



# An exploratory study of the experiences of being both a mental health professional and carer in mental health services in Norway

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## Accessible summary

### What is known on the subject?

- Many carers report feeling unrecognized by professional healthcare teams.
- Carers often report difficulty accessing mental health services for relatives.
- Carers who are also mental health professionals may experience role conflict as found for General Practitioners.

### What this paper adds to existing knowledge?

- Carers who are mental health professionals are often not recognized for their professional knowledge and face similar communication barriers as other carers.
- Difficulties for carers who are mental health professionals are concerned with information sharing, decision-making and continuity of care.

### What are the implications for practice?

- Opportunity for services to learn from the experiences of mental health professional and carers to develop better communication and shared decision-making methods for carers
- Carers who are mental health professionals should be recognized by services for their dual role (and skills).
- Service development opportunity for training in supporting and engaging carers who are mental health professionals

## Abstract

**Introduction:** Around 60% of carers of relatives with mental health problems report feeling unrecognized by professional health care, and many report a lack of engagement, shared decision-making and information sharing. There is a paucity of research examining these issues for carers who are also mental health professionals.

**Aims:** This was an exploratory study to (a) explore the extent of this role among health service staff, (b) gather an indication of the issues faced by carers when interacting with the health system and (c) test the feasibility of conducting research.

**Abbreviations:** UK, United Kingdom; USA, United States of America; professional and carer: a person who is both a mental health professional and a carer for a relative with mental health problems.

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**Methods:** Mental health professionals in mental health services completed an online survey that assessed the frequency, content and satisfaction of the experiences of carers.

**Results:** The sample comprised 453 mental health professionals (74% female), 52% being carers. Half of carers reported having therapist contact, and 25% were satisfied with the contact. Negative experiences were related to Information, Decision-making and Continuity of care.

**Discussion:** There was a high frequency of mental health professionals who were carers. The majority were dissatisfied, and this was primarily in relation to communication with services.

**Implications for practice:** Improving information sharing through training of staff and identification of the system barriers is likely to enhance experiences for service users and families.

#### KEYWORDS

carers, continuity of care, mental health professionals, service delivery

## 1 | BACKGROUND

Mental health problems are commonly occurring with around one third of people experiencing a mental health disorder at some stage in their lifetime. The World Mental Health Surveys reported lifetime DSM-IV disorder prevalence estimates (combining anxiety, mood, externalising and substance use disorders) as 18.1%–36.1% (Kessler et al., 2009). The 12-month prevalence estimates for serious mental illness (SMI) range from 0.8% to 6.8%. Epidemiological studies show that anxiety disorders are the most prevalent mental disorders in the general population, with estimated lifetime prevalence around 16% and 12-month prevalence around 11%. Mood disorders are the next most prevalent with lifetime prevalence around 12% and 12-month prevalence around 6%. The high prevalence of lifetime mental health disorders in the population suggests that many people will have a relative who experiences a mental health problem. Thus, there is a large proportion of the population who will be carers of relatives with mental health problems. An Australian survey reported that 15% of the adult population is carers for relatives with mental health problems (Pirkis et al., 2010) with some carers also experiencing their own mental health problems. Similarly, around 16.6% of adults in the United States of America (USA) (National Alliance for Caregiving (NAC) and the AARP Public Policy Institute, 2005) and 17% of the Scottish adult population are carers while across the United Kingdom (UK) one in five adults aged 50–64 years, and one in nine workers are carers (Carers UK, 2015). Being a carer for a family member with mental health problems has been shown to impact on the carer's well-being such as high levels of distress, family relationship difficulties and impaired social life (Lobban et al., 2013).

Carers are a valuable resource for relatives with mental health problems but nearly 60% report feeling unrecognized by the professional healthcare teams and many report a lack of direct engagement with mental health services (Lucas & Eufami, 2015). A recent literature review (Doody, Butler, Lyons, & Newman, 2017) highlighted the importance of actively involving the family/carers in a collaborative partnership aiming for shared decision-making. Carers often report difficulty accessing mental health services for relatives (Olasoji, Maude, & McCauley, 2017) with access being facilitated by carer knowledge and health professionals actively involving carers in planning (Dawson et al., 2017). For carers of relatives in forensic mental health services, the amount of information provided by the services was strongly associated with level of satisfaction with the services (Macinnes, Beer, Reynolds, & Kinane, 2013). While the use of involuntary hospitalization for mental health problems is a controversial issue in psychiatry, our research has shown that more individuals would favour involuntary admission if a family member were experiencing psychotic symptoms or suicidal intentions (Joa et al., 2017). Thus, communication with carers is integral to the treatment of relatives with mental health problems.

Collaboration with health professionals was the major predictor of Canadian carers' satisfaction with mental health services (Perreault, Rousseau, Provencher, Roberts, & Milton, 2012). There have been mixed findings for the relationship between consumer satisfaction and the effectiveness of services with evidence suggesting a bidirectional relationship between satisfaction and outcomes. For example, for youth psychotherapy, higher parental satisfaction was associated with improvement in youth reported functional impairment (Garland, Haine, & Boxmeyer, 2007). In Hong Kong, satisfaction with mental health services accounted

for only 3% of variance in quality of life of Chinese carers and was associated with difficulties in managing negative symptoms (Wong, Lam, Chan, & Chan, 2012). The risk of stigma related to mental health can be a challenge for carers for a person with mental health problems. A study among health professionals found stigmatizing attitudes even towards colleagues with mental health problems and that many participants with a mental illness feared stigmatization and discrimination from colleagues (Waugh, Lethem, Sherring, & Henderson, 2017). Being both a mental health professional and a carer for a person with mental health problems might increase the risk for such stigma exposure.

Carers of relatives on compulsory outpatient mental health treatment expressed dissatisfaction with services in respect to access to information and to health professionals (Rugkasa & Canvin, 2017). The findings suggest increasing involvement of carers in the services requires for carers to be better informed and for services to find flexible ways of ensuring continuous open communication. The study also highlighted the difficulties for carers in having multiple roles such as "proxy" for patient decision-making, "gatekeeper" to services, "mother" or "expert carer." However, both this study and the literature generally fail to address the duality for those who are both a carer and a mental health professional (mental health professional and carer). Based on professional training, the mental health professional and carer are likely to be equipped with the information needed for involvement in the services provided for their relative, thus addressing a common finding for carer involvement. The other common finding for improving carer involvement and experience, namely of having contact with the health professionals has not been explored in the literature for carers who are also mental health professionals. Carers with this dual role may experience role conflict as reported in the Rugkasa and Canvin (2017) study (Rugkasa & Canvin, 2017), and the attitude of staff towards such carers is unknown. Our study sought to explore the frequency of mental health professionals being carers for relatives with mental health problems and in particular the satisfaction of this group of carers with the mental health services.

## 2 | METHOD

Given the paucity of research focused on the mental health professional and carer role, this was an exploratory study to (a) explore the extent of this role among health service staff, (b) gather an indication of the issues faced by such carers when interacting with the health system and (c) test the feasibility of conducting research with this population. We selected a study design that would minimize participant burden in order to enhance participation in the study and reduce the likelihood of missing data through incomplete questionnaires. An online survey was determined as the best method of data collection to ensure anonymity for participants and ease of completion within the work environment and schedule. Our online survey (using the "Corporate Surveyor" questionnaire solution) was open to mental health professionals

working in the Division of Psychiatry, Stavanger University Hospital, Norway.

The inclusion criteria were being a mental health professional, employed more than 50% of full time and with direct clinical patient contact. The total eligible sample identified through the hospital administrative payroll system was 1,414 mental health professionals. Beside demographic and occupational data, a 16-item (four point Likert response format) questionnaire plus free-text response items (see Table 1 for domains and example items) based on a published questionnaire (Perreault et al., 2012) was adapted together with a person with experience of caring for a relative with mental health problems. The questions addressed both the frequency and content of the experiences of carers as well as the level of satisfaction with the mental health services. All eligible mental health professionals were sent an email from the Director of Psychiatry inviting them to participate, thus indicating endorsement from the organisation for staff to participate. After reading the information about the study in the email, the respondents who consented to participate entered the survey by logging on at the designated "web address link" routing them into the survey questionnaire. The study was conducted between April and May 2015. No personal identifiable data were collected. The study received ethical approval from the local representative of the Norwegian Data Protection Authority (Personvernombud) (#Ref. no 2015/1530).

## 3 | ANALYSIS

The analysis for this exploratory study was primarily descriptive with chi-square tests and Fisher exact test of significance conducted for the carer and non-carer groups. Analysis was conducted using IBM SPSS Statistics version 24. Free-text responses were grouped against the thematic descriptors of the questionnaire.

## 4 | RESULTS

The sample comprised 453 mental health professionals predominantly women (74.17%), and half the sample were aged 31–50 years. The response rate for the survey was 32.04%. There were no significant differences between the included sample and the hospital population of mental health professionals in regard to the distribution of profession. Around half (51.66%) of the sample reported being carers for a relative with mental health problems. Table 2 shows the demographics of the sample for both carers and non-carers. The most frequent profession of the carers was nursing (28%), and a further 13% were psychologists. Nearly half of the carers had between 6 and 20 years experience of working in mental health services, and 18.4% had received treatment for their own mental health problem. Significantly more carers received such treatment from a private psychiatrist/psychologist than non-carers ( $p < .001$ ). There were no significant group differences for the other demographic characteristics of carers and non-carers.

**TABLE 1** Survey domains and example items

Domain	Variable	Example item
Carer demographics	Age	
	Gender	
	Mental health problem	Treated by GP, psychologist
Carer occupation	Mental health services employment	Duration and recency of treatment
	Profession	Duration
Carer status	Relative type	Grandparent, child, step-parent
	Duration	Recency and duration
Relative	Mental health problem	Anxiety, depression, eating disorder
	Duration of problem	Duration and recency
	Mental health services accessed	Inpatient, day patient, outpatient
Carer experience of services	Contact with therapist	Type and frequency
	Information exchange—satisfaction	Illness, medication, crisis plan
	Transition of care/ services—satisfaction	Hospital, community mental health, primary care
	Comments on treatment	Free text
	Ways to improve	Availability of therapist on telephone Verbal information from staff Written information from staff Meetings with relative and staff Role in decision meetings

Relatives being cared for by the mental health professional were predominantly a parent (26.4%) or child (23.8%) of the carer. A further 16.7% were caring for a sibling and 6.6% for a partner. The most common mental health problem of the relative was depression (34.8%) followed by child emotional or behavioural problems (16.3%). Table 3 provides details of the range of mental health problems of the relatives as reported by the carers. The duration of illness was >10 years for 42.1% of the relatives and <1 year for 16.3% of relatives. Nearly one fifth (19.5%) of relatives had received hospital inpatient treatment, and 38.8% of relatives were currently in treatment.

Responses to satisfaction with or valued importance of mental health services are summarized in Table 4 and have been grouped under the domains of Information, Decision-making and Continuity of care. Around 70% of carers in our sample were dissatisfied with information given regarding crisis care planning, and around half the carers were dissatisfied with the degree to which they were given information about the illness or medication. The highest response rates by carers were that of being very dissatisfied with (a) the transition from community mental health centre to primary care (42.9% of carers) and (b) the crisis plan information (38.1% of carers). Direct contact with the therapist (the primary treating clinician) and ability to contact the therapist received the highest response rates for “very satisfied” (24.9% and 20.4% respectively). Just over half of carers (51.1%) reported having contact with the therapist. There were

69.1% of carers who perceived meetings with the relative and staff as very important. Oral information from staff was perceived as very important by 54.5% of carers.

Examples of the free-text responses are shown in Table 5 under the domains of Information, Decision-making and Continuity of care, and reflect both positive and negative experiences of the mental health services. Two thirds of carers reported dissatisfaction with the transition from one level of the mental health services to another such as from a community mental healthcare centre to primary care. Comments from carers included “the cooperation with the local community is not functioning at all” and “the biggest challenge in psychiatry and the rest of the treatment system is the lack of continuity.” The positive experiences reflected improved treatment outcomes for the relative such as “She was very, very ill, but thanks to her therapist she is now without symptoms.” Negative experiences included “In a very long illness period the system showed little understanding of the total burden it was for my children and myself, to care for a chronically ill person,” and “The therapists found it difficult to relate to a mother with the same education and profession as themselves.”

## 5 | DISCUSSION

Around half of the mental health professionals in our sample were carers for a relative with mental health problems compared with

**TABLE 2** Demographics of mental health professionals for carers and non-carers

	Carer (N = 234) N (%)	Non-Carer (N = 208) N (%)	Significance p-value*
<b>Gender</b>			
Female	182 (78.4%)	154 (74.4%)	$X^2(df 1, N = 439) = 1.0$ $p = .32$
<b>Age</b>			
≤30 years	27 (11.6)	33 (15.9)	
31–50 years	117 (50.4)	111 (53.6)	
51–70 years	88 (37.9)	63 (30.5)	$X^2(df 2, N = 439) = 3.49$ $p = .18$
<b>Occupation</b>			
Assistant/nursing aid	35 (15.0)	32 (15.4)	
Bachelor/Masters Health Science	125 (53.4)	105 (50.5)	
Psychologist	31 (13.2)	31 (14.9)	
Doctor/Psychiatrist	18 (7.7)	12 (5.8)	
Other profession	25 (10.7)	28 (13.5)	$X^2(df 4, N = 439) = 1.72$ $p = .79$
<b>Experience working in mental health</b>			
≤5 years	92 (39.3)	96 (46.0)	
6–20 years	122 (47.9)	83 (39.9)	
>21 years	30 (12.8)	29 (13.9)	$X^2(df 3, N = 442) = 2.90$ $p = .41$
<b>Own mental health treatment</b>			
Ever had treatment	41 (18.4)	17 (11.1)	$X^2(df 1, N = 376) = 3.69$ $p = .06$
In special mental health unit	7 (3.0)	3 (1.4)	(N = 442) $p = .35^{**}$
Private Psychologist/psychiatrist	31 (13.2)	7 (3.4)	$X^2(df 1, N = 442) = 13.69$ $p < .001$
Currently in treatment	6 (2.6)	3 (1.4)	(N = 442) $p = .51^{**}$

\*Chi-square tests.

\*\*Fisher's exact test.

only 15% of adults in an Australian population study (Pirkis et al., 2010). While our sample is from one hospital setting and therefore limits generalisation, the findings raise concern over the lack of awareness that mental health professionals may have this dual role. Other reported prevalence rates do not separately identify carers of individuals with mental health versus physical health problems. However for adult carers of a person with any health problem, the prevalence rates in the general population of 17% in USA and 20% in UK as well as a prevalence of 11% for workers in UK are substantially lower than the rate found in our small sample (National Alliance for Caregiving (NAC) and the AARP Public Policy Institute, 2005; Carers UK, 2015). Our study provides an estimate of rates of mental health professionals being carers and suggests an untapped resource for supporting people experiencing mental health problems in the use of mental health services.

Given one in five of the carers in our sample had received treatment for their own mental health problems, the findings also suggest a risk of neglecting the needs of mental health professional and carers. Family focussed interventions such as the Relatives' Education And Coping Toolkit (REACT) have been shown to improve the well-being of carers (Lobban et al., 2013). Providing knowledge and skills to carers will inform the self-management approaches to mental health care including increasing access to care.

As a group, the carers did not differ from non-carers by gender, age, profession, years of experience working in mental health services or likelihood of having received treatment for their own mental health problem. The carers were most likely to be caring for a parent (26%) or child (24%). Although time spent caring was not quantified for our sample, it is likely that caring for a first degree relative such as a parent or child will have little respite time for the carer compared to caring for

**TABLE 3** Mental health professional and carer relationship characteristics

	N (%)
Relative	
Grandparent	8 (3.5)
Parent	60 (26.4)
Sibling	38 (16.7)
Spouse/partner	15 (6.6)
Child	54 (23.8)
Other	47 (20.6)
Mental health disorder of relative	
Depression	78 (34.8)
Anxiety	34 (15.2)
Psychosis	36 (16.1)
Drug	25 (11.2)
Personality	8 (3.6)
Eating	5 (2.2)
Developmental	6 (2.7)
Emotional/behavioural (Child)	14 (16.3)
Other	18 (8.0)
Duration of illness	
<12 months	39 (16.3)
1–5 years	62 (25.8)
5–10 years	38 (15.8)
>10 years	101 (42.1)
Currently in treatment	90 (30.8)

other relatives. The most common reported mental health problem of relatives was depression (35%) while psychosis or anxiety was each reported for around 15% of relatives. The demands on the carer and the importance of communication with the health service are evidenced by one in three of the relatives being currently in treatment.

## 5.1 | Satisfaction with services

While many carers rated high levels of satisfaction with contact or ability to contact the therapist (primary treating clinician), the majority of responses to satisfaction with the mental health services showed the carers were dissatisfied. Consistent with findings reported for carers not necessarily identified as mental health professionals (Macinnes et al., 2013; Valentini et al., 2016), the carers in our sample were dissatisfied with the communication between services and themselves. Research has shown that access to services is facilitated by carer knowledge and health professionals actively involving carers in planning (Dawson et al., 2017), yet few of our carers reported satisfaction with information sharing. The knowledge and work experience of mental health professionals and carers are likely to facilitate a common language for these carers with the mental health services and

staff, thus reducing the barriers for staff in sharing information with the carers. Research also shows the major criticisms by carers of services include lack of contact, information, communication and partnership with healthcare professionals (Ruggeri et al., 2003), and our findings show this is also a challenge for carers who are mental health professionals. Given the positive relationship reported for carers between perceived collaboration with health professionals and satisfaction with services (Perreault et al., 2012) this should be addressed for mental health professional and carers. It is important to highlight the bidirectional nature of communication and the benefits to carers, relatives and health services in open communication to facilitate the sharing of knowledge and flag impending changes to the delivery of care.

Continuity of care was criticised by many of the mental health professional and carers both in ratings of satisfaction with services and in the free-text responses. Research indicates that challenges to continuity of care may be ameliorated by service providers endeavouring to reduce changes of the relational therapist for the person with mental health problems as this is perceived as a critical relationship by the relatives and carers (Valentini et al., 2016). The proposed model of family carers as a “shadow workforce” argues that family carers be considered as active partners alongside healthcare providers in the implementation of chronic care (Wong-Cornall, Parsons, Sheridan, Kenealy, & Peckham, 2017). Improving information sharing and thus enlisting the resource of mental health professional and carers in the delivery of care for people with mental health problems are likely to be cost effective. This enlisting or information sharing with mental health professional and carers should be carefully managed to avoid an over burden of responsibility placed on the carer. Family carers may translate and explain health information, navigate and coordinate services, and advocate for the needs and rights of the family member (Wong-Cornall et al., 2017). However, in parallel, it is essential to provide support for the demands on such carers and recognize the potential for stigmatization in the workplace.

## 6 | WHAT THE STUDY ADDS TO THE EXISTING EVIDENCE

There is a lack of knowledge of the interactions between services and mental health professionals who are also carers. Despite evidence that access to services is facilitated by carer knowledge and health professionals actively involving carers in planning (Dawson et al., 2017), our study found that mental health professional and carers are dissatisfied with communication with the health system. These carers through professional training are likely to have knowledge of the system, and this should facilitate such communication yet it remains a problem. Knowledge gained in this study may be of value for health professionals engaged in psycho-educational family interventions and may inform service development to improve the experiences of staff who are also carers. The findings provide a framework for services to investigate the barriers to communication

**TABLE 4** Mental health professional and carer satisfaction and perceived importance with mental health services

Service contact	Very satisfied N (%)	Somewhat satisfied N (%)	Somewhat dissatisfied N (%)	Very dissatisfied N (%)
<b>Information</b>				
Illness information given	41 (22.5)	57 (31.3)	43 (23.6)	41 (22.5)
Medication information given	31 (18.3)	42 (24.9)	45 (26.6)	51 (30.2)
Crisis plan information	20 (13.1)	24 (15.7)	51 (33.3)	58 (37.9)
<b>Decision-making</b>				
Ability to contact therapist/staff	36 (20.7)	48 (27.6)	46 (26.4)	44 (25.3)
Contact with therapist	44 (25.1)	61 (34.9)	42 (24.0)	28 (16.0)
<b>Continuity of care</b>				
Transition hospital to community mental health	11 (15.3)	18 (25.0)	19 (26.4)	24 (33.3)
Transition hospital to primary care	6 (9.7)	13 (21.0)	20 (32.3)	23 (37.1)
Transition community mental health to primary care	4 (8.0)	8 (16.0)	16 (32.0)	22 (44.0)
Therapist/GP cooperation	15 (11.4)	40 (30.3)	45 (34.1)	32 (24.2)
Service contact	Very important (%)	Somewhat important (%)	Somewhat unimportant (%)	Very unimportant (%)
<b>Information</b>				
Oral information from staff	92 (53.8)	50 (29.2)	13 (7.6)	16 (9.4)
Written information from staff	68 (40.0)	55 (32.4)	29 (17.1)	18 (10.6)
<b>Decision-making</b>				
Meetings with relative and staff	130 (70.1)	28 (15.1)	9 (4.9)	18 (9.7)
Role in decision meetings	68 (41.5)	35 (21.3)		31 (18.9)

Note: Range of response rate on single items varies between 50 and 185.

with carers and thus have relevance at a system level as well as across professions.

## 7 | STRENGTHS AND LIMITATIONS

To our knowledge, this is the first study to explore the experiences of carers who are mental health professionals. The study findings are therefore limited by the lack of comparative data in the literature. Our study yielded a moderate response rate (30%) compared with most online surveys (Nulty, 2008). Although we reported the frequency of being both a mental health professional and a carer, this was not designed as a prevalence study as noted by the sample size and the convenience sampling. However, the study does provide a baseline for further exploration of the prevalence of mental health professionals as carers. Future research could build on the findings of our exploratory study by applying a qualitative methodology for a more comprehensive examination of the experiences of mental health professionals who are carers. While there are studies investigating stigmatizing beliefs of mental health professionals, this was not the focus of our study and may limit the interpretation of our findings. Our study was limited by the lack of existing literature in the field, and thus, we designed an exploratory study that could provide a snapshot of the experiences of mental health professionals as carers. The findings of our study provide a framework for future scientific enquiry in this emerging field.

## 8 | CONCLUSION

Compared with the general population of carers, there was a high frequency of mental health professionals who were carers. The experiences of services by mental health professional and carers of relatives with mental health problems showed striking similarity to the experiences of the general carer population. An overarching area of dissatisfaction was that of communication or information sharing including shared decision-making by the treatment team. For our sample, there was also a major criticism of a lack of continuity of care for relatives and in particular between mental health and primary care services. Given the knowledge of services by the mental health professional and carers, understanding changes in care delivery is likely to be even more challenging for other carers. Research on improving continuity of care has focussed primarily on staff and internal organisational factors with little attention to the needs or role of carers. Our research findings are relevant to both mental health professional and carers, and carers generally as our findings suggest a need for further examination of the barriers preventing clear communication and information sharing between services and carers.

As one of the first studies to explore the experiences of mental health professional and carers, our findings have identified important areas for further research. For example, determining prevalence rates for these carers, in depth qualitative research to explore the potential experiences of role conflict and stigma in the workplace, and then to develop training to raise awareness among mental health

**TABLE 5** Mental health professional and carer free-text responses of experiences of mental health services

Domain	Response
Information	<p>The therapists found it difficult to relate to a mother with the same education and profession as themselves</p> <p>It is some years ago now. We got very little information. Were hidden away in the old asylum</p> <p>Not very good information. A little "Laissez-faire" attitude</p> <p>He has never involved his children in his treatment</p> <p>As cohabitant I was not included in the treatment process, because my cohabitant denied me that. That was very difficult, since I was directly affected by his illness, in a bad way</p> <p>The treatment was relevant, but it was difficult to get access to the therapist outside of regular appointments</p>
Decision-making	<p>We found the therapist in the department for youth and children to be very dogmatic, and not relying on the conclusions from the formal assessments</p> <p>The therapists were too fast with setting a diagnosis, without proper assessment. My relative would not accept the first diagnosis, and after second opinion it was proven wrong, and changed</p> <p>Therapist/psychiatrist came to our home to see the patient, because our son did not want any help. This first meeting was decisive for the good therapeutic relationship that was established</p> <p>Not assessed as she should have been. Not offered the right treatment, medication included. Terminated her outpatient treatment too early</p> <p>The therapeutic relation did not function very well, and my relative should have been offered to change therapist</p> <p>The patient did not want medication, and hence he did not use any</p> <p>The therapist does a good job, and has been stable over time</p> <p>She was very, very ill, but thanks to her therapist she is now without symptoms</p>
Continuity of care/System	<p>There was no crisis plan, no cooperation between hospital and general practitioner (GP)</p> <p>After our son was discharged from the community/district mental health care centre (DPS), he was readmitted to the hospital because he was too ill to be at the DPS. Then he was discharged from the hospital because he was too well to be there. This is difficult to understand for most people</p> <p>I am on a general basis very dissatisfied with the system, not the therapist</p> <p>The threshold to access treatment is too high</p> <p>GP and school nurse seemed to know very little about mental disorders</p> <p>Very little focus on somatic ("physical") health, and very little cooperation with the GP</p>

(Continues)

**TABLE 5** (Continued)

Domain	Response
	<p>The cooperation with the local community is not functioning at all</p> <p>He became psychotic as a teenager, but it took very long time before he got any help. I have often wondered how he had been today, had he received help much earlier in the illness development</p> <p>The biggest challenge in psychiatry and the rest of the treatment system is the lack of continuity</p> <p>Our child is still very young, so it is difficult to tell, but the follow-up of our child has been good. As parents we would have preferred to have a better follow-up</p> <p>In a very long illness period the system showed little understanding of the total burden it was for my children and myself, to care for a chronically ill person</p> <p>How I was met, and taken care of as a relative, varied a lot</p>

professionals of the dual role. Training that includes awareness of the dual role for some carers provides an opportunity to enhance information sharing between services and mental health professional and carers by building on our findings of carer dissatisfaction of communication. Our results indicate an urgent need for improved communication and shared decision-making between mental health services and carers of relatives with mental health problems. This includes finding ways to better engage with carers who are also health professionals.

## 9 | RELEVANCE STATEMENT

Clinical nurses are often the greater proportion of the workforce in mental health services. It is expected that some of the nurses will be carers for a family member with mental health problems and that these family members may access the services in which the carer works. However, there is a lack of knowledge of the relationships between services and mental health professionals who are also carers. Knowledge gained in this study may be of value for mental health nurses engaged in psycho-educational family interventions and for improving shared decision-making. The findings provide a framework for services to investigate the barriers to across professions.

### CONFLICT OF INTEREST

The authors declare that they have no competing interests.

### ETHICAL APPROVAL

Ethics approval for the study was obtained from the local representative of the Norwegian Data Protection Authority (Personvernombud) (#Ref. no 2015/1530).

### CONSENT TO PARTICIPATE

Informed consent was obtained from all participants, and all data were anonymized.



## DATA AVAILABILITY STATEMENT

The final data analyses are available from the corresponding author on reasonable request.

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