., 2015; Wakida et al., 2018). The Swedish Association of Local Authorities and Regions, Public Health Agency of Sweden, and the National Board of Health and Welfare (NBHW) have together tried to unify mental health perspectives and concepts and clarify how they are related in their efforts to integrate MHS into PHC (SALAR, 2020). In their model, the concept of mental health is to be viewed from an umbrella perspective, where mental health, wellbeing, and mental illness are its underlying units (Figure 1). At the same time, it is stressed that the embedded units should not be viewed as opposites of each other.



**Figure 1.** The model of mental health in primary health care, according to the Swedish Association of Local Authorities and Regions, the Public Health Agency of Sweden, and the National Board of Health and Welfare (SALAR, 2020).

In their mental health model, mental illness is the overall concept for MHP and mental health conditions. Note that the model is in line with the definition of WHO (2003) as described earlier, where MHPs are viewed as a broad concept including many aspects, from an experience of a challenging everyday life to severe mental disorders. In PHAS (2022a) report on Mental health and suicide prevention, a need to provide PHC conditions of how to provide mental health promotion and preventive care has been emphasized. In addition, the need to increase health professionals' knowledge and competence concerning mental health and evidence-based interventions for care, support, and treatment, and thereby increase PHC availability for patients with MHPs, has also been claimed as critical.

A way of building organisational capacity for MHS and improving the effectiveness and quality of PHC is the use of interprofessional collaboration (WHO, 2008), and one way of doing so is to use the collaboration care model (CCM) (Unützer & Park, 2012). The CCM usually consists of a general physician, a Care Manager (CM), and a mental health specialist using a structured management plan based on evidence-based practice and a persons' specific identified needs (Cerimele et al., 2015; Coventry et al., 2014). A CM, usually a specialist in nursing, has been reported to create a more personal approach and provide a social context for the patient (Martel et al., 2021). They also lowered the threshold for the patient

to receive support in a non-judgmental way. Another PHC model for integrating MHS into PHC is the Integration Behavioural Health model (IBH) (Shim & Rust, 2013). In the IBH model, the function of a psychologist/psychotherapist/counsellor is introduced and becomes a key member of the team. By introducing a behavioural expert, focus is to guide other members of the team when encountering patients with behavioural challenges to support and to work directly with behavioural changes. A concern with the behavioural experts or mental health workers in the team has been their role within PHC (Supper et al., 2015). The role is often two folded, to deliver individual patient-centered care, and to teach and act as a consultant for other health professionals in PHC. Another critic of today's integration models is the lack of patient involvement during the implementation- and evaluation process (Baxter et al., 2018). A lack of focus on structural and organisational capacity perspectives has also been claimed, along with few available tools for the health professionals to use in clinical practice (Raj, 2022).

In the Good quality and local health care act (SOU 2020:19) and by the Public Health Agency of Sweden (2022a) there is a described need for MHS and PHC organizations to come together and define mental health needs, to offer mental health promotion and prevention care. Common barriers for integrating MHS into PHC context have shown to be attitudes, knowledge and skills, motivation to change, management and leadership, and resources (Wakida et al., 2018). However, a person-centered approach, to deliver a Person-Centered Care (PCC) model for example, is the core in the transition to reform PHC according to the Good quality and local health act (SALAR, 2022). Already in 2008, the World Health Organisation stated a need for PHC to move towards a transition of a PCC (WHO, 2008). The PCC model stands for empowering a person's own unique qualities and to be their support for achieving a better health (Lidén et al., 2015). To empower a person with MHPs is not currently seen as a natural part of the care provided by the PHC for the population (Haddad et al., 2005; Keller, 2020; Moreno et al., 2020). PHN primary role is to promote health yet, they describe mental health promotion activities without set goals and as an activity where they need others to collaborative with others (Grundberg et al., 2016), they have also described a need to improve their knowledge of how to support a person with MHPs (Haddad et al., 2005; Björkman et al., 2018; Björkman & Salzman- Eriksson., 2018; Janlöv et al., 2018). Still today, there is a need of evidence-based interventions which support the health professionals in their everyday practice (Raj, 2022). The research of interventions of integrating MHS into PHC comes from an organisational perspective (Raj, 2022; Shim & Rust, 2013; Unützer & Park, 2012) whereas there is a need to include the public health perspective of health promotion and preventive care in the mental health encounter, in the attempts of reducing health professionals' mental health stigma (Raj, 2022) and support the person with MHPs (Phelan, et al., 2023). The experience from PHN and the lived experience of a person with MHPs can therefore provide knowledge of how to improve the PHC conditions for mental health encounters.

# The Public Health Nurse

A PHN or a District Nurse has an academic one-year master's in nursing. As a specialist nurse their primary responsibility and main field of study is to promote health and prevent ill health from a public health perspective on a person, group, and organisational level (Benton & Shaffer, 2016; Falk-Rafael & Betker, 2012 a-b; SSN, 2019). Historically the district nurse, or as in this licentiate thesis, a PHN worked in a limited geographic area and had a nursing responsibility for the person, whole family, and society within the area. A general saying is the description of "working with families from the cradle to the grave". A PHN in PHC context encounters a person/family/work on a society level of care, of different ages and societal settings and in different care environments from Primary Health Care Centres (PHCC), Child Health Care to Municipality Health Care being the expert in nursing from a generalist holistic perspective with a person-centered approach (SSN, 2019). PHN strive to work from a health promotive and preventive perspective in every encounter (Grundberg et al., 2016; Lundin Gurné et al., 2023). Holistic nursing is a discipline - specific practice specialty which has emerged from a reflection of the academic literature of holism and ethics (Frisch & Rabinowitch, 2019). In a person-centered integrative PHC, it is therefore essential to understand the process of the PHN role in mental health encounters.

Previous findings of the PHN role in mental health encounters, within (PHCC), is described as the glue that holds the healthcare service together Janlöv et al. (2018). At the same time, however, PHNs may lack confidence (Björkman et al., 2018; Bohnencamp et al., 2019) and have feelings of insecurity about how to meet the needs of a person with MHPs. Hence, they may become uncertain of their role in these encounters (Janlöv et al., 2018; Löyttynen et al., 2023). Being reminded of that persons with MHPs fall through the cracks of the healthcare organisation has been shown to create a frustration among PHNs (Björkman et al., 2018; Björkman & Salzmänn- Eriksson, 2018). Early recognition and adequate support are thus critical. Thus, mental health support should be an explicit part of the holistic and PCC for PHN to perform in a PHC context. In the transition to Good quality and local health care act (SOU, 2020:19) it is addressed that the PHN is in a unique position to achieve and support health, including mental health, from an individual level to a group level, upstream and downstream, when it comes to health promotion and prevention (Davy, 2007; Falk-Rafael, 2005; Falk-Rafael & Betker, 2012 a-b; Kennedy, 2002). However, since previous findings regarding PHNs' MHL have shown that they feel insecure and lack confidence when encountering a person with MHPs (Björkman et al., 2018; Grundberg et al., 2016; Haddad, 2005; Janlöv et al., 2018; Kaskoun & McCabe., 2022, Löyttynen et al., 2023), there is a need to further explore and to understand their experience and process of encountering patients with MHP within PHC

## The Person with Mental Health Problems

The definition of a person with newly developed conditions or for the person unknown new signs or symptoms of perceived illness without the need of emergency care is a patient for the PHC (SAHCA, 2017). Seeking PHC for a person with medical unexplained symptoms wants health professionals to support them understand their suffering and how to make sense of their limitations in their daily life (Lidén & Yaghmaiy, 2017). Being a person with perceived MHPs and seeking care is not something the person take easily (Richards et al., 2019). Young adults with MHPs perceive PHC as experts on physical illnesses and conditions and would therefore seek elsewhere for support for their MHPs (Lovén- Wickman & Schmidt, 2023). In Westberg et al., (2020) young adults describe a fragmented health care service which made them wrestle with the structure. Young adults asked for an easy access MHS and being free of charge. According to PHNs mental illness exists in all age groups (Björkman & Salzmänn- Eriksson, 2018; SALAR, 2019). According to the Swedish Partnership for Mental Health (NSPH) the patient group express a fear of encountering variations of mental health stigma when seeking care (NSPH, 2017). When encountering mental health stigma, they describe a vulnerability and loss of autonomy (Richards et al., 2019). Patients experience health professionals to over medicalize their symptoms and signs of MHPs (Phelan et al., 2023). Where they also experience a lack of shared decision making since health professionals are jumping to conclusions before the patients has described their concerns. Therefore, visiting a PHC and receiving care for their MHPs is a challenge for patients, where low satisfaction with received PHC is more common among older patients with mental health needs compared to patients with physical health needs (Pitrou, 2020). In the Swedish context of PHCC, patients describe their experience as hiding behind a mask as a way of coping and sought care for worry, anxiety, or similar symptoms of long-time suffering (Arvidsdotter, 2016).

To our knowledge, there is little knowledge from the lived experience of patients seeking, visiting, and receiving care for MHP in a Swedish PHC context. Their generated knowledge is vital to inform a person– centered intervention of how to integrate MHS into PHC context.

# Theoretical frameworks

The theoretical framework for this licentiate thesis is *the Critical Caring theory* by Falk-Rafael (2005) and Falk-Rafael and Betker, (2012 a-b) from a person-centered approach by Ekman et al., (2011) and Ekman (2022). The PHN contribution of working downstream by empowering health and well-being for a specific person/family, group of patients or society the PHN have the opportunity of working upstream, for social justice to empower health policy makers to create opportunities for vulnerable patient groups (Falk-Rafael & Betker, 2012 a-b).

The epistemology and ontology perspective are based on the *Critical Caring theory* by Falk-Rafael (2005) where *caring* is described as the core in a relationship. It is a hybrid midrange theory of the PHN as a way of being (ontology), choosing (ethics), knowing (epistemology), and doing (praxis) within PHN relationships, whether PHNs' primary focus is the person in front of them, a person along with their significant other/families/groups or to work on an organisational level, expressed through seven carative health promoting processes (Falk-Rafael & Betker, 2012b). Falk-Rafael (2005) and Falk-Rafael and Betker (2012 a-b) derive their reasoning from Watsons' caring theory and critical feminist theories to inform PHN practice. Falk-Rafael (2005) locates *Nursing practise* within *Nursing science*, where theory is considered valuable and useful when being nourished by practice (Falk-Rafael, 2005). Nursing science is broadly defined as systematic analysis of human-environment processes of health which combines various knowledge sources including ethical, scientific, and practice (Falk-Rafael, 2005; SSN, 2019).

To better understand the context of PHC and mental health encounters (i.e., PHNs' enabling relationships and patient experiences of being a patient in need of PHC) this thesis has focused on human experiences. Human experiences can be used as a scientific tool when there is a need for thorough understanding of experiences, their meaning and interpretation and stems from a hermeneutic perspective (Polit & Beck, 2021).

## The person-centered approach – the capable person

Person-Centered Care is one of the prerequisites for the organization of PHC based on the relationship between the person seeking care and health professionals (WHO, 2008) and is one of six core competences in the nursing profession (Forsberg, 2022).

Today, there is a general agreement in society of a more holistic health care where patients are encouraged to use their own experiences of care, capabilities, and resources to be a part of the transition towards a PCC (Ekman, 2022). Yet, a known barrier of implementation is health professional stereotypical attitudes (Moore, et al., 2017) whereas “we-re already person-centered” is one of them in a traditional patient-centered care (Rantala et al., 2019).

According to Ekman et al., (2011) a person-centered approach, the person in need of care is recognized and accepted as an expertise, a person is capable (*Homo Capax*), and suffering based on Ricoeur philosophical *Hermeneutics of self* by Kristensson-Uggla (2011; 2022), valued for their knowledge as an equal by the health professionals. Ricoeurs philosophy of ethics, the hermeneutics of self, is a person who *strive for a good life with and for others, in just institutions* (Kristensson – Uggla, 2011, p18). A reflective understanding of human as a *Homo Capax*, being acknowledged and recognized as a living being, with capabilities and suffering and imagining oneself as another (Kristensson- Uggla, 2011). Since PCC was introduced by Ekman et al., (2011), where health professionals actively listen to a persons’ narrative, being an active partner in the co-creation of their documented health plan, new knowledge, and insights of the transition of moving towards a PCC has been developed (Ekman, 2022). The PCC is based on the ontological difference of being viewed as a patient or a person in need of care (Kristensson- Uggla, 2011). Grounded in the person-centered approach by Ekman et al., (2011) health and well-being are the core/ the goal for all health professionals/personnel and especially for the nursing profession, the PHN (SSN, 2019; Falk-Rafael, 2005). In a person-centered approach the goal is to co-create actions and activities aiming for a persons’ well-being (Ekman, 2022) a meaningful life for the person (Håkansson et al., 2021). The most challenging of suffering is when a person in need of care is viewed as not capable (Kristensson-Uggla, 2011) and to be recognized and cared for with respect and dignity is sometimes not the case for certain patient groups (Ekman, 2022), which has been described by patients with MHPs (Richards et al., 2019). It is, therefore, essential to explore the lived experience of a person with perceived MHPs in a PHC context.

## Public Health Nurse as an enabler of capabilities

The Critical Caring theory by Falk-Rafael (2005) was developed by observations of PHN in practice, a theory developed to guide PHN by ethics of caring and social justice. In this theory as well as in Watsons caring sciences, *Caring* is central. Caring is based of doing good (*Caring for*) and a moral point of view (*Caring about*) (Falk-Rafael, 2005; Willman, 2022) thereby becomes a moral ideal for the nurse. The Critical Caring theory is grounded on Watson’s nursing theory of Carative processes, Nightingale ‘s legacy of social activism and feminist, Critical theory

(Falk-Rafael, 2005; Falk-Rafael & Betker 2012a-b). The moral ideal is strongly linked to an ethical goal of nursing (ICN, 2021) to achieve health and well-being for the patient. Caring is an active process, which develops over time. Falk-Rafael and Betker (2012a) acknowledge the PHN to work with health promotive and preventive care from individual to organisational level, upstream- downstream to fight for social justice.

The seven-health promoting carative processes starts with to first prepare yourself (nursing perspective) to be in a relationship (Falk-Rafael & Betker, 2012b). By preparing yourself includes the possibility of professional development such as education, training of skills in communication and conflict resolution as well as leadership and political awareness. The second carative process is to develop and maintain a trusting, supporting relationship, along with critical caring as a way of being, knowing, and choosing which are core elements and therefore situated at trees' stem, a foundation for the other five carative processes to be developed. Falk-Rafael & Betker (2012a) describes According to Falk-Rafael (2005) the PHN works downstream by encountering people (patients) in need of care and upstream engaged in healthy public policy to fight for social justice. A PHN can enable a person their capabilities with a person-centered approach where the patient is viewed as a capable person and be treated as a capable person (Homo Capax). To enable a persons' capabilities the PHN need prepare themselves to be in a caring relationship and develop and maintain the caring relationship as way of being, knowing and choosing (Falk-Rafael, 2012a). Therefore, it is essential as a part of the transition towards a person- centered PHC and as a part of the integration of MHS into PHC context, to understand the role of PHN and their MHL (the capacity) based on their experience of encountering patients with MHPs.



# Rationale

Being a person with MHPs are increasing in the world and this situation is classified as a global public health concern (WHO, 2022). In Sweden the amount of self-reported MHPs is among the highest of Northern Europe (Potrneby et al., 2017). People who suffer from MHPs are at increased risk of developing mental health illness (Olafsdottir, 2019; WHO, 2022). Today, mental health illness is one of the most common diagnoses in PHC (Sundquist, 2017). However, MHS is still provided from a patient-centered approach where focus is on diagnoses and medical treatment (Phelan et al., 2023; WHO, 2022) or behavioural change (Baxter et al., 2018; WHO, 2022). Mental health stigma is unfortunately not uncommon among health professionals in PHC (Mårtensson et al., 2014). For a person with MHPs this situation may be a challenge since they may encounter negative attitudes and lack of mental health knowledge as they seek, visit and/or receive PHC for their MHPs (Ashcroft et al., 2021; Ross et al., 2015; Wakida et al., 2018), despite ongoing efforts of integrating MHS in to PHC (Baxter et al., 2018). To initiate a dialogue and address mental health is today experienced as difficult by PHNs (Björkman et al., 2018; Björkman – Salzman-Eriksson, 2018; Janlöv et al., 2018; Löytynen et al., 2023). However, the PHN is in a unique position to deliver person-centered health promotion and preventive dialogue for a person with MHPs (Janlöv et al., 2018) within the PHC context (Björkman et al., 2018; Björkman & Salzman-Eriksson, 2018; SSN, 2019). In a PCC the person with perceived illness is to be viewed, and recognised as a capable person, with capabilities and where the persons' well-being is the goal (Ekman, 2022). In the transition of working from a patient-centered to a person-centered recovery focused approach, there is a need of understanding today's challenges of mental health encounters in PHC. Therefore, it is important to develop new knowledge, to explore and understand PHNs' MHL based on their experience and process of mental health encounters, and to explore those with the lived experience of seeking, receiving, and visiting PHC for their MHPs.

# Overall aim and specific aims of the studies

To gain knowledge of how mental health encounters is managed and experienced in the PHC of today, the overall aim of this licentiate thesis is to explore the process PHNs experience and the lived experience of patients in connection to mental health encounters.

## Specific aims of the studies

- to construct a theory that explains the process public health nurses experience when encountering people with MHPs, based on their knowledge, attitudes, and beliefs about mental health
- to explore persons with mental health problems lived experience of seeking, visiting, and receiving care in a primary health care setting

# Methods

## Research Design

This licentiate thesis is based on two explorative studies aiming at developing knowledge, an understanding of the clinical practice of mental health encounters in the context of PHC, from a health care professional perspective, the PHN, and a person with perceived illness perspective. An explorative approach is according to Rendle et al., (2019) applicable when the researcher aims to generate new knowledge by studying new topics with little or no data. An overview of the studies is presented in Table 1.

## Preunderstanding

In explorative research it is of importance to acknowledge and describe your preunderstandings of a phenomenon or a situation. This notion is especially applicable to Study I, where you as a researcher is a part of the construction – a constructivist grounded theory. In Study II, where a descriptive phenomenology approach is used, the result provides the reader with an openness to the phenomenon, from the lived experience perspective of the patients. The authors' experiences are from clinical practise and mainly from the research field of nursing, occupational therapy, mental health and MHSs sciences. As stated in the section about Preface, the first author of Study I and Study II was novice in the practice of Grounded Theory, but with experience as a PHN in different settings, primarily within PHCC and School Health Services. First author (EN) has experience and knowledge from a health professional/PHN perspective, to assess, diagnose, plan, implement and evaluate nursing activities with a person with perceived illness from different care environments, recent years from PHC context. One of the co-supervisors, second author (Study I) and third author (Study II) (SJ), has a professional background as an Occupational Therapist within PHCC, experience of qualitative research methods, person-centred mental health interventions, and of being a Lecturer within the field of Occupational Therapy. The other co-supervisor, third author (Study I) and second author (Study II) (LB), is a PHN with experience of working in PHCC, Municipality Health Care, experience of qualitative research models, person-centered health interventions, and is an Associate Professor and

Senior Lecturer in Nursing, The main supervisor, last author (UB), is a Professor in Mental Health and MHSs research with a joint position at Lund university and MHSs of County Council Skåne, with previous experience of co-producing the development, evaluation and implementation of person-centred mental health interventions, including using Grounded Theory methods.

**Table 1.** Methodological overview of Study I and II.

Study	I	II
<b>Design</b>	Constructivist Grounded Theory (Charmaz, 2006) Descriptive Phenomenological Approach (Giorgi, 1997, 2000; 2005) •	Descriptive Phenomenological Approach (Giorgi, 1997, 2000; 2005)
<b>Participants</b>	A total of 13 Public Health Nurses including a student in Public Health Nursing	A total of 11 patients were enrolled in the study. The inclusion criteria were over the age of 16 years old, with experience of seeking, visiting, and receiving PHC* for their MHPs within the last 5 years
<b>Sampling</b>	Purposeful sampling – Theoretical sampling	Purposeful sampling
<b>Data Collection</b>	Interviews face to face – via LU Zoom (during the covid-19 pandemic).	Interviews via LU Zoom
<b>Data Analysis</b>	The coding process consisted of theoretical sampling, coding, constant comparison, identification, and data saturation (Charmaz, 2006).	The phenomenology analysis concerned reading and re-reading the data and by listening to the interviews to get a whole picture of what was said. Next step was to highlight meaning units (words, phrases, pr sentences) in relations to the study aim. Each meaning unit was further explored by spelling out each meaning unit and articulate it. The authors concluded the meaning, behind the participants words. To explore the essence, structures of meaning that described the phenomenon
<b>Ethical Considerations</b>	The study regards professionals' experiences and is not covered by the provisions of §3-4 the Swedish Ethical Review Act (SFS 2003:460). The Study research was conducted according to the principles of Helsinki declaration (WMA, 2013)	The study research was conducted according to the principles of Helsinki declaration (WMA. 2013). Ethical approval was obtained by the Swedish Ethical Review Authority Reference number.2022-02164-0

\*PHC = School Health Services, Student Welfare, Municipality Health Care, and Primary Health Care Centres

## Study Setting and design

Both studies were situated on the PHNs' working field, defined by The Swedish Society of Nursing (SSN, 2019), and are based on the first in line service for MHPs, which is PHC (SFS 2017:30). We therefore collaborated with PHCC, Child Health Centres and Municipality Health Care such as School Health Services, and Student Welfare, with an allocation on health- prevention and promotion responsibility.

Study I have a constructivist Grounded Theory design according to Charmaz (2006). The study design was chosen based on the limited existing knowledge and prior inductive theory of PHNs' experience of encounters with a person with MHPs. To explain actions and processes of a specific situation the relevance of choosing a grounded theory approach is saturated. Based on personal experience of encountering patients with MHPs in a PHC context, our preunderstanding of the specific situation led to the choice of a constructivist approach. In a constructivist approach the researchers are part of the construction and aware of the changing context and different perspectives of reality (Charmaz, 2006; Singh & Estefan, 2018). The consolidated criteria for reporting qualitative research COnsolidated criteria for Reporting Qualitative Research (COREQ) were used (Tong et al., 2007).

Study II employs a descriptive phenomenology design by Giorgi (1997; 2000; 2005). The study design was approached by Husserl's philosophy of phenomenology where knowledge of a phenomenon is grounded when conciseness is directed towards an objective. In-depth interviews were conducted to explore the lived experience of people seeking, visiting, and receiving PHC for their MHPs. The study design was chosen based on the limited existing knowledge of being a person with perceived illness in need of Swedish PHC.

## Participants and Sampling

In Study I, the PHN participants were included in the study, initially using purposeful sampling and later a focused theoretical sampling procedure. The theoretical sampling process involved presumptive participants of different ages from different PHC contexts, with varying work experience as PHN and experience of encounters with people with MHPs. During the theoretical sampling process, we were also interested in interviewing PHN students working in PHC, with specific experience of encounters with people with MHPs to understand the knowledge development process of mental health.

In Study II, a purposeful sampling method was used. The participants were included when they had met our inclusion criteria which were, to be over the age of 16 years old, cognitively lucid, to understand and speak Swedish and to have sought, visited, and received PHC for their MHPs within the last 5 years

## Data collection

Study I was performed between October 2019 to June 2021. A total of 13 interviews with 13 participants were completed. The interviews lasted approximately 56 minutes (range 37-67 min). The interviews were primarily performed by the author of this thesis, the first author of Study I. The interviews were conducted face-to-face in accordance with the choice of the participants, and by the time Covid-19, the format for the interviews was changed into an online meeting service, LU Zoom. The data was collected by means of using an interview guide that was constructed by the authors of Study I. The questions in the initial interview guide were based on the MHL concept areas, with a focus on PHNs primary, secondary, and tertiary health promotion and preventive working field (Appendix 1). Minor revisions of the interview guide took place after two pilot interviews were conducted; they were not included in the result. In the minor revisions, questions of organizational structure and support for the PHNs in the organisation were added. The interview guide evolved during the theoretical sampling, where the constructions of the PHN experiences steered the enrolment of participants, to understand the PHN process. All interviews were audio recorded and later transcribed verbatim.

In Study II, an information ad was created by the authors and later discussed at a workshop of students at an elementary high school. The reason for arranging a workshop was to inform the design and information content of the ad that was appealing for persons with MHP also at a younger age. The information ad was shared through social media, on pamphlets at the PHCC and School Health Services. Through the information ad potential participants showed an interest by filling out a form online. The interview was conducted during October of 2022 to April of 2023. The interviews were guided by an interview guide constructed by the authors inspired by Matua (2015), Giorgi (2000) and Robinson & Englander (2007) with open-ended questions to capture rich data with an open attitude of why, how, and what it meant for the participants lived experiences of the phenomenon (Appendix 2). The interview guide was to support narratives to be as precise and detailed as possible and with a minimum number of generalities or abstractions to the phenomenon of seeking, visiting, and receiving care for MHPs in a PHC context. Informed power was considered when the recruitment and enrolment of participants had been going for six months (Malterud et al., 2016).

## Data analysis

In Study I the coding process was based on theoretical sampling, coding, constant comparison, identification, and data saturation (Charmaz, 2006; Sing & Estefan, 2018). The early stages in the analysis were performed by all authors during the interview period. The analysis included initial coding, memo writing, and the

development of preliminary concepts (Charmaz, 2006). This analytical process resulted in modifications to the questions in the interview guide that corresponded to the topics raised during the interviews. The initial stage of the analysis process further guided the theoretical sampling. The memos written during the interviews were used to go back and forth in the data to construct meaning and actions, as an early analysis of the data. The memos were sorted to analyse their relationship and relative significance to each other i.e., clustering. Theoretical sampling was used to develop and respond to new question topics that had evolved from the initial coding and analyses. All authors contributed to this early step of the analytical process. For the results of the process and the actions to emerge from the data, codes were analysed to construct the data into forms of concepts (Study I). Categorization was made by constant comparisons between the codes and concepts that referred to the process of encountering people with MHP. The interviews were transcribed verbatim, and line-by-line coding was conducted. NVivo 12.2 software was used as a tool to organize data, as well as to store it. The initial coding was made by one of the authors, while two of my supervisors replicated the coding of four randomly chosen interview documents separately. The purpose with replicating the coding was to validate the initial coding and consensus was later found during a meeting between all authors. The last author then analysed the emerging concepts and the present theory based on an initial analysis of the coding. A workshop was then convened where the authors further explored the material and established relationships between the coding. Meaning was revealed by exploring patterns between codes. A definition of the properties and dimensions of the tentative main categories were constructed by asking how they were related. The core category and main categories were constructed by all the authors who were active in the development of the process of understanding how PHNs' attitudes, views, beliefs, and knowledge was used in the encounters with people with MHPs.

In Study II the data analysis was initiated after the data collection was finalized. The interviews were transcribed verbatim. Through a variety and in-depth descriptions of the phenomenon the phenomenon subject meaning can be reached. The subject meaning of a phenomenon is captured using reduction and thereafter searching for the essences of the phenomenon. Giorgi (1997; 2000; 2005) data analysis process is to first get a sense of the lived experiences by reading and re-reading the data and by listening to the interviews to hear the tone and the timbre of the voices. The second step was to reread the data and marking meaning units (words, phrases, or sentences) in relation to the study' aim. Thirdly, each meaning unit is to be explored further by spelling out each meaning units and the authors concludes the meaning behind the participants' words and articulate it. The last step is to search for the essence, structures of meaning that describes the lived experiences of seeking, visiting, and receiving PHC for their MHPs.

## Rigour

The guidelines for enhancing rigour and quality were used to enhance in both Study I and in Study II trustworthiness using COREQ (Tong et al., 2007). In specifically for Study I, the GUieline for Reporting and Evaluating Grounded Theory research studies (GUREGT) (Bøttcher Berthelsen et al., 2018) and in Study II, the guidance of practical implications when conducting a descriptive phenomenological nursing study (Shorey & Ng, 2022).

In Study I the criteria for evaluation are credibility, originality, resonance, and usefulness (Charmaz, 2006). The criteria of credibility were strengthened by using a theoretical sampling over a period of one year, interviewing a variety of PHN within different fields and with a range of experience as a PHN or in the process of becoming a PHN. We had a good variety of range and interview depth in the data and all the authors contributed to the construction of the social process. To meet the criteria of originality, our result has provided new insights into a very limited area of knowledge of PHNs dealing with patients with MHPs. In the reinterviews the participants' confirmed the presented theory and had no additional comments, therefore no amendments were made. To meet the criteria of usefulness, the presented theory helps to illuminate PHNs' encounters with a person with MHPs which knowledge can contribute to stakeholders' and health professionals' assimilation of useful knowledge of how to promote mental health in PHC and create meaningful encounters with a person with MHPs.

In Study II the practical implications by Shorey and Ng (2022) consist of descriptions of seven factors, research objectives, research design use of theoretical framework, sampling procedure, data collection, data analysis and presentations of findings.

## Ethical considerations

The ethical principles research on humans described in the declaration of Helsinki were adapted in this licentiate thesis (World Medical Association [WMA], 2013). The supposed benefit of being a participant in Study I and Study II (sharing their narrative of experiences), were considered higher than the risks of being a participant (respect for the participants integrity and autonomy), in the studies. At any time of the process, the participants could withdraw their participation without further questioning. The potential risks of being a participant was managed by the authors and is described separately.



## **Study I**

In respect of the participants autonomy the first author of Study I (EN) contacted operational managers in the PHC services to inform and invite them to take part in the study. Those managers that accepted the invitation, provided the names of their employed PHN to first author (EN) (Study I). In the first, second and third author (EN, SJ, LB) approached PHNs and those who showed a positive interest in participating, were given written information about the study and its aim in advance and were also orally introduced prior to the interview being conducted. A brief and standardized background narrative was provided to introduce the participants to the field of interest. To respect the participants integrity the face- to-face interviews were taken place in an environment which the participant had chosen and were felt convenient with. When Covid-19 emerged, the face-to-face interview changed to an online service, Lund University (LU) Zoom. The online meeting is a LU- platform for online communication, via a LU IP address, the data was encrypted, and all users need a specific password to log in. The interviews were audio recorded.

## **Study II**

To respect the person with perceived illness integrity and autonomy of the participants were approach by an information ad of the project “I dialog för psykisk hälsa” (In Dialogue for Mental Health). Participants who were interested to take part of the study, showed their interest by filling out an interest form on the “In Dialogue for Mental Health” projects homepage. In contact with the presumptive participants, it was critical that researcher avoided undue influence. No personal information was stored or collected during this passage of registering interest ([www.lu.se/personuppgifter](http://www.lu.se/personuppgifter)). The participant was included when they had signed the consent form and when they met the study inclusion criterions. Study II involved sensitive data (concerning participants health) according to the Swedish Ethical Review Act (SFS 2003:430) therefore, ethical approval was obtained by the Swedish Ethical Review Authority (Reference number: 2022-02164-0).

# Results

To answer the overall aim of this licentiate thesis the result is presented as a summary of the result from Study I and the preliminary result of Study II.

## The process of the Public Health Nurse

In Study I, the participants sociodemographic showed the mean working experience of PHN was 11 years (range <0- 36 years). The mean age was 41 years of age (range 30-60 years). The 13 interviews and three re-interviews resulted in the core category of the PHN process was, "Being a relationship builder - to initiate the dialogue" for a person with MHPs. The core category was constructed by three main categories, "Being on your own", "Being on top of things – knowing your limits", and "Professional comfort zone".

Public Health Nurses' process of dealing with mental health encounters depended on the capacity to deal with mental health encounters of the PHC organisation. PHN beliefs of mental health encounters are described as personal attributes, where the PHN needs to have a special interest or to be curious of mental health in general. Their belief is based on their experience of encounters where patients with MHPs does not fit into the capacity of PHC organisation. Their attitude and views of mental health encounter is acquired knowledge of mental health and the PHC organisational capacity to deal with mental health encounters, differs.

Therefore, PHNs use different strategies to deal with mental health encounters, based on factors of their MHL, which in turn creates an uncertainty of their role for this patient group. To handle their uncertainty, they use different strategies to deal with mental health encounters whereas being an intermediary and being a CM or at times a mix both is used. A natural strategy to approach mental health encounters in an PHC where *Mental health does not fit in* was to take on the role as an intermediary.

## The lived experience of a person with Mental Health Problems

In Study II, the participants sociodemographic showed the mean experience of MHPs was 10 years (range 1,5-18 years) and the median 12 years. The mean age was 38 years (range 20-66 years), median 40. The 11 interviews preliminary findings resulted in a general construction of the lived experience of patients who are seeking, visiting and/or receiving PHC for MHPs was that *Health care is asking too much of them* and constitutes the following four themes, (1) I am running out of strategies and I need support, (2) It's to be in a merry go round in pursuit of finding someone, that can support me, (3) I am fortunate and lucky if I find a specialist in mental health to support me, (4) It's a continuous struggle of emotions, questioning myself and the healthcare.

# Discussion

## Methodological considerations

Since both of our studies are exploratory and have a qualitative design there is a need to enhance trustworthiness and quality (Charmaz, 2006; Shorey & Ng, 2022). How preunderstanding of mental health encounters (Study I, credibility, Study II research design), data collection (Study I, credibility; Study II, research objectives, sampling procedure) in forms of in-depth interviews and re-interviews (Study I, resonance), data analyses, how it has affected the result (Study I originality, Study II presentation of findings) and how these were dealt with in the performance of conducting the two studies. Usefulness of the two studies can be discussed when all the other criteria are met.

## Participants sampling

A limitation in this licentiate thesis was the difficulty in recruiting participants to Study I. In Study I it can be discussed whether it concerned the PHNs' frustration, views, and attitudes when it comes to MH, their described uncertainty, and/or lack of knowledge about how to recognize, manage and promote mental health that made participation challenging. No analysis was conducted regarding the non-responders of Study I and of Study II. A larger data set may have altered the results and affected Study I resonance (Tong et al., 2007). However, since Study I was a constructivist Grounded Theory approach, data guided the data collection process. In Study II there is a general guideline in phenomenology concerning sample size, three in-depth interviews of participants are considered enough for a result (Giorgi, 2000, Robinson & Englander, 2007). Therefore, since there is limited knowledge of conducting a descriptive phenomenology study within the research group, Study II was informed by Malterud et al., (2016) definition of informed power. Informed power was considered found based on the five key dimensions (Table 2) when a variety and depth of narratives was reached. Even though study II was not theoretically driven (in need of a larger sample size) the method of phenomenology considered in-depth interviews by three participants as a result, we therefore stopped recruitment and enrolment of participants after six months and a variety of in-depth descriptions of the phenomenon was considered found. Since Study I is a

constructivist Grounded Theory and theoretical sampling is one of its prerequisites, Malterud et al., (2016) informed power was not considered applicable. For future research it would have been beneficial to understand why the participants in Study I and in Study II declined participation.

**Table 2.** Informed power of sample size in qualitative method (Malterud et al., 2016).

<b>Five Key Dimensions</b>	<b>Yes*</b>	<b>No*</b>
<b>I Aim:</b> Is the study aim considered narrow?	<i>Fewer</i>	<i>Larger</i>
<b>II Sample Specificity:</b> Does the study require a specific type of participant?	<i>Fewer</i>	<i>Larger</i>
<b>III Established theory:</b> Is the study theoretically informed?	<i>Fewer</i>	<i>Larger</i>
<b>IV Quality of dialogue:</b> Were the interviews considered good interview dialogues?	<i>Fewer</i>	<i>Larger</i>
<b>V Analysis strategy:</b> Requires the study in depth exploration such as narratives or discourse?	<i>Fewer</i>	<i>Larger</i>

\*Number of participants

## The use of interviews as Data collection

Interview is a common method to collect data in qualitative methods (Kvale & Brinkmann, 2014 and especially in Grounded Theory design (Bøttcher Berthelsen et al., 2018; Charmaz, 2006). and in a descriptive phenomenology design (Bøttcher Berthelsen et al., 2018; Shorey & Ng, 2022). Englander (2012) recommends Kvales work on qualitative interviews as a general guideline when performing interviews but stress that different qualitative methods also effect the interview technique and should therefore be adjusted based on the research question. In this thesis two different interview techniques have been used and they were grounded in the philosophical perspectives of a PCC (Kristensson- Uggla, 2022) and the chosen research methodology. Therefore, the interviews have been to capture the narrative of the participants' experiences, where listening non-judgementally and to view each participant as equal worthy is crucial. The different methodologies on how to use the data during the data collection and analysis process effects the Study I resonance (Charmaz, 2006) and Study II data sampling and data analysis (Shorey & Ng, 2022). In a constructivists Grounded Theory design, the results (gathered data) shapes and forms the next interview and who to interview next (theoretical sampling) (Charmaz, 2006) whereas in descriptive phenomenological research the researcher is interested in a persons' description of the phenomenon free from assumptions and already existing theories (Giorgi, 1997; 2000; 2005). Interviewing as a procedure in science to collect data, is deeply depended on the research question and the researchers' ability to perform the interview, which in turn effect the data analysis and the results (Englander, 2012). In both Study I and Study II the use of

interviewing through a LU-platform was used, recent research has showed this to be an alternative of providing data when face-to-face interviews was not applicable due to Covid-19 in Study I and geographically spread in Study II (Reñosa et al, 2021). Since Study II is in its preliminary stages of data analysis, the result should be considered with caution since the process of extracting assumptions and theories have not fully been met during the data analysis (Giorgi, 2000). Whereas in a Grounded Theory design (Study I) it is argued that preunderstandings of the researcher may influence the result too much and thereby affect the study's sensitivity (Seldén, 2004) and thereby originality and usefulness (Charmaz, 2006).

## Preunderstanding in relation to the Data analysis process

In both studies the authors' preunderstandings needs to be discussed, visualised, and dealt with in the construction of the data in respectively Study I and II. A researchers' preunderstanding can be viewed as the strength (e.g., constructivist Grounded Theory design according to Charmaz, 2006) and a weakness if it is not used or interpreted in alliance with chosen methodology (e.g., descriptive phenomenology according to Giorgi, 1997; 2000; 2005).

In phenomenology research Nyström and Dahlberg (2001) and Giorgi (2000) discuss the definition of preunderstanding and understanding at the same time as they are being open to a phenomenon of interest in scientific research. According to Nyström and Dahlström (2001) the preunderstanding arises from a tradition or context which the researcher/s is familiar with. Preunderstanding and understanding have the same definition in a Grounded Theory design but it is used differently. As in Study I which was based on own lived clinical experiences of being a health professional and dealing with mental health encounters, as well as the experience of being novice researcher of mental health in PHC context or experienced researcher as for the co-authors. Methodology the authors acknowledged their gathered preunderstanding and understanding therefore viewed it as a contributing factor. In a constructivist Grounded Theory, preunderstandings of the authors are a contributing factor when conceptualization of the data (Charmaz, 2006). This is also one of the discussed weaknesses against a theoretical sensitivity in a constructivist Grounded Theory according to Seldén (2004). Nyström and Dahlström (2001) further discusses the constraints of preunderstanding that the interpretation derives from this very point of departure. It is thus critical, as a first step is to deal with presumptions, acknowledge them, try to illuminate where they are emerging from. When a researcher is transparent in such a way, the possibility of being open to a phenomenon increases (Nyström & Dahlström, 2001) and would not be regarded as a weakness in a constructivist Grounded Theory inspired by Charmaz (2006).

In Study II, all authors attempt to withhold a phenomenological attitude (openness) towards the research question. The preliminary result is thus based on

the search for answers beyond the question. According to Nyström and Dahlström (2001) it is important to capture the historical events leading up to the question, but also in relation to the present and future, openness to our preunderstanding/presumptions. By constructing an interview guide about how, why, and what happened (Giorgi, 1997; 2000) the aim was to contribute to the openness of the phenomenon. According to Shorey & Ng (2022), a critical but a key element in the data analysis process of a descriptive phenomenology study is bracketing. To bracket past knowledge about the lived experience of a person seeking, visiting, and receiving PHC for their MHPs, to encounter the phenomenon freshly and describe it precisely as it is intuited (or experienced) (Giorgi, 1997, 2000; 2005). To withhold the existential index, which means to consider what is given precisely as it is given, as a phenomenon (Giorgi, 2000). Since Study II is in its initial stage of data analyses the preliminary result should be interpreted as such. Therefore, usefulness can only be taken into consideration when it comes to Study I, whereas the result can be useful knowledge that could inform future research initiatives targeting PHNs MHL.

## Result Discussion

This licentiate thesis resulted in the PHNs' process of Being a relationship builder to initiate the dialogue for mental health and a preliminary description of the lived experience of seeking, visiting, and receiving PHC for a person with MHPs where Health care is asking too much of them. The results indicate that the organisational capacity for PHN to initiate a dialogue for mental health is limited, where their experiences is expressed as "Mental health does not fit in" (Study I). Therefore, the process of actions for the PHN in the encounter was restricted and depending on their MHL, the uncertainty of their role became apparent. To bridge the limited organisational capacity of providing opportunities for initiating the dialogue about mental health some PHNs restricted themselves from being involved and viewed their role as an intermediary. As an intermediary the PHN did not ask the patient to "many" questions because of their limited involvement with patient care. Some PHNs saw their role as a CM and stood by the patient until they longer saw a need to be involved despite of whether their MHL were sufficient or not. In Löyttyinen et al., (2023) it was shown that the role development was constantly changing, and that specialisation and leading specific assignments were dependent on the PHN personal interest. Personal interest or person- dependent has also been shown in Granrud et al., (2018) where the PHN describe themselves as lone decision makers on their work tasks and to what extent they collaborated with other professionals. These findings corroborate the result of Study I that a PHNs work tasks could change depending on their special interest. However, Study I further explored that the actions and role changed from being an intermediary to being a CM, or a mix

of both, and that their MHL was deceive for which role they took. In turn, the MHL of PHNs were interpreted as depended on the organisational capacity of the PHC. Previous research also describes PHNs' uncertainty in clinical practice, which influences the possibility for them to work autonomously with the group of patients with MHPs (Björkman et al., 2018; Björkman- Salzmänn-Eriksson, 2018; Janlöv et al., 2018; Granrud, et al., 2019; Löyttynen et al., 2023). Interestingly, being a relationship builder is further described as the foundation in the Critical Caring theory (Falk-Rafael, 2012) and is considered as critical component for the PHN practice (Falk-Rafael, 2005; Falk-Rafael & Betker, 2012 a-b). When opportunities for being in a relationship becomes limited, it challenges the role of the PHN (Falk-Rafael & Betker, 2012 a-b; Löyttynen et al., 2023), in line with the results of Study I. Notably, in the Critical Caring theory, the first step is for the PHN to prepare themselves for building a relationship (Falk-Rafael & Betker, 2012 a-b). Yet, the results of Study I showed that there is a gap or lack of prerequisites in the PHC context for PHNs to become relationship builders for patients with MHPs. Today, as reflected by the result in Study I, it is up to the PHN and their personal interest and attributes to take active decisions on how to prepare themselves and take on their role with a person-centered approach in mental health encounters (Löyttynen et al., 2023) Evidently, this situation creates an uncertainty of the role (Janlöv et al., 2018; Löyttynen, 2023) but also lack of self-esteem (Janlöv et al., 2018). The PHN called for interprofessional learning which is in line with research of the field (Björkman et al., 2018; Janlöv et al., 2018, Granrud et al., 2019; Löyttynen et al., 2023). However, to bridge the gap of prerequisites there is a need to create a useful intervention or tool to support and guide the PHN, but also other health professionals in the PHC context, to initiate a dialogue about mental health. Such an intervention may consist of an open dialogue intervention to enhance narratives a helping and trusting relationship to support the development of mental health (WHO, 2022).

In the Critical Caring theory, the third step is to use a systematic, reflexive approach based on a being open and responsive to patient's needs, goals, and co-creation of care (Falk-Rafael & Betker, 2012 a-b). When given the recognition as a relationship builder, the PHN could relate to engaging in transpersonal teaching-learning (Falk-Rafael & Betker, 2012 a-b) with the patient. As reflected in Study I, the process of being a relationship builder to initiate the dialogue, the PHN were not always recognised for this competence, which may have led to that the PHN was being on their own (Study I). The last step in the Critical Caring theory is meeting needs and building capacity within the relationship (Falk-Rafael & Betker, 2012 a-b) and for those working as a CM building capacity and enabling the patients' capabilities were their goal. The lack of organisational capacity of managing mental health led to take actions that were out of their boundaries and may be viewed as a strategy of maintain as helping and trusting relationship with the patient (Study I).

As of Study II the descriptions of the phenomenon of seeking, visiting, and receiving PHC will give us further knowledge of what it can be like to be a person with MHPs in need of care. Their descriptions add to the knowledge derived from



the experiences of PHNs in Study I and is essential to understand the mental health encounter. Through a person-centered mental health dialogue the expressed lived experiences of MHPs may highlight ways to enrich recovery (Deering et al., 2021). The aim in a person-centered health dialogue is for the health professional to be responsive towards the other persons' narrative and situation, to get to know the person and identify their capabilities (Fors & Forsgren, 2020). The result stresses the importance of developing useful interventions or tools for health professionals to support the integrations of MHS into PHC. Actions of further educational and training in mental health both from a general perspective for PHNs and more specially for the PHC organisation needs to be taken to enable the capabilities for a person with MHPs. In a person-centered approach the use of patients' expertise is central when improving and developing healthcare (Ekman et al., 2011) and to successfully integrate a person-centered recovery oriented MHS into PHC there is a need to broaden the perspective of health professionals (WHO, 2021).

The collaboration care model (CCM) presupposes the role of a CM, and the CCM has shown to be efficient for patients with depression (Af Winklerfelt Hammarberg et al., 2022), the model improves the accessibility for patients of receiving health care and it increases the interprofessional collaboration (Rugkåsa et al., 2020). However, the sustainability of the CCM model is being questioned (Rugkåsa et al., 2020) since the economic foundation of PHCC builds upon visits to the general physician (SALAR, 2023). Therefore, there is a need to argue for less "invasive" and more practical clinical mental health dialogue tool, to support and guide PHN of building sustainable caring relationships with the person seeking, visiting and or receiving PHC. A practical clinical mental health dialogue tool for health professionals can support the transition from a traditional patient-centered approach towards a recovery-oriented person-centered approach and the integration of MHS into PHC.

## Conclusion and clinical relevance for practice

This licentiate thesis has provided insights of the mental health encounter in the context of PHC. The result of Study I and the preliminary result of Study II, explains and describes the mental health encounter without the organisational capacity to deal with them. The narratives of the PHN and patients helped to understand the conditions for mental health encounters, knowledge that could inform future intervention development and research to improve how health professionals could initiate the dialogue for mental health even when the organizational capacity is limited. For clinical implications, the results can supply useful knowledge of why mental health encounters may differ within a PHC and among PHC organisations. Derived knowledge may be used to inform clinical implications for health professionals to employ, in mental health encounters in the context of PHC.

- Public Health Nurses' process of dealing with mental health encounters depended on the capacity to deal with mental health encounters of the Primary Health Care organisation
- A natural strategy to approach mental health encounters in a Primary Health Care where *Mental health does not fit in* was to take on the role as an intermediator
- The preliminary general construction of the lived experience of patients' seeking, visiting and/or receiving primary health care for Mental Health Problems was that *Health care is asking too much of them* and constitutes of four themes.

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*“There is probably purpose and meaning in our journey  
but it is the pathway there, which is worth our while”*

I Rörelse av Karin Boye

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”Everybody needs good neighbours”.

Barry Crocker.

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# Appendix

## Appendix 1

**Table 3.** Examples of questions and probing questions in the interview guide of Study I

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Primary prevention

- How would you identify that the person is seeking help for mental health problems?
- Could you describe the last encounter you had with a patient with MHPs?

Secondary prevention

- Could you describe how you identify risk factors for MHPs?
- Can you describe how you work with mental health promotion and prevention at your workplace?

Tertial prevention

- Could you describe the care you as a RN/PHN offer patients with MHP?
- Could you describe which support you as a PHN have from your employer to support patients with MHPs?

Probing questions

- Could you tell me more?
  - When we were discussing ... What was your impression?
  - You mentioned XXX, can you please explain what you mean by that?
- 

## Appendix 2

**Table 4.** Examples of questions and probing questions in the interview guide of Study II inspired by Matua (2015), Giorgi (2000) and Robinson & Englander (2007).

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Aim:

**Can you describe your experience of seeking, visiting, or receiving PHC for your mental health?**

**What happened?**

- Could you describe your latest PHC encounter for your mental health?
- What was positive?
- What was negative?

**How did it happen?**

- Could you describe what prompted you to seek PHC for your mental health?
- Could you describe your strategies for dealing with your mental health?

**How did the event effect you as a person?**

- How did you experience the encounter with health professional?
- Which strategies did/do you use in contact with PHC?

**Probing questions**

- Can you describe a specific situation in detail?
  - You mentioned XXX, can you please explain what you mean by that?
-

Paper I







RESEARCH

Open Access



# Public health nurses experience of mental health encounters in the context of primary health care: a constructivist grounded theory study

Emmy Nilsson<sup>1\*</sup>, Suzanne Johanson<sup>1</sup>, Lina Behm<sup>2</sup> and Ulrika Bejerholm<sup>1,3</sup>

## Abstract

**Background** In primary health care people with mental health needs are often overlooked or masked with physical complaints. It has been suggested that public health nurses lack sufficient knowledge when encountering people with mental health problems. Low levels of mental health literacy among professionals are associated with negative patient outcome. There is a need to understand public health nurses process and strategies used when encountering a person with mental health problems in order to promote mental health. This study aimed to construct a theory that explains the process of public health nurses experience when encountering people with mental health problems based on their knowledge, attitudes, and beliefs about mental health.

**Methods** A constructivist grounded theory design was used to meet the aim of the study. Interviews were conducted with 13 public health nurses working in primary health care between October 2019 and June 2021, and the data analysis was performed according to the principles of Charmaz.

**Results** The core category, *“Public health nurses as a relationship builder – to initiate the dialogue”* reflected the process while the main categories *“Being on your own”*, *“Being on top of things- knowing your limits”*, and *“Professional comfort zone”* reflected conditions that were decisive for initiating a dialogue.

**Conclusion** Managing mental health encounters in primary health care was a personal and complex decision-making process that depends on the public health nurses’ professional comfort zone and acquired mental health literacy. Narratives of the public health nurses helped to construct a theory and understand the conditions for recognizing, managing and promoting mental health in primary health care.

**Keywords** Clinical nursing research, Public health nurse, Mental health literacy, Mental health services, Primary health care, Health promotion

## Background

The rationale of this study is to explore the knowledge, attitudes, and beliefs about mental health (MH) of public health nurses (PHN) when encountering peoples with mental health problems (MHPs) and how the PHNs deal with the situation in the context of primary health care (PHC). We use the World Health Organization’s definition: *“mental health is a state of well-being in which an*

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*individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community*" [1]. MHP is a broad concept encompassing many aspects from challenges experienced in everyday life to severe mental disorders [1]. People with MHPs are often overlooked in PHC [2]. Their mental health needs are masked with physical complaints and co-occur with other disorders that are more manifest [3–5]. Furthermore, the decision support system does not automatically recognize MHPs [6] and there are few interventions that exist that promote mental health [7]. It has been suggested in a number of studies that PHNs lack sufficient knowledge about MHPs and about how they encounter MH patients and promote MH [6, 8–10]. Moreover, a low level of mental health literacy (MHL) among professionals is associated with negative patient outcomes [11, 12]. Mental health literacy is defined here as knowledge, attitudes and beliefs about MHPs, and strategies used i.e. recognition, management and prevention of MHPs [12]. MHL is used to promote PHNs' knowledge and their ability to benefit the MH perspective of the patients they encounter. It has been emphasized that being a capable and useful nurse are important characteristics when encountering persons seeking care for their MHPs [6]. There is a need to understand the knowledge, attitudes, and beliefs about MH of PHNs in their encounters with persons with MHPs in a PHC context.

There is an increase of citizens with MHPs in Sweden [13, 14] and there is a risk of a further increase in MHPs due to the Covid-19 pandemic [15]. MHPs are known to be associated with higher levels of smoking, more frequent alcohol consumption, and a greater degree of obesity [16] which can further cause deterioration in a person's overall health [17, 18]. Persons with MHPs also have a higher risk of illicit substance use [19]. Furthermore, people with MHPs, have a greater risk of suicide than the general population [20, 21]. At the same time, encounters between staff and patients has been identified as being the most frequently occurring deficiency in PHC and MH services prior to a patient's suicide, according to Roos af Hejlsäter et al. [22]. PHC as the first-line of MH services have the opportunity to play an important role [23] in providing early support and prevention to promote health to a group of patients who are known to be in a vulnerable position in society today [1, 24].

The responsibility of providing MH care is evenly shared between the first-line PHC service and the specialist MH services [25]. The National Board of Health and Welfare emphasizes the importance of defining MH needs and providing MH promotion and preventive activities in a PHC context [23]. Common barriers for integrating MH into a PHC context have shown to

be attitudes, knowledge and skills, motivation to change, management and leadership, and resources [26]. To access MH services in this context is perceived as a challenge for patients and similarly difficult for the providers across PHC services to maintain it [26, 27]. The nursing role in PHC is a diverse one and the spheres of responsibility vary across organizations, counties, and countries [28, 29]. In addition, how nurses perform their work can vary from one to another, and the essential procedures for working with patients with MHP within the PHC have not been sufficiently evolved [2].

The PHNs' primary focus is health promotion and prevention from a public health perspective [30, 31]. They describe their function in PHC centers as being the glue that holds the health care service together for patients with MHPs seeking support [9]. However, PHNs lacked confidence [32] and felt insecure about how to meet the MH needs of the patients, and were uncertain of their role [9]. More focus is needed on mental health promotion according to the Swedish Association of Local Authorities and Regions [33]. Mental health promotion is not currently seen as a natural part of the care provided by the PHC for the population [8, 15, 34].

There is thus a need to understand the knowledge, attitude and views of PHNs, as front-line workers within PHC, from identifying to assessing a person's MH [15, 35] to meeting the challenges PHNs face as the MH needs are being integrated within PHC. The aim is to construct a theory that explains the process public health nurses experience when encountering people with MHPs, based on their knowledge, attitudes, and beliefs about mental health.

## Methods

### Study setting

A constructivist grounded theory study design [36] was used due to the limited existing knowledge and prior inductive theory of PHNs' experience of encounters with persons with MHPs. Grounded theory is relevant when a theory is needed to explain actions and processes of a specific situation [36]. The process and the actions taken by PHN in a PHC context can have multiple perspectives, and we therefore choose a constructivist approach where the researchers are part of the construction and aware of the changing context and different perspectives of reality [36, 37]. The consolidated criteria for reporting qualitative research (COREQ) were used [38]. The selection of PHC settings were based on the PHNs' working field defined by The Swedish Society of Nursing [30]. The PHC centers were situated in small and medium sized cities while the municipal school health care settings were situated in larger cities.

### Participants and sampling

According to the standards of grounded theory [36], the participants, PHNs, were gradually included in the study, initially using purposeful sampling and later a focused theoretical sampling procedure. The intention was to approach PHNs working in different PHC contexts with varied experience of the field. The theoretical sampling process involved presumptive participants of different ages from different PHC contexts, with varying work experience as PHN and experience of encounters with people with MHPs. During the theoretical sampling process, we were also interested in interviewing PHN students working in PHC, with specific experience of encounters with people with MHPs in order to understand the knowledge development process of MH.

### Data collection

The data collection was performed from October 2019 to June 2021. A total of 13 interviews with 13 participants were completed. The interviews, which were performed by the first (E.N.) and third author (L.B.), who are also PHNs, were conducted face-to-face in accordance with the choice of the participants. The location for the interviews changed to an online meeting service at Lund University, LU-Zoom, communicated via a LU IP address when the Covid-19 pandemic emerged and reduced the possibilities for physical meetings. The data was encrypted and all users need a specific password in order to log in. The interviews lasted approximately 56 min (range 37–67 min) and were digitally recorded after consent from each participant. The interview guide was constructed by the authors and were based on the MHL concept with a focus on PHNs primary, secondary, and tertiary health promotion and preventive working field see Table 1. The first author (E.N.) contacted operational managers in the PHC services to inform and

invite them to participate in the study. The PHC service that accepted the invitation then contacted PHNs and the first (EN) and second author (LB) then approached those who showed a positive interest in participating in the study. Minor revisions of the interview guide took place after two pilot interviews were conducted. In the minor revisions, questions of organizational structure and support for the PHN were added. All the participants had received information about the study in advance and were also orally introduced prior to the interview being conducted with a short background of the study's aim and that the study was a part of a larger project. A brief and standardized background narrative was provided in order to introduce the participants to the field of interest. The early stages in the analysis were performed by all authors during the interview period. The analysis included initial coding, memo writing, and the development of preliminary concepts [36]. This analytical process resulted in modifications to the questions in the interview guide that corresponded to the topics raised during the interviews. The initial stage of the analysis process further guided the theoretical sampling.

### Data analysis

The coding process was based on theoretical sampling, coding, constant comparison, identification and data saturation [36, 37]. The memos written during the interviews were used to go back and forth in the data to construct meaning and actions, as an early analysis of the data. The memos were sorted to analyze their relationship and relative significance to each other i.e., clustering. Theoretical sampling was used to develop and respond to new question topics that had evolved from the initial coding and analyses. All authors contributed to this early step of the analytical process. In order for the results of the process and the actions to

**Table 1** Examples of questions and probing questions in the interview guide

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Primary prevention
How would you identify that the person is seeking help for mental health problems?
Could you describe the last encounter you had with a patient with MHPs?
Secondary prevention
Could you describe how you identify risk factors for MHPs?
Can you describe how you work with mental health promotion and prevention at your workplace?
Tertiary prevention
Could you describe the care you as a RN/PHN offer patients with MHP?
Could you describe which support you as a PHN have from your employer to support patients with MHPs?
Probing questions
Could you tell me more?
When we were discussing ... What was your impression?
You mentioned XXX, can you please explain what you mean by that?

---

emerge from the data, codes were analyzed to construct the data into forms of concepts, see Table 2. Categorization was made by constant comparisons between the codes and concepts that referred to the process of encountering people with MHP. The interviews were transcribed verbatim, and line-by-line coding was conducted. NVivo 12. 2 software was used as a tool to organize data, as well as to store it. The initial coding was performed by the first author (E.N.), while two authors (S.J., L.B.) replicated the coding of four randomly chosen interview documents separately. This was carried out to validate the initial coding and consensus was found during a meeting. The last author (U.B.) then analyzed the emerging concepts and the present theory based on an initial analysis of the coding. A workshop was then convened where the authors further explored the material and established relationships between the coding. Meaning was revealed by exploring patterns between codes. A definition of the properties and dimensions of the tentative main categories were constructed by asking how they were related. The core category and main categories were constructed by all the authors who were active in the development of the process of understanding how PHNs' attitudes, views, beliefs, and knowledge was used in the encounters with people with MHPs.

### Trustworthiness

The guidelines for enhancing trustworthiness and quality were used to enhance the study's trustworthiness [38, 39]. The criteria for evaluation are credibility, originality, resonance, and usefulness [36]. The criteria of credibility were strengthened by using a theoretical sampling over a period of one year, interviewing a variety of PHN within different fields and with a range of experience as a PHN or in the process of becoming a PHN. We had a good variety of range and interview depth in the data and all the authors contributed to the construction of the social process. To meet the criteria of originality, our result has provided new insights into a very limited area of knowledge of PHNs dealing with patients with MHPs. In the reinterviews the participants' confirmed the presented theory and had no additional comments, therefore no amendments were made. To meet the criteria of usefulness, the presented theory helps to illuminate PHNs' encounters with persons with MHPs which knowledge can contribute to stakeholders' and health professionals' assimilation of useful knowledge of how to promote MH in PHC and create meaningful encounters with persons with MHPs.

### Results

The participants' ages ranged from 30- 60 years (mean 41 years) (see Table 3), with a range of working experience as a PHN of <0–36 years (mean 11 years). The 13 interviews and three reinterviews after the final drafts of the result, resulted in the core category, "*PHN as a relationship builder- to initiate the dialogue*" and was constructed by three main categories; "*Being on your own*", "*Being on top of things –knowing your limits*" and "*Professional comfort zone*". The main categories had two or three subcategories and are presented in turn and exemplified by quotes from the participants.

#### The core category PHN as a relationship builder – to initiate the dialogue

Being a relationship builder- to initiate the dialogue concerned the effort of creating a caring relationship, was key to recognizing, guiding, or referring and managing patients with MHP. However, the prerequisites for being able to create caring relationships differed due to the inter-related main categories of "*Being on your own*" and "*Being on top of things – knowing your limits*", which emerged to a third main category, "*Professional comfort zone*"; see Fig. 1.

The PHNs described an existing knowledge gap concerning MH in the organization and here was a knowledge diversity among PHNs. There was a different structure of dealing with MH within a PHC organization and between PHC organizations, which created an uncertainty of PHNs' professional role. To close the knowledge and MH service gap, the PHNs claimed the need for a change of the organizational structure, resources, and management support. Desirable attributes were reflected among those PHNs who had dealt with and managed encounters concerning MH more willingly than others, a social construction that was a result of the lack of organizational capacity, were mental health did not fit in. Hence, the PHNs' professional role felt uncertain, and they were caught between the patient and the organization, which are, described in the main categories of "*Being on top of things- knowing your limits*" and "*Being your own tool*". The main category "*Professional comfort zone*" reflected how the PHNs dealt with MH encounters, and how to bridge the knowledge gap of MH.

Figure 1 represents PHNs' MHL (vertical) and the organizational capacity (horizontal). The operationalization reflects different approaches and actions of the PHN in the encounter, described as *the Intermediator* and *the Care Manager*, and is a result of the PHN acquiring MHL. Higher levels of MHL and available capacity in the organization were related to greater chances of taking actions as a care manager and vice versa. When PHNs

**Table 2** Example of the analysis process

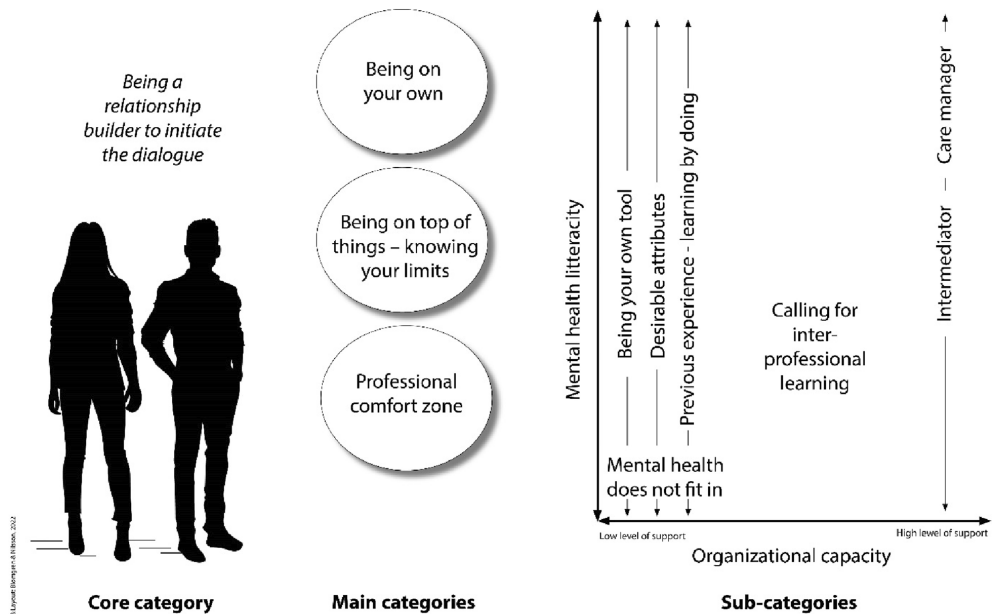
Text from the interview	Initial coding	Properties / Tentative coding	Concepts	Subcategory	Main category	Core category
<p>"think it is all about who you are. What kind of personal history you bring into the encounter. If you're used to talking about emotions and feelings in your personal life, you're more comfortable talking about in your professional role". (10)</p> <p>"Yes, if you look at our guidelines it consists of a lot of physical health, measurements of some sorts, but very little of MH; how to approach MH encounters. I think it's because MH is a lot more difficult to capture. It is easier to do guidelines based on measurements, like physical health". (9)</p> <p><b>Respondent:</b> "Yes. When it comes to MH, we're more like this needs to be taken care of by someone else, we have a responsibility to connect the patient to the counselor or the physician". (8)</p>	<p>Who you are as a person Personal history you bring into the encounter.</p>	<ul style="list-style-type: none"> <li>Depends on who you are as a person</li> <li>Personal and professional</li> <li>Experience matter</li> </ul>	<ul style="list-style-type: none"> <li>Desirable attributes</li> <li>Previous experience</li> </ul>	<p>Desirable attributes</p> <p>Previous experience—learning by doing</p>	<p>Being on top of things – knowing your limits</p>	<p>Being a relationship builder – to initiate the dialogue</p>
<p>MH is difficult to capture Very little of MH</p>	<p>Lack of organizational support</p> <p>Physical vs Mental health positions in the organization</p>	<p>Knowledge gap</p>	<ul style="list-style-type: none"> <li>Mental health does not fit—Organizational unreadiness</li> </ul>	<p>Being on your own – A knowledge gap</p>	<p>Professional comfort zone</p>	
<p>Needs to be taken care of by someone else</p>	<p>Professional boundaries</p>	<p>To guide and refer to the right person</p>	<p>The intermediary</p>	<p>Professional comfort zone</p>		
<p>We have a responsibility to connect</p>						

**Table 3** Socio-demographic characteristics of the participants

	Age <sup>a</sup>	Educational background RN = Registered nurse, PHN = Public health nurse <sup>a</sup>	Experience as Registered Nurse <sup>a</sup>	Years worked at current PHC <sup>a</sup>	Experience as PHN <sup>a</sup>
1	43	RN, PHN	≥10	5–7	2
2	42	RN, PHN	3–5	3–5	1
3	35	RN, PHN student	≥10	3–5	0
4	61	RN, PHN and <sup>b</sup>	≥10	3–5	36
5	61	RN, PHN	≥10	5–7	35
6	30	RN, PHN	5–7	5–7	2
7	45	RN, PHN	≥10	7–9	15
8	59	RN, PHN and <sup>b</sup>	≥10	5–7	20
9	42	RN, PHN	≥10	3–5	1
10	40	RN, PHN	≥10	1–3	<1
11	44	RN, PHN	≥10	3–5	6
12	49	RN, PHN	≥10	3–5	12
13	56	RN, PHN	≥10	0–1	18
Mean (range)	47 (30–61)		≥10	3–5	11 (0–36)

<sup>a</sup> Years

<sup>b</sup> Additional Specialist training



**Fig. 1** The process of being a relationship builder to initiate a dialogue should be viewed in the light of the organizational capacity with low to high support for the encounter and the PHNs' MHL. The subcategories merge into two main categories, and together they construct the third main category, the PHN professional comfort zone where different actions take place depending on PHNs' MHL and the organizational capacity

were identified as having lower levels of MHL and the organizational capacity was lacking, the PHN became an intermediary. It was easier to initiate a dialogue when the organization supported such actions. Furthermore, it was also considered easier to work as a *care manager* if there was a balance between “Being on your own” and “Being on top of things- knowing your limits.” Not all PHNs had the personal characteristics to deal with encounters with MHP, i.e., the *desirable attributes*, and tended to choose the *intermediator* role. To fully grasp the complex construction of being a relationship builder, different factors contributing to PHNs’ MHL (strategies and actions) are presented in Fig. 2.

**Being on your own**

The main category of “Being on your own” describes how the PHNs dealt with the encounter as a relationship builder in relation to the organizational capacity of MH. The organizational capacity was weak and lacked structure, resources, support, and working culture, leaving the PHN on their own to enable a dialogue about MH. This is reflected by the two subcategories *Mental health does not fit in* and *Desirable attributes*.

**Mental health does not fit in**

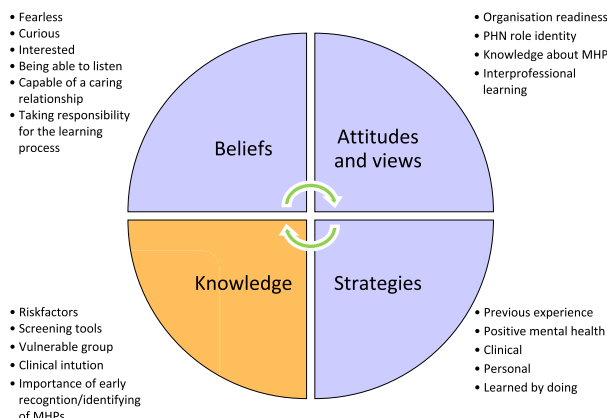
The PHC context reflected a two linear process of care; one from a physical health point of view, which was familiar to the PHNs, and a second from a MH perspective. The physical health care needs had, in comparison with the MH care needs, a given structure, resources, an adequate working environment, and formal written guidelines for the PHN to use during an encounter. Regarding MH, such resources were missing, i.e., lack of

organizational capacity and thus opportunities for enabling a dialogue about MH. This led to an ethical struggle for the PHN who then prioritized and managed physical health care needs. MH care and encounters were time consuming and shifting the focus and time from physical health care needs was not always possible. The organization had not realized that increased resources and knowledge were needed to support MH. This lack of resources may have functioned as an excuse for not advocating or dealing with MHP at the PHC.

*“But when it comes to mental health, it is not at all that easy, you cannot do the same for all persons, there is no... what do you say... such a strict guidance as there is when it comes to physical health” (Participant 9)*

When the PHN had the option to make an active decision to provide care, little room (resources) was left for them to build a caring relationship with patients who had complex MH needs. The situation led to frustration among the PHNs that encounters were being made without mandate, support, knowledge, and timely strategies of how to deal with the situation.

*“Then it’s been difficult to find a time for the patient to be assessed (to see another professional), and then it may be that someone calls, and you can hear that they’re feeling bad and then there’s no time available for four weeks. Then it feels like it is a long time, but I have no power to... Yes, I could have booked the patient for myself, but I do not feel that I could have done so much more than just listening. So therefore... yes, you feel powerless sometimes when you can’t help them sooner.” (Participant 7)*



**Fig. 2** Factors of mental health literacy described by public health nurses in encounters with patients with mental health problems



### Desirable attributes

*Desirable attributes* were a social construction for dealing with MH. PHNs were concerned and being curious, fearless, and open. The most crucial attribute was when they became particularly interested and invested in a patient. Under such circumstances, they took a responsibility for their own professional learning process and professional role development. Being fearless and having the ability to dare to take on conversations and to ask difficult questions were also critical for initiating a dialogue. The attributes described were also used to provide a positive description of colleagues who were more likely to take on encounters with MH. These were based on a description of a voluntary approach and not all PHNs had the *desirable attributes* when it came to dealing with MH encounters and this was considered as the right thing to do. Someone in the PHN group always had a special interest in MH.

*“We have a new girl here who’s only been a nurse for a year; she was a bit cautious, but now you just notice because she works here, that she like... she ends up in situations where she has to dare to ask questions. She has to be a little tough and she’s kind of just blossomed, and she asks such questions and deals with patients in such a fantastic way that I almost get a little teary-eyed when I think about it, because she’s so damn good.” (Participant 2)*

The importance of having *Desirable attributes* in an organization where *mental health does not fit in* where therefore emphasized. Being without such attributes and having little confidence and knowledge, created frustration, especially since health promotion and prevention are viewed as professional responsibilities that should be provided for their patients’ with MHPs.

### Being on top of things—knowing your limits

The PHNs’ ability to manage the encounter with patients with MHP was also characterized as *“Being on top of things – knowing your limits”*, which relates to how the PHNs described their knowledge of dealing with MHPs. Their knowledge about MH was related to *Being your own tool*, which was a description of clinical intuition where previous experience of dealing with encounters helped them learning by doing.

### Being your own tool

*Being your own tool* reflect how PHNs use themselves as a tool in terms of using open questions, characterized by motivational interview techniques, in their effort to maintain a non-judgmental attitude. Clinical intuition was one way of describing how to assess the patient in

the encounter when they used themselves as a tool. This was described as something that could not be taught, rather as something they had gained through clinical experience, and this was an individual competence. Clinical intuition was critical for recognizing and identifying MHPs and enabled the PHN to understand the underlying meaning of sentences that were not always spoken verbally. The encounter could lead to several paths and solutions, which was in line with the understanding of nursing principles. The sense of security was something that grew with the number of years of clinical experience and was less concerned with previous or ongoing educational training. The answers of how to promote MH were not always present, but they knew how to listen, when to guide and refer patients to other team members or professionals in specialist care.

*“Something that I’ve realized in recent years is that you use... when you meet a person who’s ill or persons in general, you use so many senses, you use your eyes, smells and hearing. I usually describe it as having a lot of tentacles, where you sort of scan the person, and it’s a habit you get when you’ve worked with persons for many years.” (Participant 8)*

The quality of the encounter was greatly dependent on how PHNs were able to cope with their own life situation at that specific moment in time. To be able to listen, learn about and assess the person’s MHPs, the PHNs needed to pay careful attention. If the PHNs were “Being on top of things - knowing your limits”, they had the energy and dared to open up and initiate a dialogue about MH. A dialogue about MH took more energy from themselves than encounters of physical health.

### Previous experience – learning by doing

A majority of the experiences needed to promote MH concerned a learning by doing—approach. Lacking experience increased the uncertainty of the PHNs’ caring responsibility and was associated with a fear of doing wrong. Furthermore, the organizational capacity of providing PHC for persons with MHP, and the lack of MH training in the PHN education, made it difficult for them to manage the encounters. The clinical reasoning process during the encounter concerning decisions about which actions to take was related to and depending on if, the PHNs felt as *“Being on top of things – to know your limits”*. They could take active decisions to not become involved since the encounter was outside their “Professional comfort zone” when they felt they were not on top of things. The PHNs had developed their own way of dealing with the encounter in relation to the feeling or awareness of if they were on top of things.

*It is in our nature to want to fix things, but... here it is probably not to fix their well-being, it is to help them come right, so that they can feel better. Because I do not think that, I do not feel that I have the competence so that I can fix them. (Participant 6)*

Furthermore, personal experience could concern both the PHNs' own and/or significant others' experience of suffering from MHP. Personal experience helped the PHNs to understand the health care system from another point of view, and how difficult it can be to receive the "right kind of care". Most of all, to reach out to the "right person" who could orchestrate the care. Having personal experience also contributed to the PHNs' attitude towards the group with MHPs in general, whomever they expressed as being a vulnerable group who often appeared to fall between the cracks of the health care system.

*"Yes, I've got knowledge from different courses, which haven't been very useful. The clinical training we had, has not been of much use. The knowledge I have is based on my own experiences, my own experience of MHPs, and experiences based on family members around me who have been ill or/and are ill." (Participant 11)*

### Professional comfort zone

In the end, the encounter depended on the PHNs' "professional comfort zone" which resulted into different actions depending on the organizational capacity and the PHNs' MHL. *Calling for inter-professional learning* was described as a way forward for the PHN to take an active part in health promotion activities for all patients at the PHC and to be recognized by the PHC as experts in public health promotion and prevention activities. This category constitutes of three subcategories *The Care manager*, *The Intermediator* and *Calling for inter-professional learning*.

### The intermediary

The PHNs role as an intermediary can be described as a spider in the web, as a coordinator of the care around patients with MHP. Referring patients was viewed as an act of care where the PHNs made sure that the patient reached the right person or level of care, directed by the organizational structure and the available resources. The clinical intuition guided them to refer the patient to another profession when the encounter was perceived to be outside of the "professional comfort zone". Referring patients in these circumstances was viewed as the best option for the patient to move forward. PHNs could refrain from their own nursing responsibility with

consideration for the well-being of the patient, while they at the same time limited their involvement. *The intermediary* role was also sometimes constructed and generated by the organization, as a function that should guide and refer individuals with MHP to someone else, either outside or within the organization depending on the organizational capacity.

*"I think it's difficult, it's very difficult, because you want to go into it... sometimes you can feel that they almost don't want to tell me too much, because they know that I'm an intermediary. Therefore, it feels as though they will only talk properly and open up to the person who is really going to help them, so to speak. So therefore, I can feel that it is difficult to ask too many questions, because then you go too deep, and I can... I do not feel that I can help them with any advice or so, so it is so difficult... (Participant 7)*

### The care manager

Being a care manager meant that the PHNs took responsibility for the care for the patient with MHP and were dependent on organizational support in contrast to being an intermediary. As a care manager the PHN had resources that were available for taking actions based on their assessment, follow-ups etc. It became possible to create a caring relationship based on continuous care, and to build upon a mutual trust between the patient and the PHN. A care manager had, like *the intermediary*, a responsibility to refer patients to other professions but remained in support of the patients if they needed it. A care manager was someone with a mandate to make their own decisions (autonomy) and who was reliant on his/her clinical intuition and felt confident i.e., a high level of MHL in a role that was within their "professional comfort zone". In such cases, the organizational capacity generated a flexibility for the PHN when the organizational structure and resources were in place. This flexibility made it possible for the PHNs to attempt using more unconventional actions to meet the patient needs during the encounter.

*"Mm. So that then I found an electronic advice to help you as a patient to take the right amount of your medication and at the right time, this one was locked, so the patient couldn't open it, because that was it, the problem was the patient's impulsiveness, and then the patient got the medication when he needed it and so we filled it once every four days, I think, something like that." (Participant 2)*

On the other hand, being a care manager when the organizational capacity was short on resources, left the PHN to take actions that were outside of their

“professional comfort zone”. Being forced to do this was felt as a betrayal against the patient’s trust. The PHNs could sometimes take actions as a silent protest against the organization’s inadequate capacity for MH. The silent protest was a desire to improve the situation for the patient but also to live up to the standards of being a PHN, to take time to listen and follow through. Their view of their professional role in the encounters with MHPs and the standard of being a PHN was connected to how the PHN viewed himself or herself as a person.

*“I don’t finish off a conversation because I know that there’s a red light on the phone, I don’t and I think so yes, I know that many... there are some who are affected by it and hurry up, but... I’m not that kind of person, so then... it’s probably my little protest at the system.” (Participant 1)*

#### Calling for inter-professional learning

The PHNs emphasized that one way of gaining knowledge was to be allowed to follow up on patient contacts, however, not being a natural part of the patient’s care process contributed to feelings of uncertainty. The importance of team building and collaborating with other professions that could contribute to PHN’s learning about managing patients with MHPs was also something the PHNs reflected on. However, the lack of collaboration within the PHC or between other health and care organizations concerning this group led the PHN to assume that this was not really their patient group, even though they emphasized the awareness that patients with MHP constitute a considerable proportion of the population in society today. Nonetheless, MH was part of the PHNs’ care agenda in terms of the specific target groups they were to work with, e.g., the elderly and children and/or parents at child health centers. Assessing the severity of MHP for these groups was part of the job. The PHNs considered themselves to be a temporary contact where the other encounters that were not part of their usual care work were concerned. Moreover, the PHN expressed a deep concern about how care was delivered in those encounters and a frustration for not being able to provide a standardized care.

*“Yes, it’s a group who have really been forgotten. It is a group who have been mistreated, I think; they do not get the right care. Not the help that they need and it’s like there are many who fall between the cracks a little and it’s not really... it’s both healthcare centers and hospitals, it’s like... I do not know, but it feels a bit as though... It doesn’t matter so much with them, so it... yes, they aren’t taken care of in the way that you would like it to be, I think.” (Participant 11)*

Efforts had been made to improve knowledge about MHPs at their workplaces as well as to find different ways forward to improve the awareness and the care processes. However, certain factors prevented these efforts from being successful. Importantly, the manager needed to be interested, engaged and knowledgeable (*desirable attributes*), to embrace the complexity of MHP and the resources necessary.

*“So, we have become better and more accepting, it is like... the knowledge has increased, it’s more common now, but we don’t have the resources to monitor them. We find them more easily, but what do we do with them then? ... Then they have to wait calmly and quietly for their turn.” (Participant 10)*

Calling for inter-professional learning was a description of how to improve knowledge about MH but also to incorporate the PHN in the care for patients with MHPs.

*“I imagine, my belief, my deepest belief is that I can hold the possible mental illness of a patient at a distance, if I can contribute with what I can, and try to provide a supportive conversation, mediate social contacts. So, then I think that it’s my job, to maybe make sure that X never gets there.” (Participant 5)*

#### Discussion

This study explains the process of how PHNs in PHC encounter persons in the context of MHP. Their knowledge, attitude, and view on MH (mental health literacy) depended on whether the organization had the capacity for the PHN to build a relationship with the patient to initiate a dialogue about mental health, as reflected by the core category. In order to operationalize this, the decision-making process involved different steps based on the PHN’ MHL. Our understanding of the PHNs’ mental health literacy, as defined by Jorm [12], was that their knowledge of MH was closely linked to their own personal and/or clinical experience and personal characteristics of managing encounters with persons with MHPs. Our theory further corroborates the results in the study by Ihalainen-Talmander et al. [40] who found that MH stigma among nurses in PHC was related to the extent of clinical experience. Having a longer clinical experience made nurses feel more comfortable (i.e., a higher level of MHL) when encountering patients with MHPs. Relying on previous experience/clinical intuition was of great importance for the PHNs when being in the “professional comfort zone”. According to Welsh and Lyons [41], clinical intuition is crucial when it comes to assessing the needs of persons with MHP, which was evident in the present study. Clinical experience tended to determine the ability of nurses to extend the boundaries of clinical

standards by using their intuition as well as their formal knowledge to meet the patients' needs. Ever since the introduction of clinical intuition and its definition as having a rationale without an understanding [42], it has been criticized as a complex concept, and simply not a gut feeling [43]. The PHNs tended to describe their clinical intuition as "a simple gut feeling" not realizing or reflecting on all the experienced-based knowledge they had gathered during their clinical years. We would argue that the potential of PHNs as knowledge builders about MH needs to be acknowledged by the profession for them to be able to manage the encounters with confidence.

The collaborative care approach is one way of improving the management and the integration of MH in PHC [44–47], where developing the role of a care manager is one of the requirements. The care manager role concerns assisting and managing the patient by providing structured and systematic interventions [48]. In our result, being a care manager was related to the PHNs' professional and autonomous role in PHC in MH encounters. Care management in PHC is described as an improvement in quality of care for patients with MHPs [48, 49]. The role of a care manager for MH in our findings was not experienced as being systematic and/or structured; rather it depended on the PHNs' MHL. The subcategory *Calling for inter-professional learning* could thus be interpreted as a result of the lack of structured and systematic interventions within the PHC but also a description of the lack of implementation of the PHN role for MH in PHC. It was a question for the PHNs about referring the patient to the right person within or outside the organization. The lack of integrating MH in PHC created an uncertainty in the professional role [50]. The PHNs were frustrated about not having all the tools, support, or mandate to pursue and develop their clinical judgment and apply the standards of being a PHN to create actions that were in accordance with the PHNs moral and ethical standards. Björkman et al. [6] addressed the importance of building a trustful relationship for further encounters and found restriction of having insufficient MHL. The findings in this study suggested that a PHN who took the time and fully listened to the patient's story lived up to the standards of being a PHN. A person-centered approach should be the baseline for all actions in the PHC context and not dependent on the persons' reason for seeking care [23, 30]. PHNs as care managers need to be acknowledged by PHC and by policymakers in order to be able to improve mental health prevention and promotion from a holistic point of view [47].

Knowledge about MH was reported to have been improved over time, both within the profession and from an organizational perspective. However, in this study it was found that there are still gaps in the MH knowledge,

as reflected by the subcategories targeting the lack of integration of MH in PHC and the need for inter-professional learning about encountering persons with MHP. The lack of integrating MH in a PHC context has left the PHNs being on their own to handle the encounter and this needs to be discussed from the perspective of patient rights and safety. It can be argued that if PHNs identify and approach MHP without building a relationship and not using routines and more standardized tools to verify their decision-making, persons with MHPs are at risk of not receiving adequate assessment and care. However, it is important to state that the PHNs in the present study most likely did the best they could when being on their own. They experienced that the organization failed to support them in their professional role. Furthermore, by not providing PHC with a holistic approach where MHP are considered equal to physical needs, also showed an insufficient support to the patients. There is a need to improve knowledge of MH in PHC [6, 8] and approach it in a systematic way in order to reduce MH stigma within the organization [40].

The clinical implications of our findings thus support a collaborative care approach [49]. The narratives of the PHNs helped to construct a theory and understand the conditions for recognizing, managing, and promoting MH in PHC, knowledge that could inform future intervention development to improve MHL. Further research is needed to understand patient perspectives, their previous experience, needs and preferences concerning PHC [51]. To involve both PHN and patients as stakeholders in the co-production of future PHC interventions is, however, vital for reducing MH inequalities.

### Limitations

In a constructivist grounded theory, the strengths of the preunderstandings of the authors are a contributing factor when conceptualization of the data [36]. This is also one of the discussed weaknesses against a theoretical sensitivity [52]. The authors' background in this study could be seen as a strength of the theory sensitivity. First Author, novice in the practice of grounded theory but with experience as a PHN in different settings, primarily within PHC centers and School health services. Second author has background as occupational therapist within PHC centers, experience of grounded theory and a lecturer of the field. Third author is a PHN with experience of working in PHC centers, Municipality elderly care and associate professor in nursing, and forth a senior professor in MH with experience of grounded theory. Another study limitation was the difficulty in recruiting participants. It can be discussed whether it concerned the PHNs' frustration, views, and attitudes when it comes to MH, their described uncertainty, and/or lack

of knowledge about how to recognize, manage and promote MH that made participation challenging. Regarding non-responders, it would have been beneficial to understand why they declined participation, since a larger data set may have altered the results and affected the study's resonance [36]. However, since it was a constructivist grounded theory approach, data guided the data collection process. The result should be viewed as a part of a larger puzzle and can be used to generate hypotheses for further research in the field.

## Conclusions

Being a relationship builder to initiate the dialogue was a complex construction depending on the PHNs' MHL and the organizational capacity concerning MH. It cannot be assumed that all PHNs have the MHL needed to recognize MHP and to encounter patients with MHP, which thus creates a variety of ways to manage the encounters. The PHNs also experienced various degrees of organizational capacity about how to manage and support MH encounters, which led to frustration and feelings of being abandoned in the encounter. Narratives of the public health nurses helped to construct a theory and understand the conditions for recognizing, managing, and promoting mental health in primary health care, knowledge that could inform future intervention development and research to improve MHL.

## Abbreviations

LU	Lund University
MH	Mental health
MHL	Mental health literacy
MHP	Mental health problems
PHC	Primary health care
PHN	Public health nurse

## Supplementary Information

The online version contains supplementary material available at <https://doi.org/10.1186/s12912-023-01340-7>.

Additional file 1.

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## Authors' contributions

All authors (E.N., S.J., L.B. and U.B.) made substantial contributions to the design, data analysis and interpretation of data; involved in drafting the manuscript or revising it critically for important intellectual content; given final approval of the version to be published. First author (E.N.) and third author (L.B.) gathered data and conducted the interviews. Each author have participated sufficiently in the work to take public responsibility for appropriate portions of the content; agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved. The author(s) read and approved the final manuscript.

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## Availability of data and materials

The datasets generated and/or analysis during the current study are not publicly available due to ethical considerations from the participants' point of view, but are available from the corresponding author on reasonable request.

## Declarations

### Ethics approval and consent to participate

The research was performed in accordance with the ethical practice outlined in the declaration of Helsinki [53]. In this study, no intervention was made on the participants or other intervention in the manner specified in Sect. 4, was no treatment of personal data in the manner specified in Sect. 3 of the Swedish Ethical Review Act [54]. Against this background, and that the participants were asked about their professional experiences, the study is not covered by the provisions of §3–4 the Swedish Ethical Review Act [54] and should therefore not be ethical reviewed. According to declaration of Helsinki and Swedish Ethical Review Act [53, 54], informed consent and confidentiality was adhered. The participants received written and verbal information from the operating manager and the interviewers (EN and LB) about the study aim, design and the voluntary nature of participation and confidentiality. Their written informed consent was obtained according to the principles of autonomy [55].

### Consent for publication

Non applicable.

### Competing interest

All Authors (E.N., S.J., L.B. and U.B.) declare that they have no conflict of interest.

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Paper II







# Patients' lived experience of seeking, visiting, and receiving primary health care for their mental health problems – a descriptive phenomenological study

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## Abstract

**Background:** As a first in line health service Swedish primary health care is in a unique position to deliver mental health support and care to a person with mental health problems. Mental health services delivered in Primary health care still focuses on diagnosis, medical treatment, and symptom reduction. To access mental health services in primary health care is perceived challenging for both providers and patients. An increased understanding of how the lived experience of seeking, visiting, and receiving primary health care are, may benefit how primary health care can deliver a tailor suited mental health services to its patients.

**Aim:** To explore the lived experience of seeking visiting and receiving primary health care for a person with mental health problems

**Method:** A descriptive phenomenology by Giorgi. 11 in depth interviews was conducted, between October 2022- to April 2023.

**Results:** The informants age ranged from 20- 66 (Median 40) years of age and had range 1,5- 18 years (median 12 years) of experience of mental health problems. The result will provide us with knowledge of how it is to seek, visit and or receive primary health care for mental health problems. We hope to use the knowledge provided in another co-designed study of how a person-centered mental health dialogue can support and guide health professionals in their dialogues of mental health encounters.

**Conclusions:**

*Key words:* Mental Health Problems, Primary Health Care, First in line Service, Mental health Service, Public Health.

# Introduction

The World Health Organization (WHO, 2021) description of mental health services (MHS) of today is to deliver health care based on a traditional patient-centered care approach, where focus is on diagnosis, medication, and symptom reduction. It is also concluded that health care overlooks the impact of social determinants on health, and that persons with mental health problems (MHPs) lack access to and adequate health care and support. Mental health needs are not met and MHPs is a growing public health concern (WHO, 2022). Primary health care (PHC) in Sweden has a responsibility and is in a unique position to provide persons with MHPs support, being the first in line health service to help manage and ease suffering (SFS 2017:30; SOU 2020:19). However, to access and maintain MHS in PHC are perceived as challenging for both those receiving and providing care across PHC centers (PHCC) (Ross et al., 2015; Wakida et al., 2018). A solution for this, and one of the prerequisites for the organization and delivery of MHS, is a PHC grounded in a person-centered approach (WHO, 2003; 2021). A person-centered approach is one of the corner stones of the good quality and local health care act reform in the Swedish health care services, including PHC (SOU 2020:19).

Mental health problem is a broad concept encompassing many aspects, from challenges experienced in everyday life to having severe mental disorders (WHO, 2003). It is reported in the Swedish National public health survey published by the Public Health Agency of Sweden (PHAS, 2022) that there is a general increase of MHP among Swedish citizens, especially among women. Furthermore, youth and young adults (16-29 years of age) are estimated to have the highest prevalence of MHP. Youth also reports the highest prevalence of suicide thoughts (PHAS, 2022). Furthermore, MHPs is common reason for seeking PHC (The Swedish Agency for Health and Care Analysis, SAHCA, 2017) and MH diagnoses are one of the most common among all (Sundqvist et al., 2017). Screening for suicide on a routine basis in a caring and active listening way is one example of how to support early recognition support for health professionals in their encounter with a person seeking care for their MHP is lacking (Nilsson et al., in press; Roos af Hjelmsäter, 2019). Patients with MHP express a fear of encountering negative attitudes and stigma when seeking care; they describe a vulnerability and loss of autonomy (Richards et al., 2019). A trusting relationship and tailored care, in line with the person-centred approach, are critical for how patients with MHPs perceive quality of care (Ashcroft, 2021b, Ford et., 2019; Reeves, 2018, Richards et al., 2019).

Ever since 2008 the PHC has adapted to the approach of person-centeredness (WHO, 2008), although it is primarily shaped in a patient-centered health care organization (Reeves, 2018). MHS differs between PHC organizations in local communities as well as between regions (Ashcroft et al., 2021a; 2021b). However, collaboration care model (CMM) has contributed to the adaption process of a more holistic approach where seeing the patient behind the diagnosis is fundamental (Vojtila et al., 2021). Today, there are still known barriers to the implementation process of

integrating MHS to PHC (Wakida et al., 2018), such as; health professionals' attitudes and stigma towards mental illness (Corrigan et al., 2014; Vistorte et al., 2018), knowledge and skills, motivation to change create pivotal barriers, as well as management, leadership, resources and strategies in the PHC organization (Ashcroft et al., 2021a; Nilsson et al., in press; Wakida et al., 2018) and lack of patient involvement during the implementation and evaluation process (Baxter et al., 2018). Much focus is still on delivering and improving existing models rather than on providing tailored MH care based on personal preferences, interests, and needs (Reeves, 2018; WHO, 2021). There is a lack of early recognition and intervention to promote MH today (Arvidsdotter et al., 2016; Nilsson et al., in press). Unless health professionals' have been exposed to persons with MHPs as a significant other (Mårtensson et al., 2014), or to patients whom they have built partnerships with (Nilsson et al., in press). This indicates that health professionals' mental health stigma can be targeted by educational initiatives and exposing them to the lived experience of MHPs (Mårtensson et al., 2014).

The involvement of patients in the development of care has been claimed as fundamental, meaning that those who are the most affected by the supposed problem should be involved in finding solutions (Ocloo & Matthews, 2016). The voices of lived experience of health conditions and being patients are therefore critical to explore for the transition to a person-centered practice. Exploring care seekers' lived experience of seeking, visiting, and receiving PHC is essential to understand their needs and expectations. The derived knowledge could further inform the development of a person-centered practical tool for clinicians to open up the dialogue for mental health (Farmer et al., 2017; Nilsson et al., in press; Reeves, 2018). An increased understanding of how PHC is perceived may also benefit and inform the health care delivery in general and hence outcomes for persons with MHPs (Reeves, 2018).

In previous research on care seekers experiences, seeking, visiting, and receiving MHS varies according to that the availability and access to MHS differs in- and between PHC centers (Ashcroft et al., 2021b). Furthermore, public stigma and negative attitudes are frequently described as being associated with the negative experiences of PHC (Keeley, 2014; Royal Kenton et al., 2019). In a Swedish study, care seekers described their experience as "hiding behind a mask" (Arvidsdotter et al., 2016). It was as a way for them to cope with the discomfort of seeking care for their worry, anxiety, or other symptoms of MH suffering (Arvidsdotter et al., 2016). They have also described it as having a devalued view of themselves (Yanos et al., 2008). Many of them are likely to internalize public stigma (Hanisch et al., 2016), which self-stigma becomes an obstacle for presenting MHPs and thus for successful treatment and recovery (Gulliver et al., 2010). A contributing factor for these negative attitudes among professionals' is their lack of sufficient knowledge of MH and lived experience of MHP (Lexén et al., 2021; Papachristopoulos et al., 2023; Porter et al., 2019; Vistorte et al., 2018; Wakida et al., 2018).

The involvement of patients in the development of care has been claimed as fundamental, meaning that those who are the most affected by the supposed problem should be involved in finding solutions (Baxter et al., 2018; Ocloo & Matthews, 2016). The voices of lived experience of health conditions and being patients are therefore critical to explore for the transition to a person-centered practice. Exploring care seekers' lived experience of seeking, visiting, and receiving PHC is essential to understand their needs and expectations, what matters to them. Such knowledge could possibly inform the development of practical tools for professionals to recognize and support an open dialogue about MH in their person-centered practice (Farmer et al., 2017; Nilsson et al., in press; Reeves, 2018). An increased understanding of how PHC is perceived may also benefit and inform the health care delivery in general and hence outcomes for persons with MHPs (Reeves, 2018) and may reduce the experienced inequalities care seekers with MHP are describing (Farmer et al., 2017; Nilsson et al., in press, Reeves, 2018). There is a knowledge gap with regard to how care seekers experience MHS in PHC in a Swedish context, and what matters to them and new knowledge of care seekers lived experience of MH encounters is warranted.

## Methods

### Aim

To explore patients' lived experience of seeking, visiting, and receiving primary health care for their mental health problems.

### Study design

To meet the study aim we chose a phenomenological approach by Giorgi (1997, 2000, 2005). The approach is grounded on Husserl's philosophy of phenomenology. Husserl's acknowledge meaning of a persons' life world as their conciseness directed to a phenomenon, providing us with descriptions in writing or speech, different understandings by how the phenomenon is presented to them (Giorgi, 2005). In phenomenology the data consist of descriptions of meaning of a phenomenon, using bracketing to identify the essences of the phenomenon (Giorgi, 2005).

### Context and setting

In phenomenology the data consist of descriptions of meaning of a phenomenon, using bracketing to identify the essences of the phenomenon (Giorgi, 2005). During the process of constructing the interview guide and during the data collection, *Reduction* was for us as researcher/s essential of being conscious and reflecting critically over our own experiences of the phenomenon (Giorgi, 2005). The chosen scientific perspective

is health sciences and particularly from a person-centered approach. A person-centered approach is according to Ekman et al. (2011) based on the perspective of the person seeking care, a person with capabilities is to be viewed as an active partner in the decisions concerning his/her own care and treatment in collaboration with health professionals. The research context was PHC (SAHCA, 2017). We choose to view PHC from a first in line health service to health actors with a greater responsibility of providing health promotive and prevention activities (SFS 2017:30). PHC context for us is therefore County Councils PHCC, school health services, student welfare and elderly care in Municipalities. In our research group our experienced knowledge ranged from being a novice researcher within the field of PHC and mental health to researchers within a multi-disciplinary research group and national research network context within the field of mental health and user involvement and co-production. The experienced knowledge also spans from presenting with to working as health professionals with persons with MHPs in a PHC or MHS context.

In this study, we used purposeful sampling. To reach out to potential informants, an ad with information about the study was created, involving criteria for inclusion (i.e., seeking, visiting, or receiving care for MHPs in PHC <5 years, >16 years of age, communicate in Swedish, and not being cognitive lucid). A picture was included to reflect the area of mental health and PHC. To attract young adults (highest prevalence of MHPs) as informants the picture was informed by young adults, who gave verbal and written input on four prechosen pictures (chosen by first author). Secondly, based on their comments, new pictures were selected to allow for a joint decision among authors. The information ad was digitally distributed on social media platforms of user organisations and research platforms or printed on posters to be put up on information boards at PHC, including school health services. The ad was in turn linked to a webpage at Lund University where potential informants could register their interest of participation. Potential informants were contacted thru a “Showing interest” e-mail with written information about the study aim, if they still were interested the potential informants replied or signed the informed consent form. A second e-mail was sent as a reminder, if there still was no corresponding the informant was not contacted again.

## **Data collection**

The interviews were guided by an interview guide constructed by the authors. It was inspired by Matua (2015), Giorgi (2005), and Robinson & Englander (2007) with open-ended questions to capture rich data with an open attitude of why, how, and what it meant for the informants lived experiences of the phenomenon (see Table 1). The aim was to support the narratives to be as precise and detailed as possible, and with a minimum number of generalities or abstractions. In-depth interviews were conducted. Individual interviews were conducted during October of 2022 to April of 2023, by primarily EN (first author) and secondarily by SJ (third author). A consensus discussion of the interview guide was held at an initial stage and focused on being open to the phenomenon (setting our own knowledge and preunderstanding at hold) and a critical

discussion of the relevance of the probing questions with the aim to capture the narrative of the informants' lived experience was performed, also described as the *Intentionality* (Giorgi, 2005). The interview took place at a secured LU-Zoom platform provided by the Lund university, LU, using a password and managed on servers within the EU (LU, 2022). When the recruitment and enrollment of informants had been open for 6 months, 14 informants had showed their interest of participation. Informed power was considered found after 11 performed interviews after a discussion between researchers based on Malterud et al. (2016) characteristics of informed power. The interviews lasted between 34 to 80 minutes, median 43 minutes were audio recorded and then transcribed word by word. Socio- demographic characteristics was collected to support the data analysis

**Table 1.** Examples of questions and examples of probing questions in the interview guide inspired by Matua (2015), Giorgi (1997), and Robinson & Englander, 2007)

---

Aim:

**Can you describe your experience of seeking, visiting, or receiving PHC for your mental health in detail?**

**What happened?**

Could you describe your latest PHC encounter for your mental health?  
What was positive?

What was negative?

**How did it happen?**

Could you describe what prompted you to seek PHC for your mental health?

Could you describe your strategies for dealing with your mental health?

**How did the event effect you as a person?**

How did you experience the encounter with health professional?

Which strategies did/do you use in contact with PHC?

**Probing questions**

Can you describe a specific situation in detail?

You mentioned XXX, can you please explain what you mean by that?

---

## Data analysis

The data analysis will be initiated when the data collection has been finalized. In the descriptive phenomenology analysis by Giorgi (2005) it starts by reading and re-reading the data and by listening to the interviews to hear the tone and the timbre of the voices, to get a sense of concrete descriptions of specific situations within the natural attitude of the phenomenon. The researchers will employ the phenomenological reduction, which means bracketing previous knowledge, the description from the informants is understood to be what the human experience is presented to, their consciousness is taken as presences. The analysis will involve all authors to search for essence (invariant meanings), structures of meaning that describe the general structure of the lived experiences of seeking, visiting, and receiving PHC for their MHPs. Throughout the construction of the result, the researchers will aim to understand and untangle their own perception and experienced knowledge of the phenomenon

## Rigour

The seven practical implications described by Shorey and Ng (2022) guided the conduction of this descriptive phenomenological study (i.e., research objective, design, use of theoretical framework, sampling procedure, data collection, analysis, and presentation of findings). In addition, the Consolidated Criteria for reporting Qualitative Studies (COREQ) 32-item checklist was used to promote quality of reporting qualitative data (Tong et al., 2007).

## Results

Fourteen informants were enrolled to take part of the study, all were contacted and sent information about the study. Eleven informants responded and gave their written consent to participation. Two informants were non-responders, and one declined participation after receiving initial information. The socio- demographic of the informants' (See Table 2) age ranged from 20-66 years, with a median of 40. Six informants had university degrees, while four had upper higher education and one stated a vocational degree. The average experience of MPH ranged from 1,5-18 years of experience (median, 12 years). Five informants had been in contact with a physician during their last encounter for their MHPs in PHC.

**Insert table 2 Demo  
(Now placed at the end of the manuscript)**



## Discussion

During the data collection process our interviews was held through zoom, which has shown to be an alternative high-quality data source (Renosa et al., 2021) when aiming at receiving a variation of experiences not constrained to the whereabouts of the researcher. All authors have attempted to withhold a phenomenological attitude towards the research question by constructing an interview guide by describing how we used reduction of the phenomenon. (a) bracket past knowledge about the lived experience of seeking, visiting, and receiving care for persons with MHPs in PHC, to encounter the phenomenon freshly and describe it precisely as it is intuited (or experienced), and (b) to withhold the existential index, which means to consider what is given precisely as it is given, as a phenomenon (Giorgi, 1997).

## Limitations

.

## Conclusion

## Abbreviation

CCM= Collaboration Care Model; CM= Care Manager; MH = Mental Health; MHP= Mental Health Problems; MHS= Mental Health Services, LU= Lund University; PHC= Primary Health Care; PHCC= Primary Health Care Centres; PHAS= The Public Health Agency of Sweden; SAHCA= The Swedish Agency of Health and Care Analysis

## Declaration

### **Ethical considerations**

Informants who were interested to take part of the study, showed their interest by filling out an interest form on the “In Dialogue for MH” projects homepage ([www.cepi.lu.se](http://www.cepi.lu.se)). The informants were given written and verbal information about the study by the research team. Informants gave their written approval to take part of the study. This study followed the ethical principles of the Helsinki declaration (World Medical Association, 2013) where the benefits outweigh the potential risk of participation for the informants, at any time of the data collection process, the informants could withdraw their participation without further questioning. Ethical approval was obtained by the Swedish Ethical Review Authority, Dnr: 2022-02164-0

### **Consent for publication**

Non-Applicable

### **Availability of data and materials**

The datasets generated and/or analysis during the current study are not publicly available due to ethical considerations from the participants’ point of view but are available from the corresponding author on reasonable request.

## Declaration of interest

All Authors (E.N., S.J., L.B. and U.B.) declare that they have no conflict of interest.

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## Author contributions

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Table 2. Socio-demographic characteristics of the informants

Informants	Age*	Gender	Educational background	Current employment	Experience of MHP*	Last Professional Encounter
1	42	F	Vocational training	Self-Employed/ Sick leave	18	Physician
2	20	F	Upper Secondary School	Employed	5	Psychologist
3	40	M	University Degree	Employed	2	Counselor/Therapist
4	48	F	University Degree	Employed	14	Physician
5	26	F	University Degree	Student/ Employed	1,5	Psychologist
6	32	M	Upper Secondary School	Unemployed	10	Counselor/ Therapist
7	66	F	Upper Secondary School	Retired	12	Physician
8	31	M	University Degree	Employed	15	Physician
9	26	F	Upper Secondary School	Employed/ Sick leave	12	Physician
10	40	F	University Degree	Employed	5	Specialist Nurse
11	46	F	University Degree	Employed/Sick leave	12	Psychologist
Mean (range)	38 (20-66)				10 (1,5-18)	
Median	40				12	

\* Years









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