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District nurses’ perspectives on detecting mental health problems and promoting mental health among community-dwelling seniors with multimorbidity

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District nurses’ perspectives on detecting mental health problems and promoting mental health among community-dwelling seniors with multimorbidity

Aims and objectives: To describe district nurses’ (DNs’) perspectives on detecting mental health problems and promoting mental health among homebound older people with multimorbidity

Background: Mental health problems among older people with multiple chronic conditions, i.e., multimorbidity, are challenging issues. These patients’ homes often serve as arenas in which DNs can promote health. Mental health promotion must be studied in greater depth within primary care because older people with multimorbidity are particularly prone to developing poor mental health, which can go undetected and untreated.

Design: A descriptive, qualitative study using semi-structured interviews and content analysis.

Methods: Twenty-five DNs completed individual or focus group interviews. Data were analyzed using qualitative content analysis.

Results: Most DNs stated that detecting mental health problems and promoting mental health were important tasks but that they typically focused on more practical home health care tasks. The findings revealed that DNs focused on assessment, collaboration and social support as means of detecting mental health problems and promoting mental health.

Conclusions: The DNs described various factors and actions that appeared to be important prerequisites for their involvement in primary mental health care. Nevertheless, there were no established goals for mental health promotion, and DNs often seemed to depend on their collaboration with other actors. Our findings indicated that DNs cannot bear the primary responsibility for the early detection of mental health problems and early interventions to promote mental health within this population.

Relevance to clinical practice: The findings of this study indicated that workforce training and collaboration between different care providers are important elements in the future development of this field. Early detection and early treatment of mental health-related issues should also be stated as explicit objectives in the provision of care to community-dwelling older people with multimorbidity.

Key words: aging, district nurse, mental health, mental health promotion, municipal care, Sweden
What does this paper contribute to the wider global clinical community?

- This study adds increased knowledge about DNs' detection of mental health problems and promotion of mental health among seniors with comprehensive care and support needs from different providers.

- The findings of this study may further clarify the prerequisites for DNs to complete tasks and take responsibility in providing primary mental health care to seniors with multimorbidity.
District nurses’ perspectives on detecting mental health problems and promoting mental health among community-dwelling seniors with multimorbidity

Introduction
Seniors with multiple chronic conditions (multimorbidity) are particularly prone to developing a poor quality of life (Fortin et al. 2004). Furthermore, multimorbidity is associated with mental health issues among seniors (Jones et al. 2015). In Sweden, seniors with multimorbidity often live in the community, with their homes serving as health-promoting arenas for encounters with professionals, such as district nurses (DNs). Health promotion is stipulated by law, and general practitioners (GPs) and DNs in primary care have been assigned the primary responsibility for promoting health (Wilhelmsson & Lindberg 2009). However, community-dwelling seniors with multimorbidity may lack health-promoting dialogues that could promote their mental health (Grundberg et al. 2014). The present study refers to community-dwelling seniors with multimorbidity as patients or older people living at home.

Background
Multimorbidity among older people has been associated with anxiety, depression (Jones et al. 2015) and frequent primary care visits (Fortin et al. 2004). Homebound older patients with multimorbidity are dependent on personnel from municipalities and county councils. The organizations that provide health and social services to homebound older people vary across European countries (Genet et al. 2011). In Sweden, the health care system is organized into national, regional and local levels (Anell et al. 2012). Furthermore, home health care is primarily the responsibility of the county council and is provided by DNs in primary care settings. GPs and DNs bear the primary responsibility for health promotion among patients of all ages in Sweden (Wilhelmsson & Lindberg 2009). Swedish DNs are specialized registered nurses who completed 50 weeks of extra training (75 European Transfer System [ECTS]) and post-registration as a nurse beyond a bachelor's degree in nursing (Sherman et al. 2012). These nurses receive patients at health care centers (HCCs), aim to prevent disease among and
promote the health promotion of housebound patients and provide care to primary care patients of all ages and (medical) diagnoses (Wilhelmsson & Lindberg 2009). The job also involves prescribing patients with chronic conditions, e.g., diabetes or incontinence, specific medicines, technical materials and equipment. DNs in primary care supply health care to homebound seniors (Wilhelmsson & Lindberg 2009) with the support of homecare aides (HCAs) from municipal home help services. These HCAs support patient autonomy by enabling seniors to remain in their homes for as long as possible (Perissinotto et al. 2012). DNs often delegate the administration of medicine to the HCAs providing social services in the community (Craftman et al. 2013).

Swedish DNs offer preventive home visits, including health promotion dialogues, to all individuals aged 75 years or older (Sherman et al. 2012), and preventive home visits have often been considered a health promotion activity (Stuck et al. 2002, van Haastregt et al. 2000). In addition, DNs play a key role in holistic care (Barker et al. 2014) and address mental health problems (Haddad et al. 2005), such as depression, which is one of the most underdiagnosed and undertreated health conditions in the primary health care system (Rouchell 2000).

From this perspective, previous studies have aimed to increase our understanding of the delivery of mental health care within the context of the primary care setting (Barker et al. 2014, Haddad et al. 2005, Rouchell 2000). Limited research has been conducted on DNs’ involvement and specific training in the detection and treatment of mental health problems, such as anxiety or depression. Thus, the promotion of the mental health of older people with multimorbidity must be studied further within primary care because this population is particularly prone to developing poor mental health. Considering that undetected mental health problems might be left untreated (Rouchell 2000), we aimed to increase the understanding of DNs’ experience of delivering mental health care to older people with multimorbidity.

**Aim**
The aim of this study is to describe DNs’ perspectives on detecting mental health problems and promoting mental health among homebound older people with multimorbidity.

Methods

Design
The study adopted a descriptive, qualitative design using individual (Kvale & Brinkmann 2009) and focus group interviews (Krueger & Casey 2009) to explore DNs’ experiences with and knowledge of the research topic. A qualitative interview allows the researcher to understand the participant’s perceived experiences and unique perspectives (Kvale & Brinkmann 2009). In the current study, the data were analyzed in accordance with the qualitative content analysis technique inspired by Graneheim and Lundman (2004).

Participants
The interviewees were 25 DNs from different primary health care centers in the Stockholm region. They were selected according to a chain sampling technique known as snowballing (Polit & Beck 2008), and the inclusion criterion was any experience of caring for homebound older people with multimorbidity. The first author (ÅG) contacted a local, politically neutral professional association for DNs, which distributed written information about this study. Professionals who were interested in the study contacted the first author and decided whether they wished to participate in an individual or focus group interview. Then, an interview venue and time were selected. Seven of the 25 participants preferred individual interviews, and the remainder were assigned to one of three focus group interviews, each including five to seven participants. The informants were women between 31 and 83 years of age. Two participants were also specialized registered nurses in mental health care (60 European Transfer System [ECTS]). Four DNs had a bachelor’s degree, and six had a master’s degree in nursing. Most of them had completed formal education in Motivational Interviewing (MI). Their professional experience as DNs ranged between four months and 34 years. Most of the participants worked full time, and one retired DN (83 years old) was employed part time and provided services when other DNs took vacations.

Data collection
Individual and focus group interviews were conducted to extend our understanding of the participants’ experiences with homebound older people suffering from several chronic conditions. The first author (ÅG) conducted all of the semi-structured interviews. The interviews began with a question about the interviewees’ experiences detecting the mental health problems of older people with multimorbidity and views of how these patients’ mental health could be promoted. Follow-up and probing questions were utilized to learn more about the participants’ experiences. The interviewer then briefly summarized the content and asked whether the participants’ answers had been properly captured and understood. At the end of each focus group interview, the interviewer repeated the two main questions and asked whether the participants had any further thoughts to add. The semi-structured interviews lasted between 31 and 52 minutes, and the duration of the focus groups was between 44 and 65 minutes. All interviews were recorded and collected from November 2013 to April 2014.

**Data analysis**

The interviewer were transcribed the interviews verbatim and subsequently re-read them several times to assess the material. All transcripts were coded and checked for accuracy using the corresponding audio file. The data were analyzed using an inductive, manifest and latent content analysis developed by Graneheim and Lundman (2004), as described in a recent study (Grundberg et al. 2014). According to Sandelowski (1998), crucial insights can arise from different individuals’ interpretation of data. In this study, four authors, one of whom was a trained DN (ÅG), read the material independently to gain a sense of the complete text. Two authors (AH, ÅG) then re-read all the interview transcripts to ensure consistency with the aim of the study and with the qualitative content analysis. Units of text, such as sentences, whole paragraphs or words, that seemed to answer the two research questions were highlighted, condensed into a description of their manifest content and coded. We analyzed the individual and focus group interviews separately because the results could differ in depth or data richness. All the individual interviews were designated as one unit, and all focus group interviews were labeled as another unit. All codes were then compared based on similarities and dissimilarities and were organized into three categories and eight subcategories. In the final step, the underlying meaning of the material was formulated into an overarching theme that encompassed all the categories (Table 1).

**Rigor**
The study’s reliability was enhanced through careful monitoring of the analysis process and documentation of this process in a matrix. For the sake of consistency, the first author conducted all of the interviews using an interview guide, and the second author documented the process of all focus group interviews to ensure that the first author identified quotations during transcription. These two authors also performed the majority of the analysis. All four authors read all transcripts and discussed all steps of the analysis, the findings and reliability until consensus was reached.

**Ethical considerations**

The study was approved by the Regional Ethics Board (No. 2008/149-31 & 2015/45-31) at Karolinska Institutet. Ethical considerations were applied to every step of the procedure. Participants received written and verbal information about the study and provided their written consent to participate.

**Results**

Most DNs stated that detecting mental health problems and promoting mental health were important tasks but that they typically focused on more practical home health care tasks. The analysis showed no obvious differences in the findings from the seven individual and three focus group interviews. These results are presented collectively in three main categories: Assessment, Collaboration and Social Support. The theme “Being competent and accessible for continuous assessment and individualized support in the home environment” captured means of detecting mental health problems and promoting mental health (Table 1).

**Assessment**

Several DNs stated that to detect mental health problems, health care professionals – including themselves – could observe patients’ home environment (e.g., messy), behavior, (e.g., poor appetite), and emotional changes (e.g., starting to cry very easily). In these matters, the DNs had to provide continuity and begin the dialogues with these patients because the patients rarely expressed their emotions or issues concerning mental health:
I do believe that you have to know the person well to detect mental health problems … because not everyone tells us or shows it at once.

According to the DNs, patients without multimorbidity typically discussed their mental health issues while talking about their medical conditions. DNs reported that the assessment of a patient’s behavioral and emotional changes over time, through personal interviews or assessment instruments, was necessary to properly assess mental health status. According to several DNs, depression, anxiety, sleep problems and phobias were the most common mental health problems among the studied population. Most participants preferred using more structured, open-ended questions or MI. DNs also considered sufficient time to be an important factor in detecting mental health problems through questions, assessment instruments or patient self-reporting:

Their social situation may, for instance, be reflected when you ask questions associated with health promotion dialogues with 75-year olds…then you may discover these things … and then you have the time to ask questions about family and relatives, and how do you feel?

**Collaboration**

Most DNs viewed collaboration with other health care professionals as essential because they considered their own assessments of the patients’ states of mind to be insufficient. The DNs discussed their patients with other caregivers, (GPs, psychologists or counselors) if such professionals were available in their organizations. The DNs also wanted to consult physicians specializing in geriatrics or psychiatry so that they could gain knowledge about mental health issues among elderly people or refer some of their patients to professionals in mental health care:

Sometimes I can feel that these patients should receive earlier attention from the psychiatric profession … sometimes it feels like they have to be half a person … it has to have gone very, very far … before … they can get any help … If they got help much earlier then it wouldn’t be so hard … or difficult … it would get easier … and perhaps it could be alleviated or cured … or whatever.

A number of DNs believed that they had sufficient competence to identify states of depression, anxiety and sleep disturbance. Conversely, the DNs seemed dependent on other
health care and social service providers’ knowledge about a specific patient’s mental health status or how to promote the patient’s mental health. Some of the DNs asked the patients’ close relatives, neighbors, social caregivers and former health care professionals about their impressions of the patients’ state of mind. DNs also advocated increased teamwork with other professionals so that they could increase their own and others’ knowledge about mental health issues. Several DNs described themselves as the coordinator of collaboration among caregivers:

I often feel like the hub of the wheel … taking care of … and trying to find … I think we are … in our organization or at least at my place … kind of … it starts a process … and then you try to solve the problem!

Most participants expressed that they needed increased competence regarding mental health promotion activities and information about the resources that society could provide for community-dwelling older people. These DNs also wanted to increase their knowledge about how to motivate a patient to engage in social and physical activities. Some participants wanted to learn more about how to identify patients at risk for suicide using questions or instruments that identify general mental health problems:

I know too little … I need to learn more … not just only asking questions … to understand … how I should … get inside those who are … so sad and difficult and closed and … yes … to open a few more doors.

Most participants considered detecting mental health problems and promoting mental health to be important tasks. Several DNs reported that they did not have sufficient time for these tasks because they were assigned more practical tasks. The DNs stated that it was quite difficult to be responsible for older peoples’ mental health, and they seemed to depend on other professionals’ information about patients. Identifying mental health problems and promoting mental health were regarded as joint operations for primary care and municipal social services. Collaboration and good relationships with HCAs were viewed as important because HCAs often contacted the DNs and informed them of cases. Several DNs expressed the importance of increasing HCAs’ knowledge about general health problems, especially mental health problems such as anxiety and depression. Other DNs wanted to be more active in supervising HCAs because they often met older people regularly and therefore possessed
important information, such as information about weight loss, decreased compliance with medication, and emotional or behavioral changes:

Yes, the home care aides may contact us ... so we should give them a bit more information ... and if they have knowledge about somebody ... who is in need of home care from our side of course ... for example, those with mental illnesses.

**Social Support**

Most participants reported that older people with multimorbidity appeared to require different types of social support or supportive assistance from other people because they primarily lived alone and felt lonely. According to the DNs, this unwanted loneliness seemed to explain why older people living alone, especially women, felt sad and developed depression. If the seniors had few visitors and few opportunities to leave their homes, they likely experienced further isolation and worsened mental health. A number of DNs stated that they sometimes performed regular home visits to check a patient’s mental health status or to reduce the patient’s feelings of loneliness. The importance of providing informational support about the positive effects of physical and social activities was mentioned several times:

You feel better being ... yes, both physically activity and doing things ... and that you meet other people. Being stimulated both physically and mentally ... because it is not going to get better just sitting home alone ... and wondering ... and many [patients] that I have observed ... they sit and dwell on things. They feel sorry for themselves and end up in some kind of vicious circle that can't improve the depression, dysphoria or anxiety ... they end up in a declining downward spiral.

A few DNs informed the patients about their medical illnesses, current medical treatments or suitable physical activities. Others provided examples of instrumental support, such as contacting other professionals or personnel via telephone, and practical help in terms of prescribing food supplements, following up with current medications or delivering prescription drugs from the pharmacy to the patient’s home. Other DNs stated that they referred patients to special interest organizations, churches, or municipal social care or contacted other health care professionals or the patient’s relatives or care managers (CMs) within the gerontological social work sphere who could organize different social activities or increase social support:
The support could be phoning [the patient] regularly, checking how they are doing … helping them with … basic things … like booking different appointments and so on … not anything else but … that you help and are available as support to coordinate or that you talk to the care manager if there is something that does not work or …

One DN reported that she talked with her patients about their futures and informed them that a DN would always be available to them. Other DNs provided examples of different types of emotional support, such as engaging in supportive dialogue to discuss everyday problems:

Well, it could be about relationships … with children … worries about finances, how to manage … or that somebody … a wife or husband who is ill, and that is the most important topic.

Several DNs repeatedly stated that supportive dialogue was dependent on continuity and the time available because it was important to sit down, listen and reflect on the patient’s narrative about medical illnesses and life situations – without necessarily suggesting different solutions. Other participants mentioned that they typically talked about the patients’ relatives in a relaxed fashion to distract patients from anxiety or worries about the future. Some DNs stated that their role was to help elderly patients express their emotions and thoughts and change their perspectives about their lives. Other DNs expressed a supportive dialogue typically involves discussing the weather or more positive, cheerful or pleasant topics because patients sometimes need help stopping negative thoughts:

But, we [the DNs] tried to liven her up [the patient] … because if you visit the patient on a daily basis … in some way … you don't want to dig down there [pointing at the floor] all the time without trying to be more positive and talking about nicer, fun things.

According to some DNs, recurrent supportive dialogues were important for introducing a framework for an open dialogue, which could help patients feel more confident about describing their true feelings and whether their mental health was expressed in negative or positive terms. DNs also attempted to encourage and motivate patients to live a healthier lifestyle on a continuous basis and to ask patients about what might improve their mental health:
One important question to ask when you notice that they [the patients] are sad or feeling down is … What makes you feel better? When do you feel more alert and feel better? In which situations? And then they can describe things like … that they enjoy company when eating meals or when they can get out and leave their homes.

**Discussion**

This paper focuses on DNs’ perspectives regarding the detection of mental health problems and the promotion of mental health among community-dwelling elderly patients. The primary results of this study indicated that no guidelines or structured goals were established in mental health care for the studied patients. Furthermore, the participants did not express that the early identification and treatment of mental illness or the early implementation of interventions that promote mental health was important. In addition, the continuous assessment of the patients’ behaviors and emotions in their home environment seemed crucial for detecting mental health problems. These assessments could be compared with evaluations of cognitive and physical impairment and observations and questioning about individuals’ state of mind. According to these findings, to assess patients’ state of mind or facilitate dialogue about more general health-promoting topics, DNs needed to ask relevant questions and help patients verbalize their current emotions. The participants seemed to prefer structured and open-ended questions when assessing a patient’s mental health status. Despite their experience, several DNs wanted more knowledge about interview techniques and assessment instruments in this process. Furthermore, the study found that patients preferred to discuss their physical conditions rather than their mental health. Therefore, different scales may be useful for identifying somatization problems in persons with poor mental health (Kroenke et al. 2010).

Furthermore, DNs’ mental health promotion actions indicated that they primarily engaged in counseling to promote a healthy lifestyle in general, referred patients to other professionals, actors or agencies, and continuously provided different types of social support. Social support seemed crucial because loneliness and social isolation were described as the main causes of depression. Two aspects of social support that DNs provided were instrumental and informational support. Instrumental, or practical, support involved prescribing food supplements and following up on and evaluating current medications, which they delivered to the patients’ homes. This information mainly concerned current medical illnesses and social
and physical activities, which seemed to be crucial factors for, and important actions in, mental health promotion. As we know, the maintenance of the health status of older people with multimorbidity is an important goal in itself; thus, the optimal care of these patients should encompass the assessment of different factors that may lead to negative health status and further actions that may address these factors (Bayliss et al. 2007). Although the DNs seemed certain of the positive effects of different psychosocial interventions and completed formal training in MI, they experienced difficulties in motivating patients to participate in social activities. They also appeared to believe that patient training in current medical treatment and the expected effects of physical and social activities would improve patients’ knowledge about medication and promote their overall health. Although the DNs may have good intentions with their health education, patients with multimorbidity and depression should be provided with a proactive, integrated collaborative care approach, which could be delivered in collaboration with practice nurses in primary care (Coventry et al. 2015).

Although the size of the impact might be difficult to determine, collaborative care that integrates short, low-intensity psychological interventions may reduce depression and improve self-management among patients with physical and mental multimorbidity (Coventry et al. 2015).

DNs also provided emotional support. Specifically, they described engaging in supportive dialogues to help the patient adopt a more positive mood. Such dialogues were typically geared toward supporting the patient in expressing his or her emotions and thoughts that could assist in detecting mental health problems and motivating the patient to embrace a healthier lifestyle. Some of the DNs in this study appeared to have difficulties in providing emotional support, which was mainly provided in an unstructured manner without a conscious or explicit purpose or goal. The main question that arises is how DNs can evaluate mental health promotion activities, such as social support, without setting goals. In addition, with the aim of promoting mental health, nurses should focus on a patient’s lived experience of mental health and how his or her health may be promoted in general (Hedelin & Strandmark 2001).

However, although social support could decrease feelings of anxiety and depression, the recipients must continue to have the ability to choose and perform actions independently to maintain their autonomy (Warner et al. 2011).

According to further findings of this study, resources appear to be a crucial prerequisite for home visits and mental health care. Although the interview guide did not pose questions about
timing or DN resources, most DNs expressed that they lacked time for these assignments. Most DNs seemed to believe that detecting mental health problems and promoting mental health were important tasks but that more personal resources, i.e., time, were necessary for these assignments. This time aspect was partly in line with the results of our earlier study, which showed that older people with multimorbidity wanted partners who were accessible to engage in dialogue that could improve their mental health (Grundberg et al. 2014). The findings of this study may be explained by the DNs’ feeling of responsibility for more practical tasks related to the patient’s chronic medical conditions. Nevertheless, accessibility is an important factor because DNs could feel as though they had to choose between health promotion and disease-oriented work (Wilhelmsson & Lindberg 2009). Another potential explanation is that the DNs believed that detecting mental health problems and promoting mental health were only partly their responsibility or that they were dependent on other actors to fulfill these responsibilities. They also desired more teamwork and seemed to depend on collaboration with other caregivers regarding patients’ status and the mutual exchange of knowledge to improve their own and other care providers’ competencies in mental health care. Several DNs reported that their own professional competencies appeared to be an important factor and that they wished to be more skillful and knowledgeable in detecting mental health problems and providing mental health promotion activities for homebound older people. The DNs also wanted to discuss issues with – or refer specific patients to – other health care professionals to improve their competencies in mental health and geriatric care. These findings may reflect insecurity in this field of work because DNs may be concerned about their knowledge and skills in supporting their patients with mental health needs (Barker et al. 2014). Furthermore, several DNs seemed to feel as though their knowledge and skills were insufficient, and they struggled with their involvement, responsibility and workload for competing assignments. This finding should be compared with that of a prior study, which showed that DNs’ attitudes toward mental health problems, such as depression, seemed to be crucial determinants of aspirations to work in this field and develop their professional competencies in this area (Haddad et al. 2005).

Collaboration, especially with caregivers such as HCAs and CMs, was regarded as crucial. The DNs typically referred older people to HCAs and CMs for social and physical activities. The DNs seemed especially dependent on HCAs and seemed to lack structured, planned meetings for collaboration with and supervision of several HCAs. These findings are in agreement with those of a recent study that found that DNs wanted improved collaboration.
with HCAs, which could be more easily achieved if both professionals were governed by the same authority (Craftman et al. 2013). However, because of the current organization of home care and home health care, it seems reasonable to focus on providing these patients with integrated care. Thus, patients with complex, comprehensive care needs within primary care should be managed using collaborative care models involving interprofessional competencies (Stans et al. 2013). In addition, a comprehensive continuum of care intervention may be successful if it includes care planning in the patients’ homes and with case managers and a multi-professional team (Berglund et al. 2013). Finally, the DNs in this study also lacked a structured forum for collaboration with physicians, such as GPs, regarding matters of the mental health care of these patients. In addition, better collaboration between health care professionals could improve the development of primary health care professionals’ competencies so that they could share the burden of addressing the mental health problems of patients with multiple chronic conditions (Berk et al. 2014). Collaborative care, including individualized and comprehensive care planning, can also lead to improvements in health status and people's capacity to self-manage their chronic conditions (Coulter et al. 2015).

Strengths and limitations

When conducting this study, the authors initially experienced difficulty in identifying a sufficient number of DNs who had time to complete an interview. Regarding the trustworthiness of a qualitative study, Graneheim and Lundman (2004) emphasized that the concept of credibility arises when determining the focus of the study, selecting the context, and sampling and collecting the data. The participants were chosen with the notion that they would contribute to the dissemination of experience likely to be found in the context of primary care. According to this experience, snowball sampling (Polit & Beck 2008) seemed to be an appropriate strategy for recruiting participants into a study in which they chose whether to participate in an individual interview or a focus group interview. However, allowing individuals to recommend other participants for a study could result in bias (Faugier & Sargeant 1997) because participants who are very interested in and share similar experiences with a topic may be recruited, which could be regarded as sampling bias. Therefore, the findings of this study must be interpreted with caution (Faugier & Sargeant 1997). The use of two methods of data collection may initially be regarded as a limitation; however, combining
individual interviews and focus groups may enhance data richness and increase the reliability of the findings (Lambert & Loiselle 2008). To further increase reliability, all four authors were involved in the analysis and discussed the findings until consensus was reached.

**Conclusion**

The DNs described various factors and determined actions that appeared to be important prerequisites for their involvement in primary mental health care. Nevertheless, there were no expressed goals for mental health promotion, and DNs often seemed to be dependent on their collaboration with other actors. Our findings indicated that the DNs cannot bear primary responsibility for the early detection of mental health problems and early interventions to promote mental health within this patient population. Based on these results, we believe that implementing effective mental health promotion activities in the community, including risk assessment, and reducing the occurrence of mental and behavioral disorders are possible only when effective partnerships are developed between core stakeholders. Further research should focus on the HCA perspective on mental health problems and how the mental health of community-dwelling older people with multimorbidity may be improved.

**Relevance to clinical practice**

DNs in primary care settings are expected to promote health despite patients’ ages and medical conditions. Professionals such as DNs must also actively identify and participate in managing mental health issues. Risk assessments and screening by health care professionals in primary care are also extremely valuable for the early identification of mental health problems, such as depression. These tasks must be emphasized because the responsibility seems to be more significant in the face of an ongoing movement against increased integration of mental health care within the context of primary care. The findings of this study indicated that workforce training and collaboration between different care providers are important elements in the future development of this field. Early detection and early treatment of mental health-related issues should also be stated as explicit objectives in the provision of care to community-dwelling older people with multimorbidity.
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Contributions
Study design: ÅG, DR: data collection and analysis: ÅG, AH, PH, DR; and manuscript preparation: ÅG; with comments from: AH, PH, DR

Conflicts of interest
No conflicts of interest have been declared by the authors.

References


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<tr>
<th>Examples of meaning units</th>
<th>Subcategory</th>
<th>Category</th>
<th>Theme</th>
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<tr>
<td>And then that is not always explicit, but you can see… or they cannot sleep or have poor appetites or… well, such little things that they do not even… relate to… mental illness.</td>
<td>Behaviors</td>
<td>Assessment</td>
<td>Being competent and accessible for continuous assessment and individualized support in the home environment</td>
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<tr>
<td>Then, I see a change… I see that… something has happened … and you usually notice it is the case in their judgment… that they become emotional very easily; they start to cry very easily.</td>
<td>Emotions</td>
<td></td>
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<td>In conjunction with drug screening, we have a form that I do not know. It is different where you work I think, but where there are mental… it's sort of health, how they perceive their lives, and if they feel concern about something in life… so if you experience depression and… It is quite detailed… three, four, five or perhaps even six questions about the mental part.</td>
<td>Instruments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>But, it's also… knowing how doctors work and the resources they have… if I can get the support and help needed for this patient… and also knowing how, where to turn and various collaborations. So… it takes a little while before you learn this.</td>
<td>Instruments</td>
<td>Transfer of knowledge</td>
<td>Collaboration</td>
</tr>
<tr>
<td>Personnel from the home help service said she was… very low and depressed… and I met her only every other week… so it was not so often … and so it can of course also be… that these [home care assistants] pay attention to it…</td>
<td>Transmittal of information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I may have information about contacts… for all these different… associations, meeting places and group activities.</td>
<td>Informational support</td>
<td></td>
<td>Social support</td>
</tr>
<tr>
<td>I can help them [the patients] call the home care manager to hear if they [the patients] can get social daycare.</td>
<td>Instrumental support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drop in [for home visits] and discover in time, to be there, give support… to help so that they could have… Many [patients] need to talk about themselves… just sit down for five minutes and talk with them.</td>
<td>Emotional support</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>