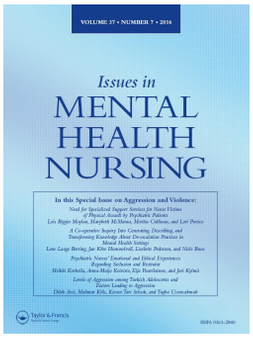

Issues in Mental Health Nursing

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/imhn20

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To cite this article: Øyfrid Larsen Moen , Hege Skundberg-Kletthagen , Lars-Olov Lundquist , Marianne Thorsen Gonzalez & Agneta Schröder (2020): The Relationships between Health Professionals' Perceived Quality of Care, Family Involvement and Sense of Coherence in Community Mental Health Services, Issues in Mental Health Nursing, DOI: 10.1080/01612840.2020.1820119

To link to this article: https://doi.org/10.1080/01612840.2020.1820119

Published online: 29 Sep 2020.

ISSUES IN MENTAL HEALTH NURSING
https://doi.org/10.1080/01612840.2020.1820119

The Relationships between Health Professionals' Perceived Quality of Care, Family Involvement and Sense of Coherence in Community Mental Health Services

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ABSTRACT

Mental health professionals have a responsibility to ensure the best possible quality of care. Family is strongly involved in the patient's everyday life. The aim of this study was to investigate the relationship between health care professionals' perception of the quality of care, attitudes of family involvement and their own sense of coherence. A descriptive quantitative study with fifty-six health professionals, completed "Quality in Psychiatric Care–Community Outpatient Psychiatric Staff", "Families' Importance in Nursing Care–health professionals' attitudes", "The Sense of Coherence Scale-13". The health professionals perceived quality as high and did not perceive the families as a burden.

Introduction

Due to the transition from inpatient to outpatient care, treatment and care in community mental health services has developed and increased considerably (The Norwegian Directorate of Health, 2014; Sather et al., 2018). Consequently, more patients with mental health challenges live at home, where their families become more involved and have more responsibility in the patient's everyday life (Aass et al., 2020). This situation affects the health professionals' work situation and also requires family involvement in their clinical work (Ministry of Health and Care Services 2014). Addressing the family as a system implies having an understanding that change or worsening of mental health in one family member will influence the family as a whole (Wright & Leahey, 2012). This family approach allows health professionals to address the interaction among, and between, family members and the challenges within the family (Shajan & Snell, 2019).

Historically, health professionals have often addressed families as either causing or aggravating mental illness (Marshall et al., 2003; Riebschleger, 2001). Families themselves have also tended to support hospitalisation of their family members and have thereby contributed to institutionalisation (Jones, 2002). This is understandable, as family members experience a lot of responsibility when a person suffering from mental illness is living at home, and they often ask for cooperation with professionals in community mental health services (Aass et al., 2020).

Mental health professionals have a responsibility to provide the best possible quality of care to people with mental illness (Nashrath et al., 2011; World Health Organisation, 2006). The extent to which the best quality of care occurs is influenced by the attitudes of professionals (Middleton et al., 2004) and their work situation (Takase et al., 2001). Hence, the professional's own perceptions of the quality of care is a significant indicator when measuring perceived quality of care (Arnetz, 1999). Health professionals' positive attitudes to the families' involvement in the patient's care are crucial for facilitating a therapeutic change (Marshall & Harper-Jaques, 2008). Moreover, Ewertzon et al. (2010) describe how family members may experience negative attitudes from the health professionals in relation to their involvement in care. This can create feelings of alienation in families with regard to involvement in care. Thus, a positive attitude from the mental health professionals regarding family care involvement is of great importance in ensuring that each family member and the family as a whole are offered high quality of care (Sveinbjarnardottir & Svavarsdottir, 2019). This is important as patients' (or family members') experiences of high quality of care are reported to be associated with improved treatment outcomes and improved quality of life (Blenkiron & Hammill, 2003). Likewise, the families'

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involvement in care may be effective in reducing the patients' distress (Dixon et al., 2010). Considering that patients living at home and receiving follow-up support in community mental health services, the families' involvement may improve quality of care. For this to happen, families and health professionals need to reach a mutual understanding of the complex situation.

The community mental health service represent an ever-changing service, and can be characterised as stressful (Ministry of Health and Care Services Norway, 2014). A stressful working environment often affects the mental health professionals' abilities to provide good quality of care (Weigl et al., 2015) and thereby contribute to experienced stress. The Sense of coherence (SOC) construct reflects a person's capacity to respond to stressful situations (Antonovsky, 1996). Sense of coherence encompasses the degree to which the individual perceives life as meaningful, comprehensive and manageable, as well as how people understand, manage and make sense of change (Antonovsky, 1996). For nurses as health professionals, meaningful relationships with their patients have always been a major issue in their ongoing commitment to their work since the humanistic caring paradigm requires nurses to develop a deep personal and interpersonal understanding and sensitivity when providing quality in care (Mackenzie et al., 2006). Studies have shown that mental health professionals who reported strong SOC, believe they have resources available to meet the demands in their work environment, and perceive these demands as challenges worthy of investment and engagement (Levert et al., 2000). The degree to which the work environment is regarded as organised, predictable and explicable also plays an important role in making the demands in life manageable (Antonovsky, 1996; Levert et al., 2000). It is further reported that SOC influences job satisfaction in mental health nurses (Ando & Kawano, 2018). SOC may be influenced by working conditions, as well as working resources (control, role clarity, social support from colleagues and social support from supervisors). People with a resourceful working environment may help to build and strengthen their SOC (Vogt et al., 2016). To our knowledge, the relationship between perceived quality of care in community mental health services and the health professionals' SOC, has not yet been explored. Furthermore, the attitudes of health professionals towards families' involvement in the community mental health care service, need to be further explored. This study, therefore, addresses these issues.

Aim

The overall aim of this study was to investigate the relationship between health care professionals' perceptions of quality of care, attitudes towards family involvement and their own sense of coherence.

The following research questions were addressed:

1. Are there any differences in the health professionals' personal characteristics and their perception of quality in care, and attitudes towards families' involvement?
2. Are there differences in the health professionals' sense of coherence level and their perceptions of quality in care, and attitudes towards families' involvement?
3. What characterises the multivariate relationships between health professionals' gender, sense of coherence, work experience, attitudes towards family involvement, and quality in care?
4. Are there differences across the different profession groups conserving quality in care, and attitudes towards families' involvement?

Methods

Design

The study has a quantitative cross-sectional design.

Study setting

In Norway, the municipalities are required by law to provide mental health care to their residents (Health and Care Services Law, 2011). Health professionals in community mental health services for persons over 18 years old include a range of professions: General Practitioners (GP) (not included in this study), occupational therapists, nurses, social educators, social workers and psychologists, some with further education (family therapy/mental health/cognitive therapy). To some extent, these professionals have similar responsibilities towards the patient, but they also undertake different responsibilities and tasks. This include preventing and reducing problems, as well as promoting mental health and patients' coping in everyday life (e.g., housing, employment, reducing dropout from schools, social inclusion, personal economy and day care) (Ministry of Health and Care Services Norway, 2014).

Sample

Mental health professionals working in Norwegian municipalities were the target group for this study. Selected municipalities were urban and rural, located in central, north and south parts of Norway. The managers of the mental health services in 17 of the 356 Norwegian municipalities administered the invitations (envelope with an invitation letter and a questionnaire). All the mental health professionals who met the inclusion criteria e.g. working in the community mental health service with adults having a mental illness and having at least one year of work experience, were asked to participate.

The mental health professionals received an information letter and those who agreed to participate received and responded to the questionnaire at their workplace. They returned the written consent from and the questionnaire by mail directly to the research team. A gentle reminder was distributed 1 month after the first distribution of the questionnaires directly to all the health professionals to avoid informing the managers of who was participating in the study.

Fifty-six health professionals, mostly women (n = 50) aged between 24 and 68 years (M = 45.7, SD = 10.8) agreed to participate. The sample consisted of nurses (n = 31), social educators (n = 17) and other occupations as occupational therapists, social workers and psychologists (n = 7). About 82% of the professionals had further education in mental health. The length of time in the present occupation ranged from 1–42 years (M = 17.8, SD = 10.6).

Data collection

Data were collected with use of one complete questionnaire composed by three standardised and validated instruments, as well as questions regarding age, gender, nationality, occupation, work experience, further education in mental health and experience of serious illness in their own family. The data collection took place from November 2017 to May 2018.

Instruments

Quality in Psychiatric Care – Community Out-patient staff (QPC-COPS). The Norwegian QPC-COPS is based on the Swedish instrument Quality in Psychiatric Care – Outpatient care staff (QPC-OPS) (Schröder & Lundqvist, Ongoing). The QPC-COPS consists of 30 items that cover health professionals' perceptions of quality of care in eight dimensions: *Encounter* (items 11, 12, 15, 18, 20, 25), *Participation; Empowerment* (items 1, 5, 6), *Participation; Information* (items 13, 14, 27, 29, 30), *Discharge* (items 8, 17, 21), *Support* (items 19, 22, 23, 24), *Environment* (items 2, 4, 9), *Next of Kin* (items 10, 28) and *Accessibility* (items 3, 7, 16, 26). The responses are given on 4-point Likert type scales, ranging from 1 (totally disagree) to 4 (totally agree). For each item it is also possible to answer, "Not applicable." The total scale score ranges from 30 to 120 for the whole instrument; the higher the score, the more positive the health professionals' perceived quality in care. The original Swedish QPC-OPS was translated and back-translated by professional translators into Norwegian and adapted to the Norwegian cultural context (Skundberg-Kletthagen et al., 2020). The internal consistency for the total, in the original Swedish QPC-OPS Cronbach's alpha was 0.94 (Schröder & Lundqvist, 2020) and in the first adaption into Norwegian cultural context Cronbach's alpha of 0.91 (Skundberg-Kletthagen et al., 2020) and Cronbach's alpha coefficient for the total QPC-COPS in the present study was 0.87.

Families' Importance in Nursing Care – Nurses attitudes' (FINC). The FINC measures health professionals' attitudes towards including families in care. The instrument consists of 26 items comprising four dimensions: *The family as a resource in care* (items 3, 4, 5, 7, 11, 13, 20, 21, 22), *The family as a conversational partner* (items 1, 6, 9, 12, 14, 15, 19, 24), *The family as a burden* (items 2, 8, 23, 26), and *The family as its own resource* (items 16, 17, 18, 25). The items are rated on 4-point Likert scale (Strongly disagree to Strongly agree). The scores range from 1 to 4 for each item and each item had an alternative "Not applicable" response (5). The dimension *The family as a burden* has negatively valued items, and were reversed in the calculation of the mean of the total dimension. The total scale score ranges from 26 to 104 for the whole instrument; the higher the score, the more supportive are the health professionals' attitudes towards families (Benzein et al., 2008). The original Swedish FINC was translated and back-translated into Norwegian by the research group, and some items were reworded to fit the context of Norwegian community mental health service. To fit the context, health professionals working in this service other than nurses were able to answer. The Cronbach's alpha coefficient of the Swedish FINC is reported to be 0.88 (Benzein et al., 2008). In the present study the Cronbach's alpha coefficient was 0.87.

The Sense of Coherence Scale-13 (SOC-13). SOC-13 was developed from the original 29-item version by Antonovsky (1987). The items address the degree to which participants experience various aspects of life as meaningful, comprehensible and manageable (Antonovsky, 1996). This instrument is reported to adequately represent the construct captured with the full version of the SOC scale (Antonovsky, 1993). This version consists of 13 items rated on 7-point scales with the anchors defined. The total scale score ranges from 13 to 91, with higher scores denoting a stronger SOC. The Cronbach's alpha coefficient is reported to be 0.86 (Moen et al., 2015). In the current study, the Cronbach's alpha was 0.81.

Data analysis

Statistical analyses were performed by using IBM Statistics SPSS, version 25.0. Descriptive statistics with frequencies, percentages, means and standard deviations were used. The SOC-13 scores were divided into two groups, giving Group 1 with low to medium scores, 30–70 (n = 27), and Group 2 with the higher scores, 71–90 (n = 29) as previously modelled by Antonovsky (1987). Comparisons between groups were analysed using the Mann-Whitney U test, and for differences between three or more groups the Kruskal-Wallis test with Mann-Whitney U test as a post-hoc test. To test the hypothesis that mental health professionals' sense of coherence and their attitudes to family involvement influence perceived quality of care a linear multiple regression analysis was performed with QPC-COPS as a dependent variable' with, gender, work experience, FINC and SOC-13 serving as independent variables. All tests were two-tailed and the p-value $p < 0.05$ was regarded as statistically significant.

Ethical considerations

Ethical research principles were followed during the entire research process (The World Medical Association, 2018). The principles of autonomy and confidentiality were emphasised, with information given on the right to withdraw. The participants were taken care of in that they could

Table 1. Quality in psychiatric care for health professionals in community mental health services.

QPC items by dimensions	M	SD
Total QPC–COPS (30 items)	**3.22**	**0.27**
Encounter (6 items)	3.48	0.40
11. Shows empathy	3.45	0.54
12. Cares if patients get angry	3.36	0.52
15. Respects the patients	3.55	0.50
18. Shows understanding	3.34	0.50
20. Has time to listen	3.38	0.56
25. Cares about patients' treatment and care	3.64	0.49
Participation—Empowerment (3 items)	**3.19**	**0.51**
1. Patients have influence over their care	3.29	0.58
5. Patients' view of the right care is respected	3.09	0.61
6. Patients take part in decision-making about their care	3.20	0.62
Participation—Information (5 items)	**3.20**	**0.40**
13. Benefit drawn from the patient's earlier experience of treatment	3.36	0.52
14. Patients helped to recognise signs of deterioration	3.20	0.62
27. Patients informed in a way that they understand	3.18	0.58
29. Patients have knowledge about their mental troubles	3.29	0.59
30. Patients receive information about treatment alternatives	2.91	0.70
Discharge (3 items)	**3.21**	**0.37**
8. Patients' treatment helps	2.95	0.40
17. Patients are offered help in finding occupation	3.12	0.67
21. Patients know where to turn	3.55	0.63
Support (4 items)	**3.39**	**0.47**
19. Stops the patients from hurting others	3.07	0.78
22. Stops the patients from hurting themselves	3.13	0.77
23. Nothing shameful about having mental troubles	3.62	0.56
24. Shame and guilt must not get in the way	3.71	0.50
Environment (3 items)	**2.99**	**0.40**
2. Trust the health care professionals	3.14	0.58
4. Feel secure in their own home	2.98	0.58
9. Feel secure in their own neighbourhood	2.80	0.59
Next of Kin (2 items)	**3.04**	**0.45**
10. Next of kin invited to take part	2.64	0.80
28. Respects next of kin	3.47	0.60
Accessibility (4 items)	**3.00**	**0.39**
3. Easy for the patients to contact the contact person by phone	3.18	0.57
7. Easy for the patients to get an appointment with the contact person	3.41	0.53
16. Easy for the patients to reach the contact person by phone	3.09	0.55
26. Easy for the patients to contact the doctor/GP by phone	2.25	0.70

reach the researchers by e-mail and phone for questions or other reasons. The study was approved by the Norwegian Social Science Data Services (NSD), ref. no: 54962.

Results

Health professionals' perceptions of quality in psychiatric care

The ratings of QPC-COPS were generally high, 82% had mean scores over 2.5 (the mean of the total scale). The Encounter dimension had the highest scores and the Environment and Next of Kin dimension had the lowest scores. The items with the lowest scores were: "Easy for the patients to contact their doctor/GP by phone" (M = 2.25, SD = 0.70) "Next of kin invited to take part" (M = 2.63, SD = 0.80) and "Feel secure in their own neighborhood" (M = 2.80, SD = 0.59). The items with the highest scores were: "Nothing shameful about having mental troubles" (M = 3.62, SD = 0.56) "Shame and guilt must not get in the way…." (M = 3.71, SD = 0.50) and "Cares about the patient's treatment and care" (M = 3.64, SD = 0.49) (Table 1).

To investigate personal characteristics and influence on perceived quality in care, the health professionals' work experiences were divided into three groups. The group of health professionals with more than 21 years of work experience (n = 21), rated the total quality of care lower (M = 3.10, SD = 0.23, X = 6.24, $p < 0.04$) than those with less than 10 years of experience (n = 13) (M = 3.27, SD = 0.23) and those with 11 to 21 years of experience (n = 22) (M = 3.29, SD = 0.29). The health professionals with more than 21 years of work experience also rated the Encounter dimension as lower (M = 3.30, SD = 0.39, X = 6.35, $p < 0.042$) than those with less than 10 years of work experience (M = 3.64, SD = 0.32). The Participation-Empowerment dimension was rated lower by the health professionals with more than 21 years of work experience (M = 2.86, SD = 0.42, X = 14.53, $p < 0.001$) compared with those with less than 10 years of experience (M = 3.41, SD = 0.49) and those with 11 to 21 years of experience (M = 3.38, SD = 0.44).

Health professionals' attitudes towards families' involvement in care

Analysis of the FINC data showed that the health professionals generally had a positive attitude to family involvement with scores for the mean of total scale FINC instrument of (M = 3.06, SD = 0.37). The health professionals were positive about including the families in the community mental health service and they did not perceive the families as a burden. The dimension "Family as a conversational partner" had the lowest mean scores (M = 2.74, SD = 0.48). The items with the lowest ratings were; "I invite family members to have a conversation at the end of the patient contact period" (M = 2.12, SD = 0.76), "I invite family members to actively take part in the patient's care" (M = 2.18, SD = 0.72) and "I invite family members to speak when planning care" (M = 2.36, SD = 0.70). The items with highest scores were: "It is important to find out what family members a patient has" (M = 3.77, SD = 0.43), "A good relationship with family members gives me job satisfaction" (M = 3.68, SD = 0.54) and "It is important to spend time with families" (M = 3.63, SD = 0.52). The results of the FINC dimensions are presented in Table 2. There was a significant difference in the mean score in the dimension "Family as a resource in care" between mental health professionals who had experience of serious illness in their own family and those who had no such experience. Those who had experienced illness in their family (n = 34) had higher mean scores (M = 3.33, SD = 0.39) than those without this experience (n = 18) (M = 3.07, SD = 0.43, Z = 1.99, $p < 0.047$).

Health professionals' sense of coherence

The health professionals' average score on the SOC-13 was M = 74.38 (SD = 7.77). There were no SOC-13 differences related to the professionals' ages. However, when comparing

Table 2. Description of families' importance in care.

Item by dimension	M	SD
Total FINC (26 items) Total score 79.80	3.06	0.37
Family as a resource in care (FAM-RNC) Total score 32.14	**3.25**	**0.42**
3. A good relationship with family members gives me job satisfaction	3.68	0.54
4. Family members should be invited to actively take part in the patient's care	3.07	0.74
5. The presence of family members is important to me as a health professional	3.38	0.56
7. The presence of family members gives me a feeling of security	2.84	0.78
10. The presence of family members eases my workload	2.93	0.71
11. Family members should be invited to actively take part in planning patient care	2.93	0.63
13. The presence of family members is important for the family members them selves	3.14	0.52
20. Getting involved with families gives me a feeling of being useful	3.15	0.70
21. I gain a lot of worthwhile knowledge from families that I can use in my work	3.46	0.57
22. It is important to spend time with families	3.63	0.52
Family as a conversational partner (Fam-CP) Total score 21.90	**2.74**	**0.48**
1. It is important to find out what family members a patient has	3.77	0.43
6. I ask family members to have a conversation at the start of the patient's contact period	2.55	0.97
9. Discussions with family members during first care contact saves time in my future work	2.93	0.76
12. I always find out what family members a patient has	3.18	0.79
14. I invite family members to have a conversation at the end of the patient contact period	2.12	0.76
15. I invite family members to actively take part in the patient's care	2.18	0.72
19.I invite family members to speak about change in the patient's condition	2.80	0.72
24. I invite family members to speak when planning care	2.36	0.70
Family as a burden (Fam-B) Total score 13.24* (6.70**)	**3.39**	**0.40**
2. The presence of family members holds me back in work	3.43	0.68
8. I don't have time to take care of families	3.11	0.85
23. The presence of family members makes me feel that they are checking up on me	3.27	0.80
26. The presence of family members makes me feel stressed	3.46	0.63
Family as own resource (Fam-OR) Total score 12.11	**3.05**	**0.53**
16. I ask families how I can support them	2.82	0.82
17. I encourage families to use their own resources so that they have optimal	3.00	0.81
18. I consider family members as co-operating partners	3.34	0.67
25. I see myself as a resource for families so that they can cope as well as possible with their situation	3.05	0.56

Rated 1–4 (strongly disagree to strongly agree).
*Values in Fam-B has been turned from negative to positive (**neg value of the total).

the two SOC groups, the low SOC group 1 (n = 27) rated the total measures of QPC-COPS as lower (M = 3.14, SD = 0.28) than the high SOC group 2 (n = 29) (M = 3.28, SD = 0.27, Z = 2.52, $p < 0.04$). There were statistically significant differences between the two groups regarding the other dimensions of QPC-CPOS. The low SOC group 1, rated the dimensions lower than the high SOC group 2: Encounter, Discharge, Environment, Accessibility (Table 3).

The low SOC group 1, rated the family more as a burden, (reversed values) (M = 3.24, SD = 0.38) in FINC than the high SOC group 2 (M = 3.53, SD = 0.37, Z = 2.69, $p < 0.002$).

To investigate the association of gender, work experience, attitudes towards family involvement and sense of coherence and quality of care, the linear regression analysis showed that the independent variables explained 19.8% of the variation in the dependent variable, QPC-COPS ($p < 0.02$). After controlling for gender, work experience, attitudes towards family involvement and sense of coherence, only SOC-13 showed statistically significant relationship with QPC-COPS (β 0.36, $p < 0.007$). Hence, the higher SOC, the higher perception of QPC-COPS.

Differences across professions concerning QPC and FINC

In respect of analyses related to profession groups (Table 4), nurses rated the Participation-Empowerment dimension in QPC-COPS lower (M = 3.08, SD = 0.47) than the other professions (M = 3.33, SD = 0.53, $p < 0.048$). The Environment dimension in QPC-COPS was rated greater by nurses (M = 3.11, SD = 0.32) than the other professions (M = 2.86, SD = 0.44, $p < 0.04$). There were no differences regarding the health professionals' work experience or profession and total FINC. Furthermore, the nurses had higher ratings of the 'Family as a resource in care' dimension (M = 3.33, SD = 0.35) than the other professions (M = 3.16, SD = 0.48, $p < 0.021$). Nurses also had higher ratings of the 'family as own resource' dimension in FINC (M = 3.16, SD = 0.69) than the other health professionals (M = 2.92, SD = 0.43, $p < 0.005$).

Discussion

The overall aim of this study was to investigate the relationship between health care professionals' perception of the quality of care, attitudes towards family involvement and their own sense of coherence. The main findings illustrate that the mental health professionals perceived the quality of care as high and that the family was not perceived as a burden in their clinical work. However, they regarded the family as a conversational partner to a minor degree. SOC had a significant relationship with QPC-COPS.

Health professionals' perceptions of quality in psychiatric care (QPC-COPS)

A large number of the mental health professionals (82%) perceived the quality of care as high. This finding is in line with other studies using the QPC instrument as an in-patient staff instrument reporting from various mental

Table 3. Health professionals' perception of quality in care and families' importance in care related to their SOC.

	Low/medium SOC scores[a] (30–70) n = 27	Higher SOC scores[a] (71–90) n = 29	Mann Whitney U-test	
	M (SD)	M(SD)	*Z*	*p*
QPC total[b]	3.14 (0.28)	3.28 (0.27)	2.52	0.04*
Encounter (11,12,15,18,20,25)	3.36 (0.39)	3.57 (0.38)	2.21	0.03*
Participation Empowerment (1,5,6)	3.19 (0.43)	3.20 (0.58)	0.30	0.77
Participation Information (13,14,27,29,30)	3.17 (0.44)	3.21 (0.39)	0.56	0.58
Discharge (8,17,21)	3.11 (0.42)	3.30 (0.31)	2.01	0.04*
Support (19,22,23,24)	3.33 (0.45)	3.41 (0.43)	0.82	0.41
Environment (2,4,9)	2.85 (0.39)	3.09 (0.39)	2.30	0.02*
Next of Kin (10,+	3.00 (0.57)	3.09 (0.57)	0.92	0.36
Accessibility (3,7,16,26)	2.87 (0.38)	3.09 (0.33)	2.19	0.03*
FINC total	3.00 (0.36)	3.12 (0.38)	0.16	0.87
FINC-RCN (3,4,5,7,10,11,13,20,21,22)	3.20 (0.40)	3.30 (0.43)	0.62	0.53
FINC-CP (1,6,9,12,14,15,19,24)	2.69 (0.45)	2.79 (0.51)	1.36	0.17
FINC-B (2,8,23,26)	3.24 (0.38)	3.53 (0.37)	2.69	0.002*
FINC-OR (16,17,18,25)	3.04 (0.52)	3.07 (0.56)	0.12	0.91

[a]SOC – Sense of coherence scores divided in two groups: low/medium scores and higher scores.
[b]QPC total – The total score in QPC-COPS.
FINC total – The total score in FINC.
*$p < 0.05$.

health service contexts and cultures, for example in Indonesia (Lundqvist et al., 2019) and in Denmark (Lundqvist et al., 2014).

Moreover, some specific results related to the mental health professionals' QPC perceptions caught our interest. Considering that the Encounter dimension (which contained interpersonal relationships items) was reported as highest in QPC-COPS, this is not unsurprising as it is in line with earlier research showing that the interpersonal relationship is a central factor regarding the staff's quality of care (Schröder & Ahlstrom, 2004).

The single item related to whether patients could easily contact their doctor/GP (General Practitioner), from the Accessibility dimension had lowest scores. Considering that the GP possess a gatekeeper role to all mental health services, and the GP's having a key role in the follow-up of the patient's treatment and medication, this is a core issue to address. This finding is however in contradiction to findings reported over 10 years ago by Bjertnaes et al. (2009) in that patients perceived contact with their GP by phone as satisfactory. Regarding that more patients having mental illnesses are currently being treated by the community health services, and consequently resulted in new and often more challenging work conditions for the GP's. Additionally, the health professionals with the longest work experience (more than 21 years) rated the encounter dimension and the participation empowerment dimension as lower than did those with shorter work experience. These health professionals (more than 21 years work experience) had been working in the current service during the last year's changes, and arguably they might have perceived that the patients encounter with health professionals and the patients' participation in the service have changed.

The three single items with the highest scores in QPC-COPS were: "Shame and guilt must not get in the way" and "Nothing shameful about having mental troubles" from the Support dimension, and the item "Cares about patients' treatment and care" from the Encounter dimension (see Table 1). These findings may indicate that the health professionals in this study were aware of the painful feelings of shame and guilt, and presumably offered emphatic and supportive dialogues with the patients about their feelings. These findings can be held together with findings reported by Schröder et al. (2006) who have emphasised that patients need support from the staff in order to reduce feelings of shame and hope that staff act in a non-judgmental way when addressing these delicate issues. Likewise, Beckers et al. (2019) underlined that patients preferred support from the community mental health service as opposed to the specialist mental health service, mainly due to the absence of stigma they associated with the former services used. Sawrikar and Muir (2018) also reported that stigma was experienced both within the family and outside the family by patients as well as family members. The findings from the current study indicate that the health professionals were aware of shame and guilt and let these feelings float into treatment and follow-up. Vuokila-Oikkonen et al. (2002) reported that patients actually attempted to talk about the experience of shame, but the professionals did not seem to be interested in responding to their needs. Rather, they tended to shift the discussion to issues related to the provision of care. Thus these clinically reported findings underline the significance of offering family-centred support conversations as a supplement to other treatment in the community mental health service, and to demonstrate that this might ease the families' burden, guilt and distress (Sveinbjarnardottir & Svavarsdottir, 2019).

The dimension Environment (QPC-COPS) has the lowest scores, illustrated by the individual item also having a low score: "Feel secure in their own neighborhood". The findings might be mirrored against the findings of a meta-synthesis in which it was reported that housing tenants with serious mental illness tended to fear other tenants' behaviour, drug use and stealing (Gonzalez & Andvig, 2015). Reed et al. (2018) have also described how mental health professionals regard patients' living conditions as unacceptable, and that these facts underscore ethical and moral issues for health professionals.

SOC-13 was statistically significant, given that in the regression analysis, personnel with a higher sense of

Table 4. Comparing professions regarding Quality in psychiatric care and Families' importance in care.

	Nurses n = 28	Other health professionals[a] n = 26	Mann Whitney U-test	
	Mean (SD)	Mean (SD)	*Z*	*p*
QPC-COPS total mean[b]	3.19 (0.27)	3.26 (0.29)	0.98	0.33
Encounter [11,12,15,18,20,25]	3.40 (0.41)	3.57 (0.36)	1.55	0.12
Participation Empowerment [1,5,6]	3.08 (0.47)	3.33 (0.53)	1.95	0.047*
Participation Information [13,14,27,29,30]	3.13 (0.43)	3.27 (0.36)	1.60	0.11
Discharge [8,17,21]	3.26 (0.33)	3.15 (0.41)	1.21	0.22
Support [19,22,23,24]	3.42 (0.47)	3.38 (0.43)	0.48	0.63
Environment [2,4,9]	3.11 (0.32)	2.86 (0.44)	2.02	0.04*
Next of Kin [10,28]	3.02 (0.42)	3.08 (0.48)	0.45	0.65
Accessibility [3,7,16,26]	2.93 (0.37)	3.10 (0.39)	1.65	0.10
FINC total mean[c]	3.12 (0.37)	2.99 (0.37)	1.46	0.14
FINC-RCN [3,4,5,7,10,11,13,20,21,22]	3.33 (0.35)	3.16 (0.48)	2.31	0.021*
FINC-CP [1,6,9,12,14,15,19,24]	2.80 (0.47)	2.66 (0.49)	1.24	0.21
FINC-B [2,8,23,26]	3.25 (0.50)	3.40 (0.40)	0.87	0.38
FINC-OR[16,17,18,25]	3.16 (0.69)	2.92 (0.43)	2.80	0.005*

[a]Other health professionals – representing occupational therapists, social workers, psychologists and social educators.
[b]QPC-COPS = Quality of Psychiatric Care – Community Out-Patient Staff.
[c]FINC = Families' importance in nursing care.
*$p < 0.05$.

coherence perceive a higher degree of quality of care. The independent variables described 19.8% of the variation in the dependent variable, QPC-COPS. To our knowledge this has not been investigated before. Earlier studies (Ando & Kawano, 2018; Levert et al., 2000) have reported that those with higher SOC believe they have the resources available to meet the demands of their work situation. These demands are regarded as challenges worthy of their commitment efforts to achieve a structured and predictable work situations (Antonovsky, 1996).

Health professionals' attitudes of families' involvement in care (FINC)

In this study the health professionals in community mental health services were positive to the families in care (FINC). When comparing these findings with findings from other Scandinavian studies, the participants in the current study reported lower total scores on FINC than participants in a study from an Icelandic mental health hospital setting (Sveinbjarnardottir et al., 2011) and from a Swedish community health service setting (Benzein et al., 2008). In the Icelandic setting, those with less experience and a higher degree in mental health, perceived the family more as a burden (Sveinbjarnardottir et al., 2011). There were no significant differences between these groups in the current study. However, it is important to add that the findings in different countries and settings may not be comparable and that these issues therefore need to be further explored.

Overall, the mental health professionals did not perceive the family as a burden. This is in line with Sveinbjarnardottir et al. (2011) reporting from a psychiatric hospital setting. Interestingly, the findings from the current study endorse the use of flexible and individually adjusted support for families (Reed et al., 2018). Skundberg-Kletthagen et al. (2020) reported that mental health professionals experienced that applying a family-centered focus in their clinical practice was new and unfamiliar. However, they clearly expressed that they acknowledged the family as a resource and as a reciprocal system. The mental health professionals also described that patients' reluctance to involve family members, and patients' prejudice as fear of stigmatisation, represented hindrances and barriers that were impossible to overcome. Sveinbjarnardottir et al. (2011) reported nurses perceiving family to a minor degree as a burden after having been educated, trained and supervised in family-centred support conversations and may imply higher quality of care. Mental health professionals in the present study who had experienced serious illness in their family were more likely to report "family as a resource in care". Their personal experiences might have developed as well as their empathy and interest regarding families. This is in line with Sveinbjarnardottir et al. (2011) with mental health nurses working in hospital wards. The health professionals with the lower SOC tended to a larger degree to report family as a burden on FINC. It is anticipated that lower SOC ratings may indicate that the health professionals did not experience their work as meaningful, comprehensive and manageable (Antonovsky, 1996). This also may reflect their commitment and their relationship with the patients (Mackenzie et al., 2006).

Health professionals in the current study scored low on the Conversational Partner, dimension in FINC. The two items with lowest scores were, 'I invite family members to actively take part in the patient's care' and 'I invite family members to have a conversation at the end of the patient contact period', naming invitation of family members in planning care. These two items were also lower rated, compared to other studies that used the FINC (Benzein et al., 2008; Sveinbjarnardottir et al., 2011). The item from QPC-COPS, the Next of kin dimension, "Next of kin invited to take part" was also rated low. A number of studies have reported the complicated nature of family–staff relationships (Jervis, 2006). The mental health professionals are obviously aware of the families' right to involvement in care, but this is not always feasible, as there is not always sufficient time to enable families to participate (Sjöblom et al., 2005). The main problem, however, seems to be that the guidelines and policy regarding family involvement are missing in relevant documents (Blomqvist & Ziegert, 2011). Consequently, if the

health professionals do not themselves involve the family in the care, the family may not be offered the information and knowledge needed to support the patient in their everyday life (Schröder et al., 2007). Health professionals are legally obliged to listen to and look after the family or next of kin and to involve the family in care (The Norwegian Directorate of Health, 2014).

From the professional perspective, the registered nurses were in general more positive than the other health profession groups regarding the importance of families in care and rated the family as a resource in their clinical work and the family its own resource to a higher degree. One the other hand, the nurses rated the participation-empowerment dimension in QPC-COPS to a lower degree than other profession groups. Considering nurses as health professional group with the closest follow-up of the patients, this finding is of interest (Karlsson & Kim, 2015). The focus on nurses' attitudes and perceptions of quality of care is therefore of particular importance.

Strengths and limitations

This study has several strengths. First, it addresses the quality of family care in community mental health services, something rarely addressed. The study has three additional strengths: the use of well-established instruments with good internal consistency; all participants responded to the complete questionnaire, which implied that imputations were not necessary; and that despite the small sample size, the assumptions for using non-parametric tests (Field, 2013) and linear multiple regression (Katz, 2011) were fulfilled. The results might possibly have been somewhat different if data were collected from a larger sample. On the other hand, the results did not differ from earlier studies where the same instruments were used. Moreover, the instrument items seemed to be understood by the respondents.

The obvious limitation of the study was the low number of participants, despite several reminders. This low response rate is however, in line with survey response rates in many countries (Rindfuss et al., 2015). The low response rate may be explained by the participants completing the questionnaires at their workplaces, and due to lack of time some may have not responded. Another sample limitation was that most of the participants were women. The educational background in the participants are various. Nurses were the largest group with common educational background. The group of mental health professionals called 'other' represented occupational therapists, social workers, psychologists and social educators. The diversity of educational background may influence the results, but this also reflects the realities of the community mental health services in Norway.

Concerning the possibilities of generalizability, the study has strengths and limitations. The participants represented three out of five regions in Norway both urban and rural, most of them were women, and they represented professions working in the community mental health services reflecting in a general Norwegian context. The generalizability must be interpreted with caution but may give an indication of health professionals' perceptions.

Conclusions

The main findings in this study were that the health professionals addressed a number of deficiencies in the quality of care in the community mental health services. Overall, they rated quality of care generally high, the encounter dimension as highest and the environment and next of kin dimension as lowest. The health professionals with longest work experience rated the quality of care lower than those with less experience. Families were regarded as important and were not perceived as a burden, even though health professionals did not perceive the family as involved in the patient's care and as a conversational partner. Health professionals with lower SOC scores reported families more as a burden than those with higher SOC scores. The health professionals' sense of coherence had most impact on quality of care.

Implication for practice and further research

The findings in this study imply several clinical recommendations and contribute with important knowledge that invites for reflection as well as guide community mental health professionals and decisions makers in their improvement of their services.

Firstly, the findings that health professionals with lower SOC to a lager degree tended to report family as a burden, challenge leaders to facilitate support and supervision in order to improve the professionals' working conditions.

Secondly, the findings indicate that there is a need for some organisational changes so that family members get invitations to actively take part in the patients' care and treatment as conversational partners. On this issue, the health professionals themselves are challenged to increase their efforts.

Thirdly, the health professionals' concerns regarding the low accessibility of the GP are an important issue for the overall health care management to improve the planning and organisation of community mental health services.

Fourthly, the findings also illustrate that the health professionals, above all the nurses, need to be more alert on the patients' needs for participation in order to improve quality of care. This implies to create an environment that promotes patient participation.

Finally, the low ratings of quality of care among the professionals with the longest work experience should challenge management and decision-makers concerning what issues are at stake for improvements in the community mental health services.

Likewise, the findings call for a diversity of further research projects. To our knowledge the impact of work experience on quality of care in community mental health services has not yet been investigated and researchers are challenged to further address this issue. These studies should preferably be both qualitative and quantitative aiming for an

increased understanding of how the work experiences have an impact on quality of care, as well as how this valuable competence best can be taken care of through professional support, peer group programs or other staff care interventions or strategies.

The relationship between perceived quality of care in community mental health services and the health professionals' SOC and attitudes of involving families in care have not been investigated in previous studies. Researchers are challenged to investigate why those with low SOC rate QPC-COPS and FINC to a minor degree than those with a high SOC. It is anticipated that involving the family in the patients' care may strengthen the families, and the family can be an important collaborative partner in the care of the patient.

Overall, the health professionals were positive about including families and did not perceive the family as a burden, but they did not perceive the family as a conversational partner, and the implications related to this issue needs further investigation.

Acknowledgment

We would like to thank all participants for answering the questionnaires and the leaders in the municipalities for valuable help.

Ethics approval and consent to participate

The ethical standards from Declaration of Helsinki principles were followed during the entire research process. The study was approved by the Norwegian Social Science Data Services (NSD) (reference number 54962). All participants gave written consent to participate.

Authorship: Study design: ØLM, AS, L-OL, MTG and HS-K; data collection: ØLM and HS-K; analysis: ØLM, L-OL and AS, manuscript preparation: ØLM, AS, L-OL, MTG and HS-K. All the authors have seen this last version and agreed upon it.

Disclosure statement

The authors declare no conflicts of interest with respect to the research, authorship and/or publication of this article.

Funding

This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

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