REDUCING NURSING STIGMA OF PATIENTS DIAGNOSED WITH PSYCHIATRIC ILLNESSES ON A MEDICAL-SURGICAL INPATIENT UNIT

Brittany Danielson

A project submitted to the faculty at the University of North Carolina at Chapel Hill in partial fulfillment of the requirements for the degree of Doctor of Nursing Practice in the School of Nursing.

Chapel Hill
2017

Approved by:

Victoria Soltis-Jarrett

Mary Lynn Piven

Julia Aucoin

ABSTRACT

Brittany Danielson: Reducing Nursing Stigma of Patients Diagnosed with Psychiatric
Illnesses on a Medical-Surgical Inpatient Unit
(Under the direction of Victoria Soltis-Jarrett)

Background: Individuals diagnosed with psychiatric illnesses are frequently hospitalized
in non-psychiatric settings for either medical illnesses, surgery, and/or for symptom
exacerbation. The nurses who care for those patients often do not have adequate
education and training to provide clinically competent and culturally sensitive
psychiatric-mental health nursing care.

Purpose: The purpose of this project was to: (a) increase medical-surgical nurses' and
nursing assistant's understanding of psychiatric illnesses, (b) enhance compassionate
care, and (c). decrease the negative attitudes associated with stigma related to patients
who have comorbid physical/psychiatric illnesses in the inpatient medical-surgical
setting.

Methods: This Quality Improvement Project followed a step-by-step process (PDSA) to
identify the learning needs of nursing staff and the potential for negative attitudes and
stigmatizing behaviors on an inpatient medical-surgical unit in a community hospital. The
administration of a learning needs assessment initiated the QI process and the 4-week
interactive educational-training program that incorporated evidence-based stigma
reduction modalities and education tailored to the setting's patient population. The
nursing staff's attitudes were measured as a group pre- and post-program completion

using the Mental Illness: Clinicians' Attitudes, Version Four Scale (MICA v4). A post-survey was administered to assess the nursing staff's perception of compassion and understanding after program completion.

Results: Overall, the QI project was successfully implemented and focused on patient-centered nursing care. The post-program evaluation indicated that the project promoted nursing staff to have a better understanding of psychiatric illnesses, while also enhancing their ability to provide compassionate nursing care. The MICA v4 scores (using aggregate data) decreased from 38.8 to 33.8, indicating an improved attitude (and decreased stigma) towards patients with psychiatric illnesses. An unpaired t-test resulted in a p-level of 0.00067 indicating a potential correlational relationship between the education/training program and attitudinal change.

Conclusion/Implications: The project was able to meet and exceed its three main purposes, with the potential of replicating this program hospital-wide. Limitations included low attendance, use of a low strength statistical correlational test, and use of a stigma tool that requires further research. Future programs should track individual stigma scores, measure behavioral outcomes, and use a stigma survey that has been widely used.

KEYWORDS: Stigma, medical-surgical nursing, psychiatric illnesses, quality improvement, attitudes, compassionate care

To every patient I have encountered in the past and will encounter in the future. You are brave, worthy, and inspiring. Thank you for sharing your stories with me. I promise to be your biggest advocate.

ACKNOWLEDGEMENTS

First and foremost, I want to thank God for helping me to discover my true passion in life. If you had told the younger version of myself that I would one day be a psychiatric-mental health nurse practitioner, I would not have believed you. I vividly remembering being a nursing student and thinking, 'what in the world have I gotten myself into?' but I had this gut feeling that I needed to continue to trust God and the plans He had for me. Now, looking back, it all makes sense. I can now see how every event in my life and every person I have met has prepared me to take on this role. He helped me realize that life isn't about money or success, but rather about using my talents to help those most in need. I will continue to place my trust in Him as I embark on this journey as a psychiatric-mental health nurse practitioner.

To my project chair, Dr. Victoria Soltis-Jarrett. You have supported me in more ways than one and I cannot thank you enough. You took me under your wing when I entered the program and helped evolve this medical-surgical nurse into a PMHNP. You are a true mental health advocate, educator, mentor, innovator, and leader. Most importantly, you have shown me what a compassionate and empathetic PMHNP is.

To my committee members, Dr. Piven and Dr. Aucoin. You both embraced my passion and helped develop it into a scholarly project. I am forever grateful for your guidance and expertise.

To my Mama: You didn't just watch me on this journey, but you were there right next to me every step of the way. Thank you for providing everything I needed to reach this goal. I love you!

To my Daddy: You have always been the inspiration behind the work that I do. I am thankful for everything that we have experienced together. Without it, I would not be where or who I am today. I hope you know how much I love and admire you.

To Stacey Thompson and the 7E staff: I could not have asked for a better group of nurses and nursing assistants to spend the last six years with. Thank you for your dedication to this project.

To the group of nurses who have helped shape me into the nurse I am today and who encouraged me when I doubted myself: Ann Hart, Brucene Bechtel, Mimi Alvarez, and Elizabeth Rochin. I am lucky to have had you all as mentors and role models.

And finally, to my friends and family who have continued to believe in me. I could not have done this without your support. Thank you for helping me to #FightStigma!

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

LIST OF ABBREVIATIONS

ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
APA	American Psychiatric Association
BPD	Borderline Personality Disorder
CNO	Chief Nursing Officer
DNP	Doctor of Nursing Practice
DSM	Diagnostic and Statistic Manual of Mental Disorders
ERMIS	Emotional Reactions to Mental Illness Scale
HIV	Human Immunodeficiency Disorder
IHI	Institute of Healthcare Improvement
IOM	Institute of Medicine
IOOV	In Our Own Voice
MI	Myocardial Infarction
MICA V4	Mental Illness Clinician's Attitudes Scale, Version 4
NAMI	National Alliance on Mental Illness
NIMH	National Institute of Mental Health
OMS-HC	Opening Minds Scale for Healthcare Providers
PDSA	Plan-Do-Study-Act
PEP	Provider Education Program
PTSD	Post-traumatic Stress Disorder
QI	Quality Improvement

RIBS	Reported and Intended Behavior Scale
TRA	Theory of Reasoned Action
USDHHS	United States Department of Health and Human Services
WHO	World Health Organization

CHAPTER 1: INTRODUCTION

It is believed that the term stigma originated in ancient Greek culture when women who presented with excessive emotions were described as having a wandering uterus (Traniello, 2014). It was labeled hysteria, coming from the Greek word *hystera*, meaning uterus (Traniello, 2014). Since that time, stigma has been researched, conceptualized by various disciplines, and applied to social injustices; however, a widely accepted contemporary definition describes it as stereotypes and prejudicial beliefs that lead to discriminatory behavior directed towards a particular group (Corrigan, 2000). Stigma affects all facets of an individual's life and results in several forms of discrimination (Corbiere, Samson, Villotti, & Pelletier 2012).

Over the past decade, there has been a growing interest in abolishing the stigma associated with individuals and their families diagnosed with psychiatric disorders (Ungar, Knaak, & Szeto, 2015). This is particularly significant for patients hospitalized in non-psychiatric settings with comorbid physical and psychiatric illnesses. According to patients who experience symptoms of a psychiatric illness, healthcare providers and nurses are the primary contributors to stigmatization (Ross & Goldner, 2009).

The National Institute of Mental Health (NIMH) lists stigma as a primary interest for research (Dalky, 2012). Additionally, the Surgeon General's Report on Mental Health states that public stigma, or stigma targeting others, contributes to decreased quality of life and worsening of distressing physical and behavioral symptoms (United States Department of Health and Human Services, 1999). Stigma has been recognized as

more harmful than the diagnosis and symptoms of a psychiatric illness itself, making it a central barrier to overcome in healthcare (World Health Organization, 2001).

Problem Statement

An estimated one in four adults suffers from at least one psychiatric illness, making it the leading cause of disability in the United States (NIMH, 2014). Of those individuals who suffer from a psychiatric illness, nearly 58% also have a comorbid medical illness such as diabetes, hypertension and/or obesity that can often require medical hospitalization (Mather, Roche, & Duffield, 2014). Despite research indicating its neurobiological, psychosocial and genetic basis, healthcare providers, consciously and/or unconsciously, continue to endorse stereotypes and/or exhibit stigmatizing behaviors toward those who suffer from psychiatric symptoms and disorders (Ross & Goldner, 2009). Additionally, stigma is exacerbated by both societal and individual factors that further negatively impact the health of individuals diagnosed with psychiatric illnesses. The prevalence of stigma and its wide array of societal and individual contributors creates an environment where those with mental health care needs are subject to injustices and inferior health care.

System level factors such as gaps in mental health parity, the psychiatric provider workforce shortage, and policies related to insurance reimbursement and coverage significantly impact the community's access to mental health care, and thus, making it increasingly difficult to receive care to alleviate behaviors the behaviors that are highly stigmatized (Outlaw, Bradley, & Davis-Williams, 2014). As a consequence, individuals diagnosed with psychiatric illnesses commonly present to emergency departments and are either discharged with no follow-up or are admitted to general inpatient units staffed by

nurses who may lack the knowledge and understanding to provide nonjudgmental, compassionate care (Mather et al., 2014). Studies have shown that nurses' negative attitudes often lead to under-diagnosis and neglect of physical and emotional complaints, which contributes to mediocre care and overall poorer patient outcomes (Stubbs, 2014).

Research also indicates that individual factors, such as a person's negative attitudes or biases about psychiatric disorders, are often a result of health care providers lacking the skills, knowledge, confidence, and support in caring for this specialized population (Atkin, Holmes, & Martin, 2005; Munro, Watson, & McFadyen, 2007; Giandinoto & Edward, 2015). While several studies have revealed the prevalence of general nurses' negative attitudes when caring for patients with co-existing psychiatric/physical illnesses, none have assessed the presence of individual and societal factors empirically shown to contribute to these negative attitudes nor how these factors could be used to develop an effective anti-stigma program.

Purpose of Project

The purpose of this project is to: (a) increase medical-surgical nurses' and nursing assistant's understanding of psychiatric illnesses, (b) to enhance compassionate care, and (c) to decrease the negative attitudes associated with stigma related to patients who have comorbid physical and psychiatric illnesses in an acute care setting.

This Doctor of Nursing Practice (DNP) project will follow a step-by-step process to assess for the presence of those factors that have been empirically shown to contribute to negative attitudes and stigmatizing behavior. Examples include: a lack of psychiatric clinical skills, knowledge deficit of psychiatric illnesses, fear, psychiatric illness myths, and inadequate resources/support available to assist with providing compassionate care.

Administration of a learning needs assessment helped guide and develop a 4-week

interactive psychoeducational-training program to increase the nurses' understanding of

psychiatric illnesses and enlighten nurses' attitudes towards caring for this population,

subsequently decreasing stigma. Nurses' attitudes were measured prior to immediately

after the intervention to evaluate the program using the Mental Illness: Clinicians'

Attitudes, Version Four Scale (MICA v4) (Gabbidon et al., 2013).

Clinical/Practice Question

Will a psychoeducational intervention that is grounded in empowering nurses and

nursing assistants with knowledge change their attitudes about planning and

implementing nursing care for individuals with psychiatric symptoms and/or illnesses?

CHAPTER 2: REVIEW OF LITERATURE

This section will address the relevant literature and theoretical underpinnings responsible for shaping the concept of stigma and understanding its effects within society. The following sections will be presented and discussed: (a) conceptualizing stigma; (b) stereotypes and prejudicial beliefs of psychiatric illnesses in healthcare; (c) discriminatory behavior exhibited towards patients with psychiatric illnesses; (d) the interface of physical and mental health; (e) physical effects of stigma; (f) emotional effects of stigma; (g) contributors of stigma and (h) anti-stigma programs in the research. The review of literature lays the foundation for why an anti-stigma program is warranted for a medical-surgical inpatient unit.

For the purpose of this paper, several terms need to be clarified and presented as a means of understanding the historical underpinnings of stigma and how language has perpetuated its negative connotations. The term *psychiatric illness* is used throughout this paper rather than *mental illness,* since the latter is highly stigmatizing and sends the message that the patient is mentally incompetent. The phrase *mental illness* also disregards the multifaceted etiology of psychiatric conditions and places shame on an individual. Secondly, while the term *psychiatric illness* is frequently used throughout this paper, recent advancements in research have shifted medicine and specifically psychiatry's focus from the classification of patients based on diagnosis to an approach that views psychiatric symptoms on a spectrum (Lobo & Agius, 2012). In other words, patients may experience signs and symptoms that don't meet the Diagnostic and

Statistical Manual of Mental Disorders (DSM) (American Psychiatric Aassociation,

2013) criteria for a psychiatric illness yet they are clearly suffering in their overall health

and well being. In other instances, patients may experience signs and symptoms that are

applicable to various psychiatric diagnoses but do not consider their symptoms related to

one psychiatric illness. Additionally, in this paper, the term *stigma* will reflect its three

components: (a) stereotypes; (b) prejudice; and (c) discrimination. Each factor will be

discussed separately but use of the word *stigma* collectively references its three

characteristics. Finally, the focus of this project was to decrease stigma as measured by

attitudinal change. Negative attitudes influence all three components of stigma;

therefore, by targeting negative attitudes the DNP project aimed to target stigma.

Conceptualizing Stigma

Erving Goffman, a renowned sociologist and anthropologist, is considered a

pioneer within the field of stigma research. He is credited with being one of the first to

observe human interactions where an individual was mistreated for being different from

mainstream society. His conceptualization is commonly used to analyze the social

phenomenon of stigma, specifically forms of discrimination, within a broad range of

settings. Although he spent much of his career studying the experience between patients

and their caretakers, he also studied encounters involving prisoners, prostitutes, and those

with physical disabilities (Goffman, 1963). Through his observations in the asylums, he

noticed that individuals (providers) interacted differently with patients who were

experiencing psychiatric symptoms and that these providers frequently exhibited negative

attitudes. He observed that these encounters led to the patient's sense of shame, loss of

identity, and decreased ability to care for oneself (Goffman, 1963).

Goffman (1963) further argued that there are certain human conditions commonly viewed as abnormal, different or marginalized within society, including psychiatric problems, behaviors, and illnesses. Goffman (1963) was able to identify language (words) and behaviors that contributed to a patient's understanding of their *self* in relation to others without psychiatric illnesses. Individuals who had characteristics that were outside of the 'norm' were deemed inferior members of society and subsequently were susceptible to social rejection, shame or judgment by others in their social group. In other words, Goffman articulated that societies decide what behaviors and conditions are "abnormal" or "normal," leading to either acceptance or isolation and social discrediting of the human being. Those who are not stigmatized tend to increase their social distance from these individuals and consider themselves superior. Additionally, those who were marginalized by stigma could also experience discrimination in other aspects of life (Goffman, 1963).

Corrigan and Watson (2002), both prominent researchers of stigma, elaborated on the social construct by creating a paradigm delineating two types of stigma: public and self-stigma. Public stigma refers to the general public's negative attitudes, beliefs and behaviors towards those with a psychiatric illness (or any other stigmatized group). An example of public stigma related to this project is the negative attitudes, prejudicial beliefs, and discriminatory practices exhibited by nurses to patients with psychiatric behaviors (i.e. avoiding patient encounters in the hospital). Self-stigma is a common consequence of a psychiatric diagnosis and/or public stigma and results in the individual's feelings of worthlessness and inferiority because of others' perceptions of the illness (Corrigan & Watson, 2002). Corrigan and Watson's studies (2003) mirror

7

Goffman's findings that public stigma can negatively impact the course of an individual's illness, ability to care for themself, and self-worth. Both of these concepts will be further discussed within the review of literature in order to understand stigma's presence and effect within the hospital setting; thus, underscoring the need for an anti-stigma program.

In addition to differentiating between types of stigma, Corrigan and Watson (2002) also identified three core characteristics of stigma; (a) stereotypes; (b) prejudice and (c) discrimination. Stereotypes are a set of widely shared false beliefs about a particular group of people. For example, individuals suffering from an addiction to substances are often stereotyped as being irresponsible, uncooperative, erratic, and manipulative (Bjorkman, Angelman, & Jonsson, 2008; van Boekel, Brouwers, van Weeghel, & Garretsen, 2015).

The authors further explain that a stereotype evolves and proliferates to become a prejudicial belief when a person endorses or condones a community's negative label of a particular group; thus, causing the "stigmatizer" to rapidly form impressions and expectations of another human being based on their illness or disease process (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003). Prejudice creates a dichotomous culture of "us" versus "them," similar to what can occur in the health care setting (Corrigan et al., 2003). For example, the nurse who is caring for the patient with an addiction to substances may verbally express that the patient is going to be "crazy" and "uncooperative" before ever meeting the patient. The nurse's prejudice (e.g. negative attitude) could also influence him/her to treat this patient differently than other patients. The negative attitude that leads to behavioral changes is also known as discrimination.

Discrimination is a visible, behavioral response directed toward the stigmatized individual that is reflective of prejudicial beliefs (Corrigan et al., 2003). For example, taking the issue above (the nurse caring for the patient with an addiction to substances), discrimination would be evident if the nurse approaches the patient with hostility and intentionally ignores the patient's requests. Discrimination can be direct and intentional, as seen with this particular example, but it can also be quite understated. Some psychiatric illnesses are more subtly discriminated against through the use of segregation (Corrigan et al., 2003). For example, many healthcare providers believe that persons with severe and persistent psychiatric illnesses should be institutionalized rather than managed in the community (Corrigan et al., 2003). This belief could potentially lead to the assumption that the mental health care needs are not a clinician's responsibility. They may also defer from making needed psychiatric referrals and collaborating with mental health care providers. This unwillingness to help care for the psychiatric needs of a patient and provide holistic care is also an inconspicuous form of discrimination (Corrigan et al., 2003). The manifestations of discrimination within the healthcare sector will be thoroughly discussed later in this paper.

Stereotypes and Prejudicial Beliefs of Psychiatric Illnesses in Healthcare

In order to fully discern how stigma functions within the health care system and affects patients, we must first identify the stereotypes surrounding this population in our society. Several research studies have identified various types of stereotypes shared by nurses. One common theme identified is that stereotypes can be general or specific to a particular illness. An example of a generalized stereotype is that anyone with a psychiatric illness is incompetent, irresponsible, unpredictable, strange, dangerous, and

lacking self-control (Bjorkman et al., 2008; Davey, 2013; Griffith & Kohrt, 2015; Ross & Goldner, 2009).

In a study conducted by Bjorkman, Angelman, and Jonsson (2008), negative attitudes were more prevalent on medical-surgical units than in other psychiatric settings. In other words, psychiatric nurses were aware of stereotypes but did not necessarily believe them. On the contrary, medical-surgical nurses endorsed these beliefs (prejudice). Bjorkman et al (2008) surveyed nurses about their attitudes towards patients diagnosed with the following illnesses: (a) severe depression, (b) panic attacks, (c) schizophrenia, (d) dementia, (e) eating disorders, and (f) addiction to alcohol and/or other substances. Overall, the nurses' responses indicated negative beliefs with perceptions that all patients with psychiatric disorders, regardless of diagnosis, are dangerous, unpredictable, hard to talk to, blame-worthy, unusual, and unlikely to recover from their illness with medical or psychiatric treatment. Bjorkman's study (2008) also found that registered nurses and nursing assistants share the same negative views as the general public despite their health care training. Through a thorough review of the literature, it was determined there are no studies that evaluated whether are differences in attitudes between nurses and nursing assistants.

As previously mentioned, some psychiatric illnesses and/or behaviors are linked to specific prejudices or are more highly stigmatized than others. Like other studies that explored the attitudes within healthcare (Livingston, Milne, Fang, & Amari, 2012; Ross & Goldner, 2009), schizophrenia and addiction to substances were more feared and linked to more negative attitudes (Bjorkman et al., 2008). Certain symptoms of psychiatric illnesses are also viewed by nurses as being 'controllable' by the patient and

are, therefore, more severely stigmatized. Individuals diagnosed with borderline personality and bipolar disorder are most harshly stigmatized and stereotyped as difficult, annoying, manipulative, attention seeking, and in control of suicide attempts (Ross & Goldner, 2009; Thornicroft, Rose, & Kassam, 2007). The diagnosis of severe depression, an eating disorder, and/or panic attacks was associated with less negative attitudes. This data suggests that some patients are more susceptible to stigma and may need to be targeted in anti-stigma programs.

In addition to stereotypes and prejudicial beliefs being categorized as general versus specific, there are certain prejudicial beliefs that are thought to lead to more discrimination. Corrigan, Markowitz, Watson, Rowan, and Kubiak's research (2003) identified three stereotypes that are most prevalent within society and that frequently lead to discrimination. They include the beliefs that: (a) people with psychiatric illnesses are dangerous and should be avoided, (b) that having a psychiatric illness is a character flaw, and (c) that persons with psychiatric illness are incompetent and incapable of making healthy living choices. This data suggests that providing interventions that challenge these commonly held false assumptions could potentially raise awareness of both attitudes and nursing care.

Collectively, these studies demonstrate that stereotypes and prejudices vary based on diagnosis, behavior, and health care setting. Additionally, some are predictive of discriminatory behavior. In conclusion, the design of an anti-stigma program must incorporate a careful assessment of two major foci: (a) patient population (e.g. what psychiatric illnesses are cared for on the unit) and (b) the current attitudes of nurses towards these patients. Designing a program based on the patient population and

assessment of prejudicial beliefs is a key component of a successful stigma intervention and a characteristic that has been frequently overlooked (Pinto-Foltz & Logsdon, 2009). Perhaps careful integration of these factors in program planning could lead to changes in how nurses care for patients and, subsequently, counteract the individual and societal perpetuators of stigma.

Discriminatory Behavior Exhibited Towards Patients with Psychiatric Illnesses

The aforementioned prejudicial beliefs often influence behavior and emerge into conscious and unconscious discriminatory care practices of healthcare providers. Negative attitudes have been shown to complicate inpatient nursing care, leading to some of the nurses responding differently to medical problems of those patients diagnosed with a psychiatric illness versus those without one (Zolnierek, 2009). Discriminatory care is reported by between 17% and 31% of patients and can lead to detrimental physical and emotional effects (Henderson et al., 2014).

Discrimination in health care is evident through avoidance. Avoidance is not overtly detrimental to patients, but it can inhibit the development of the therapeutic nurse-patient relationship that is so integral to promoting positive patient outcomes (Macneela, Scott, Treacy, Hyde, & O'Mahony, 2012). Nursing staff may minimize the number of encounters with patients who are diagnosed with psychiatric illnesses and will avoid having to go into their rooms. If nurses are not interacting regularly with patients, then it can be assumed that critical interventions are not being completed such as: (a) medication education, (b) psychiatric and/or medical illness education, (c) post-operative care, (d) and discharge care. Inadequate nursing care and education could potentially lead to adverse events and will be discussed further in this chapter.

Poor engagement is a result of healthcare providers not engaging and/or incorporating interventions that meet the specific needs of acutely ill patients experiencing perceptual disturbances, thought disorders, and/or disorientation (Doherty & Gaughran, 2014). Avoidant nursing care is most often experienced by patients who suffer from an addiction to substances or those diagnosed with schizophrenia and is influenced by the stereotypes discussed in the previous section (Bjorkman et al., 2008; Buechter, Pieper, Ueffing, & Zschorlich, 2013; Corrigan & Watson, 2002). Patients hospitalized for diabetes control, cardiovascular events, or post-operative care are susceptible to adverse events because of nurse-patient engagement difficulties (Bjorkman et al., 2008; Doherty & Gaughran, 2014). Avoidance can lead to a multitude of other medical complications and will be discussed later in this chapter.

Discrimination is also manifested through diagnostic overshadowing, which occurs when health complaints are given little credibility or even completely dismissed, potentially leading to worsened medical status and longer hospital stays (McDonald, Frakes, Apostolidis, Armstrong, Goldblatt, & Bernardo, 2003; Ross & Goldner, 2009). Discriminatory care diminishes the amount of patient education and interaction necessary to provide optimal nursing care. This then leads to the potential for neglectful health services and decreased patient adherence to treatments (Oliveira, Martins, Richter, & Ronzani, 2013).

It has been reported that some medical-surgical nurses don't believe it's "their job" to attend to a patient's psychiatric health needs and may prioritize physical needs of other patients first (Bjorkman et al., 2008; Davey, 2013; Stubbs, 2014). The stigma associated with patients diagnosed with psychiatric illnesses, in addition to the

fragmented health care system and separation of physical and mental health care, has created an illusion that an individual's mental health care needs are not a medical-surgical nurse's responsibility. Yet, the two are intricately related and affect one another. A broad and simplified explanation of the mind-body relationship will be explained in the following section. Afterwards, medical conditions exacerbated by stigma will be discussed.

The Interface of Physical and Mental Health

The review of literature has shown that stigma is present on medical-surgical units and that it affects patient outcomes, yet there is a paucity of anti-stigma programs. Perhaps the relationship between psychiatric and medical health has been overlooked (Mather et al., 2014). Recognition and coordination of a patient's whole health (mental and physical health) is vital for providing holistic and optimal care (Institute of Medicine, 2007). However, without mental health, there is no health (WHO, 1946) and stigma continues to contribute to dismissal of any bodily complaints (Bjorkman et al., 2008; Lambert & Salmon, 2014). To this end, the World Health Organization has named integrated care education as essential in improving patient outcomes by honoring the whole person-body and mind (WHO, 2008).

While this project's intervention will not provide an in-depth integrated care curriculum, it will provide supplementary education about the strong link between physical and mental health, which seems to have been forgotten in the medical-surgical setting and is therefore needed to further argue the significance of implementing this project. There are multiple comorbid conditions that have been presented in the literature and will be addressed in the next few paragraphs to highlight examples of interface of

14

physical and mental health. The broad and simplified explanation will further support the need for the project.

Individuals with psychiatric illnesses are already a vulnerable group and susceptible to developing chronic, medical conditions such as cardiovascular disease, diabetes, cancer, and HIV/AIDS (Giandinoto & Edward, 2015). Their poorer state of health is due, not only to poor disease management, financial insecurity, medication side effects, inactivity, service fragmentation, and substance misuse, but also because of stigma (Giandinoto & Edward, 2015; Gill, Murphy, Zechner, Swarbrick, & Spagnolo, 2009). Psychiatric illnesses and substance use disorders are also associated with asthma, gastrointestinal orders, diabetes, cancer, neurological disorders and acute respiratory disorders (Lambert & Salmon, 2014).

In a systematic literature review that included 12 studies that assessed outcomes of medically hospitalized patients with co-existing psychiatric illnesses, Zolnierek (2009) highlighted the patients' susceptibility to adverse outcomes. Outcomes reported that patients had longer hospitalizations with functional impairments that could last nearly one year after discharge from the hospital

A higher incidence of morbidity and mortality is partially attributable to unhealthy, high-risk behaviors that are used as coping mechanisms for patients (Gill et al., 2009). Gill (2009) listed these coping mechanisms as abuse of substances, a sedentary lifestyle, an unhealthy, unbalanced diet, and smoking. Additionally, the researchers stated that those who use substances are also at increased risk of participating in risky behaviors such as intravenous drug use, needle sharing, and unprotected sex. Collectively, these behaviors increase their risk for human immunodeficiency virus

(HIV) and other blood borne diseases. The high prevalence of nicotine dependence

contributes to cancer, respiratory illnesses, and cardiovascular disease (Gill et al., 2009).

Perhaps the most documented relationship is the one between second-generation

antipsychotics and the resultant metabolic syndrome. Clients prescribed this category of

psychotropic medication commonly develop secondary metabolic diseases such as

diabetes mellitus, dyslipidemia, coronary artery disease, and obesity (Gill et al., 2009).

These secondary effects place clients at higher risk for heart disease and stroke (Gill et

al., 2009).

Cardiovascular disease and depression have been shown to have a strong

correlation (Doherty & Gaughran, 2014) and nearly 20% of hospitalized patients post-

myocardial infarction (MI) also suffer from major depression, while depression itself is a

risk factor for heart disease and increased mortality (Pozuelo, 2009). Depression alone is

also associated with increased hospital mortality (Farley-Toombs, 2012). Additionally,

patients with comorbid cardiac disease and psychiatric illnesses have a 40 to 60%

increased chance of dying prematurely, with an average reduced life expectancy of 25

years, when compared to those without a psychiatric illness (Giandinoto & Edward,

2015; Gill et al., 2009; Viron & Stern, 2010).

This data shows that those diagnosed with a psychiatric illness are especially

susceptible to poor health conditions and increased mortality, even without the influence

of stigma. In order to improve their chances of recovery and living a healthy and

functional life in society, stigma must be addressed in hospitals. Although approximately

30 to 50% of patients who are admitted to a general inpatient unit have comorbid medical

and psychiatric illnesses, these individuals are considered challenging by nursing staff

and often receive poor care in the acute setting (Giandinoto & Edward, 2015). Providing stigma free, holistic nursing care is critical during hospitalization for this vulnerable population.

Physical Effects of Stigma on Patients with Psychiatric Illnesses

Research within the past few years has begun investigating the secondary physical effects of stigma (Farley-Toombs, 2012; Henderson et al., 2014; Mather et al., 2014; McDonald et al., 2003; Ross & Goldner, 2009; Thornicroft et al., 2007). As previously discussed, stigma has the potential to exacerbate medical conditions and contribute to preventable hospital complications. The discriminatory care practices of avoidance, neglect, and diagnostic overshadowing have been associated with negative physical consequences.

Stigmatization of psychiatric illnesses has also led to the over administration of anxiolytics, sedatives, and antipsychotics in acute care settings (Farley-Toombs, 2012). When non-psychiatric providers witness agitated or aggressive behavior, they tend to medicate the patient instead of determining the etiology of the exhibited behavior. The caveat to this 'quick fix' is that it contributes to a higher risk of delirium (Farley-Toombs, 2012) and the potential for serious and lethal adverse effects such as neuroleptic malignant syndrome or tardive dyskinesia. As a consequence, a vicious cycle begins with using medications to control behavior, which then leads to decreased mobility, increased medication side effects, and longer hospital stays.

Patients diagnosed with psychiatric illnesses have also been shown to receive inferior care for comorbid illnesses, especially diabetes mellitus and myocardial infarctions (Desai, M., Rosenheck, R.A., Druss, B.G., & Perlin, J.B., 2002). Hospitalized

17

patients with schizophrenia experience more "hospital acquired infections, postoperative respiratory failure, postoperative deep vein thrombosis, and postoperative sepsis" (Farley-Toombs, 2012, p. 151). Acutely ill patients with comorbid psychiatric illnesses are generally at greater risk for the previously discussed hospital adverse events, morbidity, and mortality (Farley-Toombs, 2014).

With recent healthcare reform, there is a greater emphasis on quality of care and prevention of hospital acquired infections, indicating the need to engage with these patients and assist them to understand how to care for their wound and/or surgical site after discharge from the hospital. Not doing so prevents engagement and, as a consequence, contributes to unfavorable hospital events and decreased treatment adherence (Farley-Toombs, 2012). In addition to the previously discussed physical effects, patients also suffer from emotional consequences when they perceive a caregiver as judgmental.

Emotional Effects of Stigma on Patients with Psychiatric Illnesses

Negative attitudes and discriminatory care often leads to patients feeling patronized, punished, and humiliated (Thornicroft et al., 2007). These feelings of self-consciousness and inadequacy worsen self-stigma and can contribute to patients not seeking healthcare treatment as well as to poor treatment adherence (Thornicroft et al., 2007). Patients also report feeling dehumanized because they are spoken to in a child-like manner, are excluded from important health decisions during hospitalization, and are viewed as incapable of any responsibility (Corrigan, 2015). The increased level of self-stigma leads to an individual's neglect of both medical and mental health care. Even if

the patient doesn't experience an adverse hospital event or hospital acquired infection, they're still at risk for self-neglect if made to feel poorly by others.

Contributors of Negative Attitudes

Determining the origins of stigma can help in designing effective anti-stigma programs that target the various causes and in achieving the overall goal of enlightening those who have negative attitudes. The drivers of stigma found in literature were incorporated into the learning needs assessment and evaluated for their presence on the unit. This helped tailor the intervention to the nurses and the unit. The major contributors of stigma were related to the nurses' perceived ability to provide care and included: (a) lack of clinical skills, (b) lack of knowledge about psychiatric illnesses and psychopharmacology, (c) fear, (d) negative attitudes, (e) not feeling supported in the job to care for these patients, and (f) not feeling that it's one's responsibility to tend to a patient's mental health care needs (Giandinoto & Edward, 2015; Reed & Fitzgerald, 2005).

Lack of Skills and Knowledge

Even though nurses have educational backgrounds in the causes, symptomology, and treatment of psychiatric illnesses, they often share a skewed perception about its origins and symptoms (Buechter et al., 2013; Davey, 2013). Weakness of morals and personality, laziness, lack of self-control and reduced discipline are frequently described as a conscious choice of the individual by healthcare providers (Ross & Goldner, 2009). As a consequence, nurses and physicians are often pessimistic about an individual's recovery from psychiatric illnesses and consider treatment ineffective (Thornicroft et al., 2007). It is critical for nurses to understand that the behaviors seen in this patient

population are not a personal choice but rather a symptom of a brain disease. Many nurses who feel unprepared to care for these patients have not had much, if any, experience in psychiatry. Because of this, it can be assumed that these nurses also aren't familiar with the individuality and uniqueness of each patient story. In other words, they don't hear the life stories, struggles, triumphs, traumas, and lived experiences of these patients; all of which are integral personal awareness and empathy development.

Non-psychiatric nurses also do not feel well prepared to clinically care for this population. In a multi-site study to assess non-psychiatric nurses' perceptions of their competency to care for patients with psychiatric illness, medical-surgical nurses ranked in the bottom five of 10 subspecialty areas surveyed (Rutledge, Wickman, Cacciata, Winokur, Loucks, & Drake, 2013). With a score of zero representing no competency and five representing total competency, medical-surgical nurses scored a 3.4, with the lowest level of perceived competency associated with knowledge of psychotropic medications and assessment skills (Rutledge et al., 2013). Deficits in these competencies contribute to overall negative attitudes.

Role Adequacy, Role Legitimacy, and Role Support

In a randomized controlled trial, Munro and colleagues (2007) identified components that are integral to the formation of a therapeutic nurse-patient relationship. These influences included role adequacy, role legitimacy, and role support (Munro et al., 2007). Role adequacy is the degree to which clinicians feel prepared to care for patients with psychiatric illnesses. Role legitimacy is the extent to which nurses believe that meeting mental health care needs of patients is part of their job. Role support is the belief

that necessary resources and personnel are readily accessible to assist the nurse when caring for a patient with a psychiatric illness (Munro et al., 2007).

A feeling of unpreparedness and not feeling supported can quickly lead to frustration and burn out on a fast-paced, medical-surgical unit. As a result, negative attitudes are formed that can lead to prejudicial thinking and discriminatory care practices that interfere with the nurse-patient relationship. Aiming to improve role adequacy, legitimacy, and support helps improve overall negative attitudes (Munro et al., 2007). If there is a perceived deficit in available resources to effectively care for this population, this information can be relayed to the setting's managerial and executive team. By assessing the presence of stigma contributors within a particular setting, appropriate anti-stigma interventions can be implemented.

Fear

Nurses have not only voiced fears of being hurt by patients, but also fear of physically or ethically harming the actual patient (Reed & Fitzgerald, 2005). They attribute this fear to some of the other general causes of stigma such as lack of workplace support, lack of education and clinical skills, lack of accessibility to professional mental health clinicians, and negative past experiences (Reed & Fitzgerald, 2005). In fact, nurses felt most comfortable engaging with patients when they felt supported and educated (Reed & Fitzgerald, 2005). This data reveals that fear and vulnerability can be reduced when nurses are given tools to care for and communicate with this specialized population.

Additionally, inaccurate portrayals of patients diagnosed with psychiatric illnesses in the news, media, and filmmaking industry have elicited a sense of fear in nurses,

21

nursing assistants, and the general public (Corrigan & Watson, 2002; Opening Minds, 2013).

Conclusions

This data suggests that negative attitudes are not just innate feelings of nurses, but rather that they are acquired and intensified by a myriad of factors. In reality, several of the previously discussed risk factors are related to one another and are modifiable. In other words, there are ways to address the barriers that produce negative attitudes and inhibit quality nursing care of patients diagnosed with psychiatric illnesses. Awareness of these factors yields anti-stigma programs that target negative attitudes through education, direct contact, and protestation.

Anti-Stigma Programs

The recognition of stigma, identification of its numerous causes, and heightened awareness of its detrimental effects on patients has resulted in the emergence of anti-stigma interventions aimed to target negative attitudes; however, the majority of programs have been implemented and directed towards clinicians in specialized psychiatric settings. While several studies have explored the perceptions of medical-surgical nurses when caring for patients exhibiting psychiatric symptoms, there are few that assess the transferability of anti-stigma programs in the medical unit setting.

Corbiere (2012) and fellow researchers suggest that the design of anti-stigma programs incorporate, either in isolation or in conjunction, three modalities: education, contact, and/or protestation. They also suggested that the following thematic content be included: (a) person-centered, (b) recovery, (c) social inclusion, and (d) reflexive consciousness. Person-centered and social inclusion content involves presenting patients

22

as human beings rather than defining them by their diagnosis. In other words, the audience is able to learn the patient's unique personal attributes and role in society. Recovery content focuses on psychiatric rehabilitation and the ability of the person to lead a meaningful life. Reflexive consciousness facilitates opportunities for nurses to self-reflect and restructure negative beliefs, attitudes, and perceptions (Corbiere et al., 2012).

Education

Education can be provided about several topics and delivered in a variety of forms. The education must be implemented with the delivery method, content, and applicability to the unit in mind. Education planning should also be guided using the previously discussed thematic content associated with lowering stigma and includes: (a) addressing myths, (b) using a recovery focus, (c) skills training, and (d) presentation of communication techniques. Most of the following educational interventions included at least one of these themes incorporated into the content.

One major theme shared among studies was that education must be tailored to the setting's patient population in order to be effective (Dalky, 2012). For example, anti-stigma programs with a psychosis emphasis will not necessarily be beneficial or change attitudes of nurses who rarely encounter psychotic illnesses. Additionally, the learning preferences of the target population must be considered prior to program development.

Many educational interventions are designed based on the assumption that stigma stems from ignorance. They seek to dispel myths by providing factual information about psychiatric illnesses, ultimately identifying and addressing the common stereotypes (Corbiere et al., 2012). However, other themes need to be integrated in order for the

education to be effective. Education that solely highlights characteristics of psychiatric illnesses such as signs, symptoms, and treatment can result in minimal attitudinal change or even exacerbate negative symptoms (Corrigan, 2015; Dalky, 2012; Griffiths, Carron-Arthur, Parsons, & Reid, 2014).

It seems that a large proportion of the general public is under the false assumption that patients cannot function in the community (i.e. work, live independently) even with medication management and psychotherapy; therefore, a recovery-oriented approach has been incorporated and evaluated in some studies. In Knaak's synthesis of evaluative studies (2014), educational programs that emphasized recovery from psychiatric illness were most predictive of positive changes. In an evaluation of training modules implemented within a mental healthcare organization, Wilrycx and colleagues (2012) discovered that emphasis and education about how patients can recover from psychiatric illnesses improved providers' attitudes and beliefs. Additionally, education that emphasizes skills and communication training to enhance the clinician-patient relationship has been shown to be most effective among the different types of educational offerings (Collins, Wong, Cerully, Schultz, & Eberhart, 2012; Opening Minds, 2013).

Other program evaluations found that education raises awareness of negative attitudes but does not necessarily lead to behavioral change, which is the ultimate goal of many interventions (Farley-Toombs, 2012); however, only one study was found that attempted to measure behavioral change. These variations in stigma interventions make it difficult to accurately assess the true influence education has on attitudinal change. Educational programs without an adjunctive anti-stigma modality, such as social direct contact, had minimal or worsened attitudinal change (Griffiths et al., 2014).

Multiple learning modalities (e.g. live presentations, discussions, movies) should be incorporated within the program to ensure that the audience is able to connect and understand the content (Knaak et al., 2014). Some educational interventions have been successful through the utilization of empathic video portrayals of individuals with psychiatric illness as well as through interactive, web-based interventions (Dalky, 2012).

Direct Contact

Direct contact interventions involve the interaction between an individual with a psychiatric illness and all others. Direct contact interventions can take the form of video or live, in-person interaction. Evidence has shown that providing an opportunity for clinicians to engage with individuals who have a psychiatric illness to be highly effective in decreasing negative attitudes associated with stigma (Corbiere et al., 2012; Farley-Toombs, 2012). Direct contact also has the ability to result in long-term attitudinal change (Dalky, 2012). Some studies have found psychiatric education in conjunction with direct patient care to be the most effective method in decreasing stigma (Bjorkman et al., 2008, Collins et al., 2012; Cook, Purdie-Vaughns, Meyer, & Busch 2014; Griffiths et al., 2014).

Clement and colleagues (2012) led a randomized controlled study to determine whether filmed or live contact interventions were more effective in reducing stigma in nursing students. The DVD and live interventions were similar in their effectiveness, but were shown to reduce negative attitudes more than lecture alone (t= -2.72, P = 0.003) (Clement et al., 2012).

Researchers studying anti-stigma programs funded by the Mental Health Commission of Canada found that interventions targeting health care providers are most

effective when social contact, skills training, and interactive education are utilized (Opening Minds, 2012). Effectiveness of these 13 programs were evaluated using the Opening Minds Stigma Scale for Healthcare Providers (OMS-HC) which measures attitude and intended behavior (Opening Minds, 2013). The programs that provided an incentive, multiple forms of direct contact, additional sessions, and focused on one specific illness were more successful than others (Opening Minds, 2013).

Protest

Protestation incorporates campaigns and message portrayals that condemn the stereotypes, prejudicial beliefs, and discriminatory behaviors associated with psychiatric illnesses. Protests often target negative representations of psychiatric illness shown by the media and filmmaking industry (Corbiere et al., 2012). Protestation is minimally effective in decreasing negative attitudes and has not been shown to influence behavioral change. The directedness of protestation interventions is also capable of increasing levels of stigma (Corbiere et al., 2012).

Multimodal interventions

While educational and direct contact interventions have been found to be most successful, there are variations in what content is provided and how it is presented that influence a program's effectiveness. Additionally, studies have tested the effectiveness of combining both education and direct contact into anti-stigma programs. Examples of various multimodal interventions will be discussed below.

The National Alliance on Mental Illness (NAMI) created the Provider Education Program (PEP) that provided healthcare providers with multimedia educational presentations and interactive discussions with an adult living with a psychiatric illness

(Wong, Collins, Cerully, Roth, Marks, & Yu, 2015). The program also includes

discussions hosted by the client's family member and mental health care provider. This

study used a pre- and post-test assessment tool to evaluate changes in attitudes/prejudice

and behavior. Researchers used mean effect sizes to analyze changes in stigma with 0.2

being a small effect size, 0.5 a medium effect size, and 0.8 a large effect size with $p < 0.5$

to be considered statistically significant. Knowledge about supporting people with

psychiatric illnesses most significantly increased (ES=0.44) with small to moderate

changes in willingness to socialize (ES = 0.38) and willingness to move next door to

someone with a psychiatric illness (0.44) (Wong et al., 2015). There was only a small

change in the belief that people with psychiatric symptoms are dangerous/violent

(E=0.27). There were not significant changes in beliefs of recovery, awareness of stigma,

or treatment seeking attitudes, but this could be attributable to a small sample size (*N*=73)

(Wong et al., 2015).

In another program evaluation, Wong and fellow researchers (2015) evaluated

another NAMI's program called In Our Own Voice (IOOV). IOOV is a program in

which a client shares their personal testimony of living with a psychiatric illness. IOOV

takes a recovery-oriented approach in that the client also shares what types of treatment

are available for specific illnesses. Using the same statistical analysis as the PEP

evaluation, IOOV demonstrated improvements among a person's willingness to work

with someone with a psychiatric illness (ES=0.53), move next door to them (ES=0.56),

believe in their recovery (ES=0.46), and perceive them as dangerous (ES=0.46) with a p

level < 0.0001 (Wong et al., 2015).

Both of Wong's studies were also included in a data synthesis that evaluated 22 anti-stigma interventions that targeted healthcare providers (Knaak et al., 2014). Programs that included recovery-focused content and multiple forms of direct contact were found to be most effective ($p < 0.05$) in reducing stigma measured by the Opening Minds Scale (Knaak et al., 2014). Additionally, the evaluative study identified six key ingredients of anti-stigma programs that were most effective in reducing the level of stigma. These elements included a recovery focus, providing multiple forms of contact, setting the tone, sharing personal testimony, teaching skills, and dispelling myths (Knaak et al., 2014).

In a comprehensive evaluation of anti-stigma programs called *Opening Minds,* the Mental Health Commission of Canada (2013) also identified key characteristics that made their programs successful. Twenty-four anti-stigma interventions targeting healthcare providers in various multidisciplinary settings were analyzed. Programs that emphasized various methods of social contact, incorporated skills training, and tailored the program to the environment's specific patient population were found to be most effective in decreasing stigmatic attitudes and behaviors of clinicians (Mental Health Commission of Canada, 2013).

Future Program Development

Despite empirically tested interventions, there are several other causes of stigma that are more individualized and haven't been used to create interventions. This may be the reason why current interventions do not result in long-term attitudinal or behavioral change. Since stigma is complex with a multitude of causes, the development of an effective intervention is difficult. As previously discussed, the level of stigma present

within a nursing unit as well as its patient population must be judiciously evaluated to deliver programs that lead to long-term attitudinal and behavioral change (Wilcryx, Croon, van den Broek, & van Nieuwenhizen, 2012).

Conclusion

Due to the growing number of hospitalized patients who suffer from comorbid and chronic illnesses, the literature suggests that more evidence-based anti-stigma programs should be implemented on medical-surgical inpatient units. Research about stigma and its consequences on patients' overall health indicates the need for such programs. Since there is a paucity of stigma programs targeted towards the general inpatient unit, this gap could be closed by assessing for the presence of those factors that exacerbate stigma. Stigma reduction modalities that have been successful in other studies could be also be used in the medical-surgical setting to determine their effectiveness in addressing negative attitudes.

CHAPTER 3: THEORETICAL FRAMEWORK

Stigma is a complex and multifaceted phenomenon that can be conceptualized in a variety of ways. In order to successfully decrease the stigma associated with psychiatric illnesses, one must understand how it arises and recognize factors that exacerbate its effects on patients. Both Goffman and Corrigan provide theories that explain both of these considerations that create the problem of stigma. This project's primary aim was to change attitudes, which can be a difficult goal to achieve. Ajzen and Fishbein developed a model that explains attitudinal change and its effect on behavior.

Theory of the Problem

As discussed in the review of literature, Goffman's philosophical underpinnings and Corrigan's conceptual model of stigma was used to guide the understanding of the problem of stigma. Goffman (1963) explained the sociological phenomenon of stigma while Corrigan (2003) described the different types of stigma as well as three of its many components. Both researchers identify components of stigma that must be assessed and targeted to promote attitudinal change.

An important aspect of Corrigan's theory of stigma not previously discussed in the review of literature is the attributes of stigma. Corrigan's attributes are a subset of identified false causes that people attribute to the development of psychiatric illnesses. Corrigan and his colleagues (2003) state that by challenging these incorrect attributes, the negative attitudes associated with psychiatric illnesses can be defied.

Theory of the Intervention

Additionally, Ajzen and Fishbein's Theory of Reasoned Action (TRA) was used to guide the project planning and implementation. TRA has been applied to various social problems including discrimination and racism. The theoretical framework aids in the prediction and change of human social behavior and, in the past, has been used to examine racism (Fishbein, 2010). According to the authors, behavior is predicted by a person's beliefs. These beliefs are influenced by the media, Internet, television, personal experiences, education, and family/friends. Behavior is also influenced by three key components, (a) attitude, (b) normative beliefs, or the social pressure felt to perform the behavior and (c) control considerations, or the skills/abilities to and facilitators/barriers of performing the behavior. Identification of these three beliefs helps in attitudinal change and predicts behavioral changes (Fishbein, 2010).

While the overall goal of the DNP project was to improve attitudes, this theory explains how attitudinal improvements can result in behavioral change. This was a secondary goal of the proposed intervention. TRA also identifies other determinants of attitude and behavioral change through the previously discussed notion of control considerations. The control considerations of stigma were assessed using the learning needs assessment, which was administered prior to the intervention and used to plan the program. Control considerations for this intervention included decreased knowledge, lack of communication/assessment skills, not feeling supported, and belief in myths of psychiatric illnesses. Therefore, in addition to improving attitudes, this project also identified elements that influence negative attitudes.

CHAPTER 4: METHODOLOGY

Overview

The Institute for Health Care Improvement's (IHI) Model for Improvement (IHI, 2017) was selected to develop a psychoeducational program with the aim to improve attitudes and the overall quality of nursing care on a medical-surgical unit in North Carolina. This quality improvement model incorporates three fundamental steps: (a) setting aims, (b) establishing measures, and (c) selecting changes, followed by a Plan-Do-Study-Act (PDSA) cycle (IHI, 2017). Figures 4.1 and 4.2 illustrate the application of this model to the DNP project.

FIGURE 4.1: Model for Improvement

Aim	To change nurses' and nursing assistants' attitudes about planning and implementing nursing care for individuals with psychiatric symptoms and/or illnesses by targeting attitudes, knowledge, and compassion.
Measures	Attitude: Measured pre- and post-program with MICA v4 Compassion & Knowledge: Post-program evaluation questions
Change	Psychoeducational program guided by a learning needs assessment

Figure 4.2: Plan-Do-Study-Act
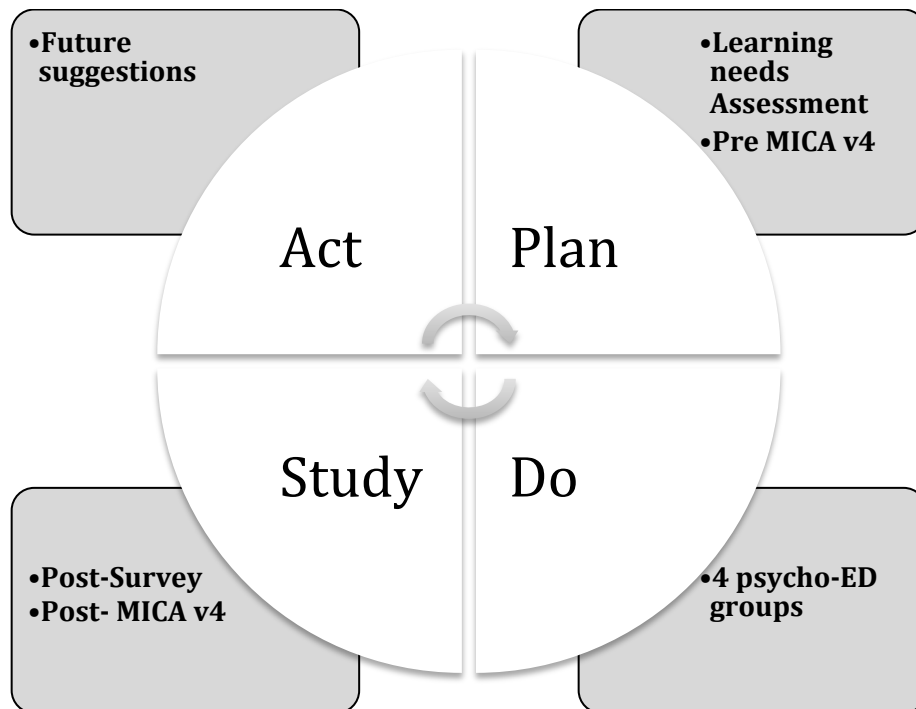
The DNP project implemented an anti-stigma program on a medical-surgical unit using suggestions from previous researchers with an ultimate goal of improving, as well as enlightening, attitudes. The project was unique in that it first conducted a learning needs assessment to the nursing staff. This survey was developed based on the literature review and was used to assess the learning needs of the nurses and nursing assistants (now known as nursing staff) (Appendix 1). There were no other studies identified in the literature that initiated this step prior to implementing an anti-stigma program.

The educational sessions were then planned using the information obtained from this needs assessment. The main outcome of the project, nursing staff attitudes, was measured quantitatively using the Mental Illness: Clinicians' Attitude Scale-Version 4 (MICA v4), which was completed by the staff prior to and immediately after program

completion (Gabbidon et al., 2013). In addition to completing the MICA v4, the staff answered three questions that yielded qualitative data (Appendix 6) and that addressed the other two purposes of the DNP project: (a) understanding of psychiatric illnesses and (b) ability to provide compassionate care. In order to prepare for the project's implementation, each of the instruments and survey will be presented, followed by a description of the setting, nursing participants, key personnel/stakeholders, human subjects protection, resources/budget, and predicted project benefits.

Instruments

The instruments used in this project included a pre-program learning needs assessment, the MICA v4, and a post-program evaluation survey. A description of each instrument's development and purpose in the stigma reduction program will be provided below.

Learning Needs Assessment

The learning needs assessment gathered information about the nursing staff's self-reported learning needs as it related to caring for individuals diagnosed with psychiatric illnesses on their medical-surgical unit. It was developed to help inform the planned intervention to be clinically relevant for the medical-surgical environment as well as address gaps identified in the literature that could potentially improve the project's effectiveness and the duration of its effects over time (Appendix 1). Each of the 15 questions in the needs assessment evaluated for the presence of major contributors of stigma identified within the literature:

- Role legitimacy, or the extent that the nursing staff felt it was their job to attend to patients' mental health care needs (Munro et al., 2007).

34

- Fear and/or negative attitudes towards patients diagnosed with psychiatric illnesses (Reed & Fitzgerald, 2005; Ross & Goldner, 2009).

- A lack of knowledge about the signs and symptoms of psychiatric illnesses, treatment, and/or the relationship between physical and mental health

- Role adequacy, or the degree to which the staff felt prepared to care for patients diagnosed with psychiatric illnesses (Munro et al., 2007).

- Role support, or the availability of appropriate resources and/or support in the workplace (Munro et al., 2007).

In addition to questions that assessed for the presence of specific contributors of stigma, demographic questions were incorporated and included: (a) highest level of education achieved, (b) years of experience as a registered nurse/nursing assistant and, (c) previous volunteer and/or work experience in a psychiatric setting (Appendix 1). It also inquired about psychiatric illnesses the nurses and nursing assistants most often encountered on the unit as well as their learning style/preferences. These questions were included in the needs assessment because they were identified as critical information needed for effective project design (Collins et al., 2012). The demographic information was also used for data analysis. Demographic questions were used to describe only the sample and structured to protect each individual's identity. For example, when asked about years of nursing experience, the answers included the following: (a) 0-5 years, (b) 6-10 years, (c) 11-14 years, and (d) 15+ years (Appendix 1).

Each question on the pre-program learning needs assessment was rated on a 5-point Likert scale and coded for the analysis to calculate an average, aggregate score.

Each answer was coded 1 to 5, with 1 correlating with: (a) not well at all, (b) not at all confident, (c) none at all, and (d) not at all important. A higher score indicated a more positive response (i.e. very well, very confident, very important).

In summary, the learning needs assessment was created to incorporate education into the sessions because it (a) assessed for major contributors of stigma and negative attitudes, (b) determined the types of psychiatric illnesses seen on the unit to make the intervention applicable and, (c) identified the nurses' learning style preferences to create a conducive learning setting.

Mental Illness: Clinicians' Attitudes Scale: Version 4 (MICA v4)

Permission was sought from and provided by the authors to use this scale for the project (Appendix 4). This scale was chosen as the pre- and post- program multimodal anti-stigma evaluation tool because of its previous use in stigma reduction programs (Gabbidon et al., 2013). The MICA v4 is used specifically to measure healthcare professionals' attitudes of patients diagnosed with psychiatric illnesses in non-mental health care settings (Gabbidon et al., 2013). It is composed of 16 Likert questions with each question requiring a response on a 5-point scale. Questions 3, 9, 10, 11, 12, and 16 are scored as follows: 6=strongly disagree, 5=disagree, 4=somewhat disagree, 3=somewhat agree, 2=agree, and 1=strongly agree. All other questions (1, 2, 4, 5, 6, 7, 8, 13, 14, 15) are scored in the reverse way: 1=strongly disagree, 2=disagree, 3=somewhat disagree, 4=somewhat agree, 5=agree, and 6=strongly agree (Gabbidon et al., 2013). Possible scores can range from 16 to 96 with a higher score indicating a more negative attitude (Gabbidon et al., 2013).

In a study that assessed the scale's psychometric properties, Gabbidon and colleagues (2013) analyzed stigma scores by calculating the data distribution, sample mean, and standard deviation to examine score differences. Authors of the MICA v4 scale participated in this study. The scale's reliability was assessed using Cronbach's alpha and was found to have good reliability with an internal consistency $\alpha \geq 0.7$. The scale's validity was assessed using convergent validity and was compared with the Reported and Intended Behaviour Scale (RIBS) and the fear subscale of The Emotional Reactions to Mental Illness Scale (ERMIS) (Gabbidon et al., 2013). Pearson correlation analysis revealed a moderate relationship with the RIBS (r=0.49) and a low-moderate relationship with ERMIS's fear subscale (r=0.32). The required threshold for moderate correlation was 0.3-0.5, classifying correlations to the other two scales as 'moderate' (Gabbidon et al., 2013). Additionally, face validity was suggested as "good" from a research group of students and professionals working in various healthcare disciplines, including nurses (Gabbidon et al., 2013).

Post-Survey

The post-survey included the MICA v4 and both qualitative and quantitative questions that evaluated the psychoeducational program (Appendix 6). It first assessed the nursing staff's perception of whether the psychoeducational intervention enhanced the ability to provide compassionate care. Like the pre-survey, these Likert questions were coded from 1 to 5, with 1 representing no enhancement and 5 representing a strong enhancement in ability to provide compassionate care. The survey then assessed the nurses' perception of whether the program improved their understanding of psychiatric illnesses. The same coding was also used for this question.

In addition to quantifying the project's three main outcomes of attitudes (stigma), compassionate care, and understanding of psychiatric illnesses, the post survey also allowed the nurses to self-reflect on variables specific to each of the four psychoeducational sessions. The educational sessions will be described further in detail later in this chapter.

The first of these class-specific questions asked the nursing staff whether the Implicit Bias presentation allowed them to reflect on their own personal biases related to patients diagnosed with psychiatric illnesses. The second question asked whether the Bipolar Disorder presentation improved their attitude about families who have a loved one diagnosed with bipolar disorder. The next question assessed whether the Addiction presentation increased their sensitivity towards individuals with an addiction to substances. The final question asked whether the last presentation improved their attitude about caring for patients with mental health care needs on a medical-surgical unit.

The final portion of the post-survey included a question that asked how the psychoeducational sessions changed the nursing staff's ability to care for patients diagnosed with psychiatric illnesses. This was a free-text response that allowed the nurses to describe their overall perception of the program.

Setting

The project took place in a large metropolitan hospital, 30-bed inpatient unit that served individuals and their families in a suburban community. The medical-surgical unit chosen for this project employed 42 nurses and 19 nursing assistants at the time of the survey distribution. The nurse-patient ratio was 5:1 for the day shift nurses and up to

38

6:1 for night shift nurses. Nursing assistants were usually assigned between six and nine patients for both day and night shifts.

The hospital was chosen for the project because it did not have a psychiatric unit or psychiatric emergency department. Until about three years ago, the project unit was considered a women and children's unit that provided care solely to pediatric, gynecological surgical, and bariatric weight loss patients. The unit had evolved into a medical-surgical unit providing care to patients undergoing bariatric weight loss, gastrointestinal, thyroid, gynecological, thoracic and other surgical interventions as well as to those with psychiatric illnesses. The unit also cared for an increasing number of patients with chronic health conditions that are highly correlated with psychiatric illnesses such as heart disease, diabetes mellitus, and obesity. In the past, the nursing staff voiced concern regarding difficulty providing care to and communicating with the growing number of patients diagnosed with comorbid psychiatric illnesses and/or symptoms admitted to the unit.

There were few classes offered at the institution that focused on the education and management of psychiatric illnesses. Courses offered included crisis prevention intervention, handling agitation/aggression, end of life issues, emergencies in the emergency department, and seclusion/restraints. There was a virtual toolbox available on the institution's educational website that provided information about mood and thought disorders as well as some medical conditions that could mimic psychiatric symptoms; however, it was called *Management of the Difficult Patient*, which is a stigmatizing title. There was one course entitled *Mental Illness in Non Mental Health Settings*, but its focus was on psychiatric crises, chemical/physical restraints, and involuntarily committed

(IVC) patients. The majority of these programs were only available online and addressed acute crises rather than patients admitted with comorbid medical and psychiatric illnesses. There was one online annual compliance course titled *Bariatric Sensitivity, which* aimed to improve nurses' empathy towards patients with obesity; however, this was the only course that specifically targeted nurses' attitudes and behaviors towards a stigmatized patient population. It was only available online and was composed of slides and a short video. Besides these few courses, there were no educational programs that addressed nurses' attitudes towards patients with psychiatric illnesses or provided opportunities for direct contact.

This DNP project aligned well with the hospital's mission of "providing the best in health services by bringing together compassionate care (UNC REX Healthcare, 2016)." The hospital also valued both clinical care and patient perceptions of care. The organization utilized the Hospital Consumer Assessment of Health care Provider Systems (HCAHPS) survey to measure patient satisfaction.

Participants

The anti-stigma program was open to all nurses and nursing assistants who worked on the designated unit. As previously discussed, the medical-surgical unit employed a total of 42 nurses and 19 nursing assistants at the time of the learning needs assessment administration.

Key Personnel/Stakeholders

Key stakeholders involved in the planning of the project included the Chief of Nursing Officer (CNO) and the medical-surgical unit's manager. The nurse manager endorsed this project as a unit activity. Permission to conduct the stigma reduction

program was sought and granted from the organization's Chief Nursing Officer and Director of Practice, Quality, and Research (Appendix 5). The unit's manager was the designated supervisor for the project and attended all educational meetings with the exception of one. Lastly, the Director of Practice, Quality, and Research was available to support navigation of the internal systems needed to conduct the project.

Key personnel involved in project delivery included the three speakers who discussed and provided interactive education on three different topics. Dr. Kim Cox, MSN, DNP, ANP-BC, APNP is an assistant professor at The University of San Francisco who was consulted on her expertise in managing psychiatric illnesses in medical-surgical patients. She granted the DNP student permission to use information in the program from one of her own presentations (Cox, 2015). Lastly, the needs assessment was designed using project-relevant literature, collaboration with committee members, and consultation provided by The University of North Carolina's Odum Institute.

Human Subject Protection

Each individual's responses to the pre- and post-survey were anonymous and without identifiers. The DNP student was the only individual with access to the data in the Qualtrics electronic polling system. Each program speaker's privacy was also protected due to the confidentiality of the information provided. The speakers signed a consent agreeing to be filmed. The videos were made available via a limited access folder.

Resources and Budget

A meeting was conducted with the unit's manager and the Director of Practice, Quality, and Research during the planning stages of the project. The manager was in full

support of the intervention and allocated finances in the budget to provide educational pay to all nursing staff as an incentive to participate. Light refreshments were provided at each educational session. Additionally, the speakers were provided with a gift certificate or honorarium in exchange for their time and project involvement. The educational department within the institution transferred the recorded presentations to a limited access folder.

Benefits/Harms

Before project implementation, the DNP student listed the following as possible benefits of the proposed project:

- Increased awareness of stigma and how it relates to assessment and communication skills

- Understanding of the nature of compassion and empathy

- Increased knowledge of psychiatric illnesses and their relationship with physical illnesses

- Understanding of the nurse-patient engagement and advocacy

Based on the review of literature, the program also had the *potential* to:

- Improve unit patient satisfaction scores

- Decrease duration of patient hospitalizations

- Reduce the number of hospital acquired and post-operative infections

- Contribute to health cost savings.

The latter list of benefits were not directly assessed or measured in the project, but just discussed as potential organizational improvements. Additionally, nursing administration

at this setting voiced the possibility of continuing the anti-stigma program in the future and/or adding it to the new employee orientation.

There was no anticipated harm associated with participating in this project. There was always a possibility of increasing negative attitudes associated with stigma, which could indirectly affect patient care.

Conclusion

This section provides the blueprint used to plan implementation of the stigma reduction program. The specific hospital unit was chosen because of the evolution it had undergone in regards to patient population. This was a once women's health, pediatric, and bariatric weight loss unit that transformed into a medical-surgical unit caring for more patients with co-existing psychiatric illnesses. Quality improvement was chosen as the methodology because this project utilized a systematic and pre-planned approach to improve the nursing care of a targeted group. The program was designed specifically for the chosen unit and required the staff's input. The instruments were chosen based on their alignment with the project's aim. The next chapter will explain the steps taken to implement the project, how the instruments were used, and the timeline of events.

CHAPTER 5: PROJECT IMPLEMENTATION

This next chapter will describe the "Do" stage of the PDSA cycle. Details will be provided regarding administration of the previously discussed instruments and each educational session. There will also be an explanation of how the sessions were designed and tailored to the chosen nursing unit.

Learning Needs Assessment Administration

The learning needs assessment was administered four weeks prior to project implementation and was used to plan the content incorporated into the educational sessions. It was distributed via Qualtrics, which is an online survey tool made available to UNC students. It was accessible to the entire nursing staff regardless of their intent to attend the sessions.

The pre-survey assessment provided a baseline stigma score to the unit and revealed educational needs to be addressed by the project. The results of the learning needs assessment will be presented in the next chapter. After completion of the pre-intervention assessment, there were a total of four educational sessions. Each of these will be discussed in further detail below.

Educational Sessions

The educational sessions were structured and implemented to provide understanding, insight and knowledge about caring for individuals with psychiatric illnesses on a medical-surgical unit with an ultimate goal of reducing negative attitudes, increasing knowledge, and enhancing compassionate care. The nursing staff was able to

attend as many as of the educational meetings as they liked. Communication of the proposed educational program occurred via unit staff conferences, emails, and the unit's staff conference bulletin board.

The educational program lasted approximately one month. There was one class per week for four consecutive weeks. The duration of each class ranged from one to two hours and took place in the hospital's educational rooms. The classes were recorded, after consent was obtained from each speaker, and made available via the unit's specialized hard-drive for those who were unable to attend the live sessions. The nursing staff was able to indicate on the post-program survey whether they watched additional sessions online if they were unable to participate in person.

Educational Session Planning Using Learning Needs Assessment

The majority of time spent on this project was dedicated towards planning each educational session with information obtained from the learning needs assessment. The delivery mode of the program was based on the nursing staff's responses to the question that assessed their learning style preferences. Figure 5.1 shows the nursing staff's responses to this question from the learning needs assessment. The top three preferred delivery modes were in-person education, guest speakers, and group discussions. The DNP student incorporated these three modalities into each educational session to meet the staff's educational needs.

Figure 5.1: Preferred Learning Modalities
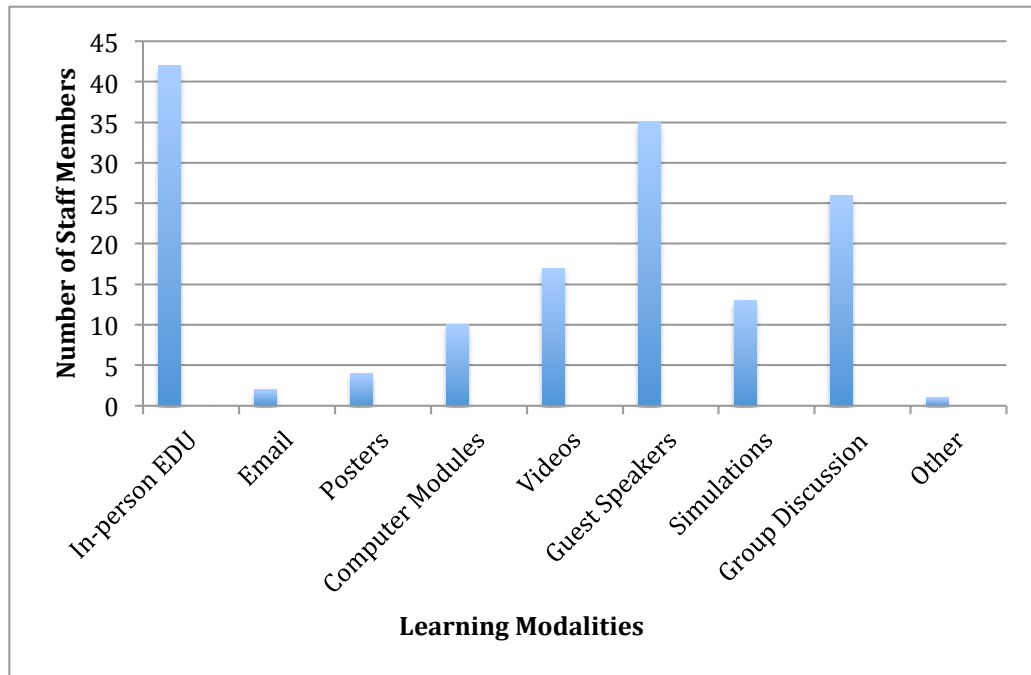
Because the literature indicated that direct contact interventions were most effective in impacting attitudes, a mental health care clinician, a family member, and an actual client were invited as the guest speakers. This is one example of how evidence was integrated to meet the nursing staff's specific learning needs.

The learning needs assessment also what psychiatric illnesses were most often seen on the unit and what illnesses the staff wanted to learn more about. Figure 5.2 shows the responses to this question. The DNP student tried to weigh which illnesses were most often cared for on the unit with the nursing staff's learning interests. The most individuals chose bipolar disorder as an illness they wanted to learn more about. Since bipolar disorders are more highly stigmatized than others, this was chosen as a topic for one of the sessions (Bjorkman et al., 2008). Substance misuse disorders were the third

most chosen illness that the staff wanted to learn about. Because these disorders are also highly stigmatized and commonly seen on the unit, this was also chosen as a topic for one of the educational sessions. Again, this illustrates how evidence and innovation were combined to create a program for the hospital unit.

Figure 5.2: Illnesses Seen on Unit and Learning Interests
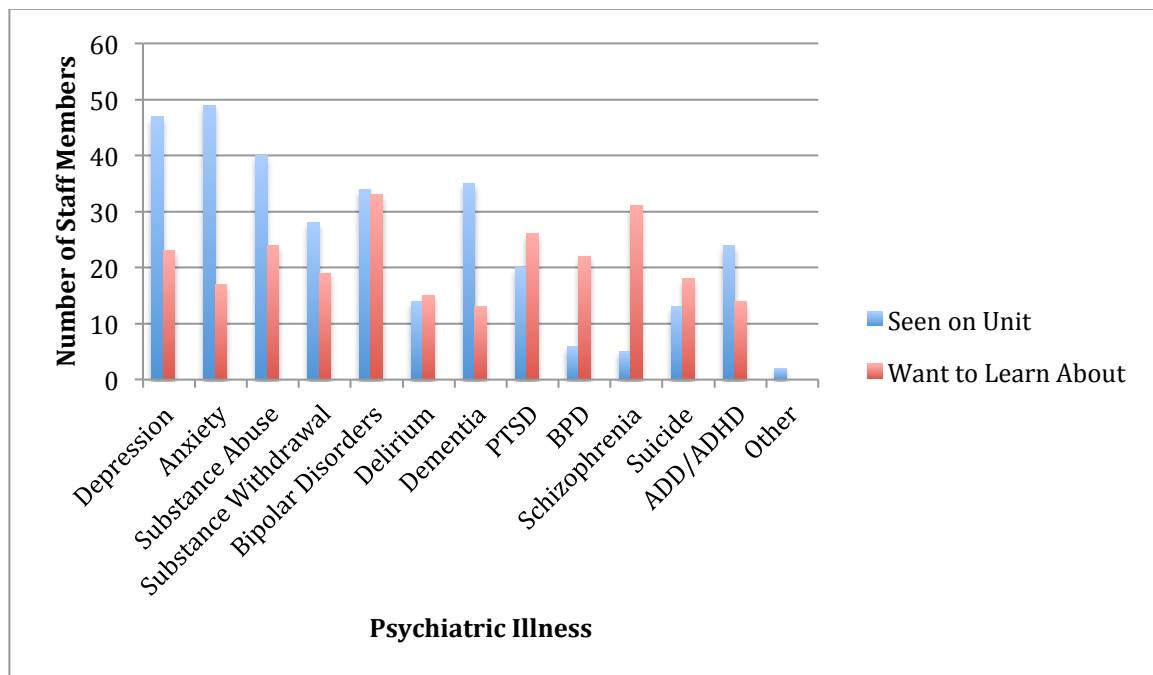
The questions assessing the presence of factors found to contribute to stigma revealed the need for further skills and communication training. This was incorporated into each session but was a major focus of the fourth and final session. The responses to this question will be further discussed in the next chapter.

Program Meeting #1: Implicit Bias

A clinical nurse specialist with a research background in implicit bias facilitated the first educational session. This topic was not chosen from the learning needs

assessment; rather, it was incorporated based on suggestions from articles that claimed

that emphasis on self reflection and recognition of personal biases could, perhaps,

decrease stigma (Corbiere et al., 2012).

In addition to explaining the phenomenon of implicit bias, she provided current

world examples of its manifestations as well as its implications on marginalized groups.

She also identified risk factors that promote implicit bias such as emotional states, stress,

and pressured decision-making. All of these risk factors are prevalent on a fast-paced,

medical-surgical unit such as the one where the project took place. Lastly, the speaker

introduced clients and facilitated discussion about the staff's initial impressions of the

patient.

A total of 25 nursing staff members either attended or viewed this session online.

The class incorporated the use of multimedia slides and group discussions as learning

modalities. The use of the clinical nurse specialist also allowed the staff to view mental

health through the lens of a mental health clinician.

Program Meeting #2: Family Perspectives and Bipolar Disorders

The second speaker shared her experience of living with and caring for a family

member diagnosed with bipolar 1 disorder. The presentation included some general

education about bipolar disorders but the majority of the class focused on how she had

been affected by her family member's illness. She discussed her experience navigating

the health care system and both the positive and negative encounters with health care

clinicians. She provided a family's perspective of living with a psychiatric illness and

offered tips as to how nurses could effectively listen to and interact with patients and

their families during hospitalization.

Seventeen individuals attended and/or viewed this session online. The class incorporated education via paper printouts, multimedia slides, a video portrayal of someone diagnosed with bipolar disorder, group discussions, and direct contact through the use of a family member.

Program Meeting #3: The Client Perspective and Addiction

The third speaker was an actual client who shared her story of having an addiction to substances. She focused on the discussion of her personal struggles and triumphs and road to sobriety. She provided insight about her life prior to addiction, its debilitating mental and physical effects, and the difficulty she experienced receiving treatment. She also shared stories of how nurses positively affected her hospitalizations and communication techniques that made a difference in her recovery.

Nineteen individuals attended and/or viewed the addiction session online. The presentation took a recovery-oriented approach in that speaker focused on her medical and psychiatric treatment process. She also discussed the progress she had made since reaching sobriety including the development of a new social support system, reestablishing familial relationships, re-entrance into the workplace, and reaching financial independence. The speaker used a photograph taken of her during her detox phase in the hospital so that the audience could see how addiction had affected her appearance but also how it had improved with sobriety. Lastly, the session included direct contact through the use of a client, communication training, group discussions, and content focused on social inclusion of individuals living with a psychiatric illness.

Program Meeting #4: Mental Health Care on a Medical-Surgical Unit

The final session was presented by the DNP student and was attended/viewed by 24 staff members. The first portion of the session included education about the medical vulnerabilities experienced by patients with psychiatric illnesses and the medical illnesses correlated with them. Information was also provided about health care complications that are a result of stigma. All of the information was gathered from this paper's review of literature.

The second portion of the session involved group discussions of patient encounters on the unit. The DNP student shared stories of patients she had taken care on the unit diagnosed with psychiatric or substance misuse disorders, self-awareness of biases, and the process of learning how to communicate and interact with different patients. She also presented past patients and difficult first encounters to communicate her initial impression of the patient. This was then followed by discussion of what the student found out about the patient that made her further reflect on the initial impressions of the patient such as prior traumatic experiences, familial conflict, poverty, and other factors that shape who a person becomes.

The final portion incorporated portions of a toolbox developed by Kim Cox, DNP, MSN, ANP-BC, APNP (2015) who is an assistant professor at The University of San Francisco. This information included basic communication skills, development of empathy, and use of symptom specific interventions (i.e. distraction). The session ended with a case presentation where nurses had to provide interventions and communication strategies for the patient. They also discussed barriers to providing mental health care on the unit.

Post-Survey Administration

The post-survey, which included qualitative evaluation questions and the MICA v4, was available for one month after the completion of the program. Instructions to complete the survey were sent via the organization email system. Since individual scores were not being tracked from to pre- to post-program completion, all staff members were able to take the survey regardless of session attendance. The questions were structured so that an individual could indicate what, if any, sessions they attended. The post-survey yielded yet another stigma score and provided feedback on how the program increased understanding of psychiatric illnesses and enhanced compassionate care. This information will be discussed in the data analysis and discussion sections.

Conclusion

At the time of project implementation, there were no known studies that sought to reduce nursing stigma associated with patients diagnosed with psychiatric illnesses on a medical-surgical hospital unit. Because of this, the DNP student utilized evidence-based modalities used in other healthcare settings while also developing innovative strategies to incorporate into the program. The direct contact sessions offered three different perspectives of mental illness through: (a) a clinician, (b) a family member, and (c) a client. Group discussions focused on communication and clinical skills that nurses could adopt when caring for these patients. Additionally, content and education focused on both the physical and mental health care needs of patients. Lastly, it emphasized recovery and the importance of social inclusion. The next chapter will discuss the project's outcomes.

CHAPTER 6: DATA ANALYSIS

This DNP project focused on the following three key concepts: (a) understanding of psychiatric illnesses, (b) compassionate care, and (c) stigma (as measured by attitudes). This chapter will present the findings of the data collected before and after the educational program.

Overview

The purpose of this project was to increase medical-surgical nurses' understanding of psychiatric illnesses, to enhance compassionate nursing care, and to decrease the negative attitudes associated with stigma in patients who have been diagnosed with physical and psychiatric illnesses in an acute care setting. The following measures were used to capture the three key concepts.

TABLE 6.1: Outcome Measures

Concept	Measure	Type of Data	Data Collection Time
1. Stigma	MICA v.4 Instrument	Quantitative	Pre/Post
2. Compassion	1 Likert Question	Qualitative	Post
3. Understanding	1 Likert Question	Qualitative	Post

This project focused on gathering and analyzing data with an overall aim to improve nursing care on a medical-surgical unit in a metropolitan hospital in North Carolina. The approach and the aim was implemented by following an organized process of resources (inputs), activities and results (outcomes) associated with Quality

Improvement (HRSA, 2011). This chapter will focus on the data collection, findings and analysis that led to the potential for improvement of nursing care. It will be divided into the following two sections: (a) descriptive data and (b) correlational data.

Pre-Survey and Learning Needs Assessment: Characteristics of Sample

Fifty-two people responded to the pre-program learning needs assessment and MICA v4 (85% response rate). Fifty-seven percent of respondents held a Bachelor's degree, 22% held an Associate's degree or nursing diploma, 16% held a high school diploma or GED, and 4% had a Master's degree (Figure 6.1). In terms of nursing experience, 23 nurses had between zero and five years of nursing experience and 16 nurses had more than 15 years of experience. These two groups represented 80% of all respondents.

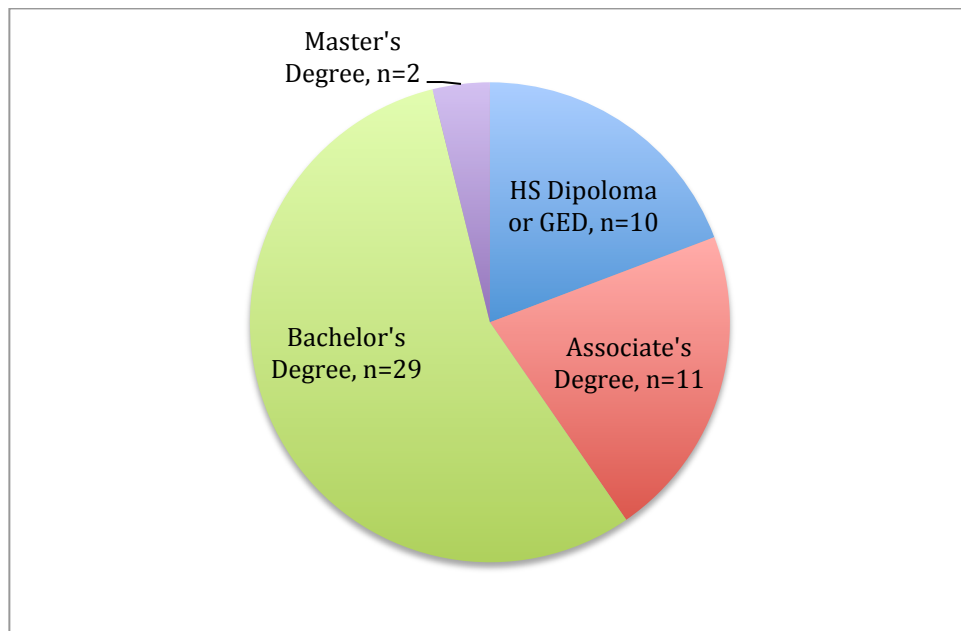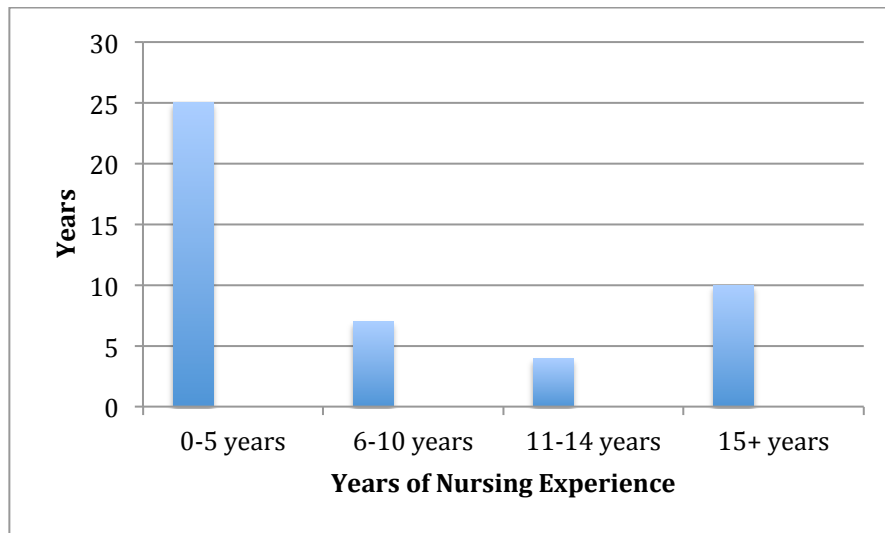Figure 6.1: Learning Needs Assessment: Education Level

Figure 6.2: Learning Needs Assessment: Nursing Experience

In regards to previous psychiatric experience, 73% (n=38) had no experience and 27% (n=14) indicated prior experience caring for patients diagnosed with psychiatric illnesses. Of those that said they had experience in psychiatry, only five indicated they had experience outside of the one clinical rotation completed in nursing school. Refer to Appendix 7 for more detailed characteristics of the respondents.

Pre-Survey and Learning Needs Assessment: Descriptive Results

As previously discussed, questions 4-10, 13, and 14 measured factors that were cited within the literature and that could influence the negative attitudes associated with stigma (Appendix 1). Appendix 8 schematically shows the nursing staff's responses to these. None of the questions scored above an average score of 3, indicating the need for improvement in the following areas: (a) identification of signs/symptoms of psychiatric illnesses, (b) symptom specific interventions, (c) recognition of behaviors indicating substance use, (d) communication skills, (e) familiarity with the mental status examination, (f) the relationship between medical and mental health, and (g) the amount

of support provided by health care team members. The only question that scored above a 3 was the one that assessed nurses' perception of the importance of learning about psychiatric illnesses. This particular question scored a 4.19.

Three MICA v4 surveys were eliminated due to incomplete data. Eliminating these surveys avoided a false, low MICA v4 score, which would have resulted in a misleading score overall. The average score resulted in a 38.78 with a minimum score of 25 and a maximum score of 56.00. The data had a standard deviation of 6.53 and a variance of 42.70 (Appendix 10).

Post-Survey: Characteristics of Sample

A total of 44 staff members completed the post-survey and MICA v4 (72% response rate). Three surveys were eliminated from analysis due to incomplete data on the MICA v4. These respondents did not answer any of the MICA v4 questions, which resulted in a score of "0," thus indicating a false low score. Therefore, a total of 41 surveys were used for the stigma score analysis. This represented a 67% response rate. The Implicit Bias presentation was the most highly attended or viewed presentation with 25 individuals indicating they either attended or viewed the session online. The next most attended/viewed presentation was Caring for Patients with Mental Health Care Needs on the Medical-Surgical Unit with 24 participants. This was then followed by the Addiction presentation (19 individuals) and, finally, the Bipolar Disorders presentation (17 individuals).

Post-Survey: Descriptive Results

The first two questions addressed the program's outcome to enhance compassionate care and increase understanding of psychiatric illnesses and resulted in a

4.5 and 4.4, respectively. As previously discussed in the methodology chapter, questions were scored from one to five, with a higher score indicating a more positive result.

The next four questions assessed certain characteristics of each educational session in the psychoeducational program. The questions were scored the same as the previous questions and can be reviewed in the methodology section.

Table 6.2: Individual Session Scores

Educational Session	Characteristic Assessed	Score
Implicit Bias	Self-reflection of personal biases	4.3
Bipolar Disorders	Attitude about families who have a loved one diagnosed with a bipolar disorder	4.5
Addiction	Sensitivity towards patients who have an addiction to substances	4.4
Caring for Patients with Mental Health Needs on a Medical-Surgical Unit	Attitude towards patients diagnosed with psychiatric illnesses	4.5

After reviewing the answers to the question that assessed how the program changed the staff's ability to care for patients diagnosed with psychiatric illnesses, three key themes were identified: (a) recognition of the human being behind a diagnosis, (b) increased awareness of personal biases and increased empathy, and (c) improved ability

to care for patients diagnosed with psychiatric illnesses. These statements and their correlating themes can be found in Appendix 9. One statement from a participant who attended all four sessions is included below and states;

> *"I have a better understanding of how mental illness waxes and wanes throughout a patient's life. I didn't realize I probably had a subconscious bias about patients with a particular disease and assumed every patient had the same behaviors depending on their diagnosis. This is NOT true at all. Everyone has a different story and copes in a different way. It truly doesn't matter what the diagnosis is, what matters is the behaviors the patient is experiencing at the time. Yes, a diagnosis helps predict what behaviors might be and what medications might help the most but you truly look at the patient and what they are going through… I can be a part of their support system during the time I spend with the patient."*

The final portion of the post-survey was the MICA v4. The average aggregate score of the unit was 33.78 with a minimum score of 22 and maximum score of 59. The maximum score (59) was an outlier and was associated with an individual who did not participate in any of the educational sessions. The standard deviation of this data set was 6.72 and the variance was 45.10. Although 41 individuals completed the survey, five respondents did not attend or watch any of the sessions. When eliminating these individuals from the MICA v4 analysis, the unit's aggregate score decreased to 32.58 with a minimum score of 22 and a maximum score of 44. This data set's standard deviation was 5.29 with a variance of 27.97 (Appendix 10). A comparison of the pre- and post-descriptive statistics can be seen below in Table 6.3 and Figure 6.3.

Table 6.3: Pre- and Post-Descriptive Statistics of Unit MICA v4 Scores

Variable	Count	Mean	Minimum	Lower Whisker	Q1	Median	Q3	Upper Whisker	Maximum
Pre	49	38.78	25	25	34	38	43	56	56
Post	41	33.78	22	22	29	33	37	44	59

Figure 6.3: Unit Pre- and Post-MICA v4 Scores
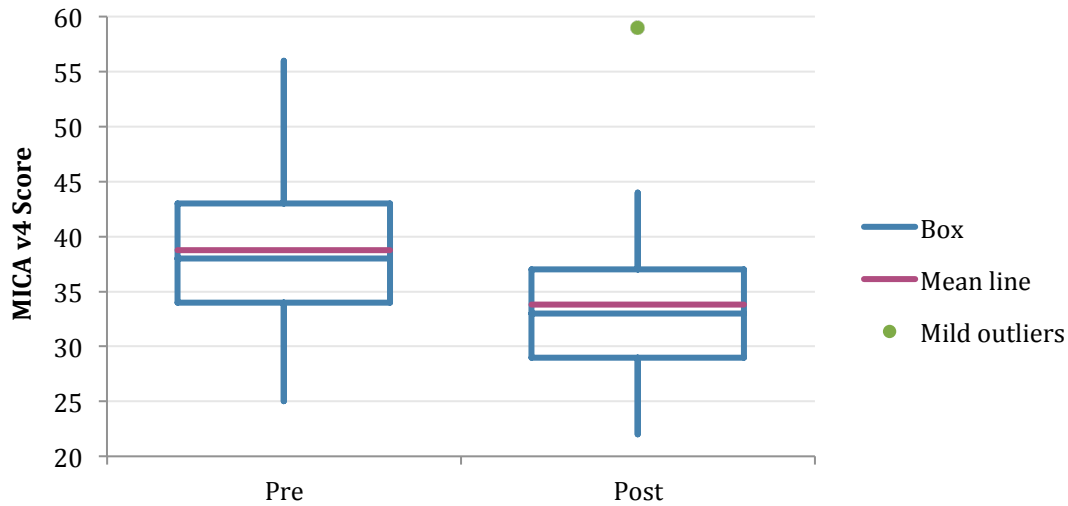
Correlational Results

One of the primary considerations for this project was the exploration of whether the educational activity would affect the nurses' attitudes as measured by the MICA v4 and, hence, provide an outcome of measuring quality improvement in the nursing care in the acute care setting. An unpaired t-test was used to determine whether the mean aggregate post-scores were significantly lower than the baseline scores. This test was purposefully chosen to examine the nursing staff's attitudes as measured pre and post-activity with the same subjects. The test was unpaired since individual scores were not tracked from pre- to post-project completion. This test resulted in a p-value of 0.00067, indicating a potential correlational relationship between the education/training program and attitudinal change.

Summary

The data was collected for this project using pre- and post-activity surveys to examine whether a psychoeducational program could have an effect on the perception ad care of individuals diagnosed with psychiatric illnesses. The overall aim was to improve the nursing care of individuals who were patients in an acute care setting and with comorbid medical and psychiatric diagnoses. The next section will discuss the outcomes of the analysis.

CHAPTER 6: DISCUSSION

This DNP project's main objective was to determine whether a psychoeducational intervention that empowered nurses with knowledge would change their attitudes about planning and implementing nursing care for individuals diagnosed with psychiatric illnesses. The program had three goals that would help answer this question: (a) to increase understanding of psychiatric illnesses, (b) to enhance their ability to provide compassionate care, and (c) to decrease the negative attitudes associated with caring for patients diagnosed with psychiatric illnesses.

These goals were measured pre- and post-activity implementation using the MICA v4 questionnaire and qualitative questions. The nursing staff responses indicated that the program met all three goals. The Likert-formatted questions assessing the nursing staff's perceptions of whether the activities enhanced their ability to provide compassionate care and improved their understanding of psychiatric illnesses both scored high, 4.5 and 4.4 respectively (on a 1 to 5 scale). The MICA v4 score for the unit decreased from 38.78 to 33.78, indicating a decrease in the level of negative attitudes held by nurses and nursing assistants. Each previously listed purpose will be discussed further in this chapter in addition to the following items: (a) quality improvement versus research, (b) strengths/limitations, and (c) conclusions.

Purpose #1: Understanding of Psychiatric Illnesses

Education was key to increasing the nursing staff's understanding of psychiatric illnesses; however, it had to be approached carefully in order to be effective and to avoid

increasing the stigma, which occurred in other programs (Dalky, 2012). Simply educating the nursing staff on the signs and symptoms of various illnesses would not have resulted in attitudinal change (Dalky, 2012); however, since the unit did not offer any education about specific psychiatric illnesses and their management on general inpatient units, the DNP student deemed this component necessary.

The learning needs assessment played a vital role in education preparation and success by gauging what illnesses were most often seen on the unit. The preferred learning modalities listed on the learning needs assessment was used to deliver education in a way that nurses could understand and appreciate. One contributor to stigma is ignorance and belief in myths, both of which are present in the healthcare setting and need to be addressed to produce change (Corbiere et al., 2012; Dalky, 2012). The learning needs assessment revealed that the staff associated having a psychiatric illness with violence, so this myth was often discussed in the educational sessions. The emphasis on recovery and social inclusion also dispelled the myth that individuals cannot work or interact meaningfully with others.

The program was also successful because it incorporated topics that were specifically applicable to the medical-surgical nursing environment by presenting/discussing patients with both medical and mental health care needs. The WHO (2008) has claimed that integrated care is crucial in improving patient outcomes and nursing competency; therefore, this was featured in the sessions. The relationship between physical and mental health was discussed as well as how symptoms can be exacerbated in the general hospital setting. This holistic-based conceptualization of health assisted the nurses to develop a new perspective of assessment and to better

identify both the physical and mental health care needs of the patient. Appendix 9

provides examples of the staff's post-survey responses that indicate an enhanced ability

to consider the physical and mental health care needs of patients.

The learning needs assessment also identified the notion that the nurses did not

feel confident in providing interventions for patients with mental health needs. With the

growing number of patients with psychiatric illnesses and a lack of access to mental

health care, it is pertinent that nurses feel confident in their ability communicate with and

care for this population. Therefore, the DNP facilitator provided brief and focused

educational sessions with information that could be used for patients diagnosed with

depression, anxiety disorders, delirium/dementia, substance misuse, and bipolar

disorders. The skills and communication training was an integral part of the education

and helped to increase the staff's self-perceived understanding of specific psychiatric

illnesses as well as strategies for helping to alleviate symptoms. Similar to other studies

(Collins et al., 2012; Opening Minds, 2013), this increased a sense of empowerment,

confidence, and competency.

While education has shown to be helpful, it best contributes to attitudinal change

when combined with another stigma reduction modality (Corrigan, 2015; Dalky, 2012;

Griffiths et al., 2014). Specifically, it is most effective when combined with direct

contact interventions (Bjorkman et al., 2008; Collins et al., 2012; Cook et al., 2013;

Griffiths et al., 2014). The direct care interventions provided in this project were critical

in reaching the second purpose of enhancing compassionate care.

Purpose #2: Enhance Compassionate Care

The incorporation of direct contact in the form of live speakers and storytelling was fundamental in providing an opportunity to enhance compassion amongst the nursing staff. Based on the results of the learning needs assessment, two speakers were included to discuss addiction and bipolar disorders. One speaker shared her struggles and triumphs on the road to sobriety and disclosed the mental and physical effects of addiction; both positive and negative hospital experiences; and the true battle of finding substance misuse treatment.

Another speaker focused on her experiences as a family member living with a parent diagnosed with bipolar disorder. She shared the unpredictable course of the illness, the debilitating effects of depression/mania, and the importance of medication maintenance. She also shared the importance of incorporating the family into care and how nurses can provide compassionate care in the hospital setting.

After analyzing the post-survey data, this project began to illuminate and define the art of nursing and the vitality of the human-to-human connection as theorized by Jean Watson. While her theory was not initially utilized as a theoretical framework, it was identified as a theory that could be used in future stigma programs. Her theory of human caring science is inherent in the art of nursing and exemplifies characteristics of a compassionate nurse (Watson, 2012). Watson placed an emphasis on "the human inner subjective life world… and the caring relationship and transaction between persons and their environment and how that affects health and healing in a broad sense (Watson, 2012, p19)." Watson also stressed the conscious choice of focusing on the "private, intimate world of human caring and healing and inner subjective human experiences

63

rather than concentrate on the public world of nonhuman 'technocure' techniques and outer behavior (Watson, 2012, p.24)."

Psychiatric illnesses are extremely complex and minimally understood which often leads to swift judgment of the person's outward behavior and discriminatory care; however, this DNP project utilized personal, client stories to familiarize the nurses with the intimate world and inner subjective human experience of those diagnosed with a psychiatric illness. The speakers did not only discuss the signs, symptoms, and treatment of a specific diagnosis, but rather, shared personal stories of vulnerability and challenges that communicated their lived experience. Their stories offered something that sole education cannot: empathy, compassion, and human connection. These themes are evident in many of the nursing staff's responses in the post-survey (Appendix 9).

Purpose #3: Change Attitudes

The final purpose of the DNP project, to seek to improve attitudes, was measured using the MICA v4. The pre- to post- score decreased from 38.8 to 33.8 with a p-level of 0.0006, indicating an overall more positive attitude at the completion of the program when compared to before the sessions. The learning needs assessment/pre-survey was essential in targeting factors known to be able to influence attitudes and deciding which content should be included in the psychoeducational program.

First, the pre-survey assessed whether the nursing staff believed myths surrounding psychiatric illnesses. The results were similar to some findings found in other research studies and articles. Past work and/or personal experience within the mental health field was associated with a more positive attitude; a finding also identified in Henderson's (2014) systematic review. Although the nursing staff had a healthcare

64

background, they still associated stereotypical factors with individuals diagnosed with a psychiatric illness: with violence being the number one response. Other common responses were non-adherence to physical/mental healthcare treatment, inability to hold a job, and being homeless. This finding was also reported in Bjorkman, Angelman, and Jonsson's study (2008) that examined nurses' attitudes towards psychiatric illnesses.

The learning needs assessment highlighted factors unique to stigma among medical-surgical nurses as reported in Reed and Fitzgerald's (2005) qualitative study. In their study, Reed & Fitzgerald examined attitudes of nurses who cared for patients diagnosed with psychiatric illnesses in a general hospital. Their findings revealed that negative attitudes of general nurses are associated with many factors. The following items identified in their study were linked to negative attitudes and also found to be factors on the project's unit: (a) lack of knowledge and clinical skills needed to care for this population, (b) lack of support and resources to provide safe, competent care, and (c) fear. Ross and Goldner (2009) also found that negative attitudes were partially contributed to perceived lack of skills and education, shortage of resources, and fear. These are associations that should continue to be targeted in future stigma reduction programs.

The successes of this DNP project are attributed to the design of the psychoeducational program. The project was designed using recommendations from literature that potentially could influence or change attitudes including: (a) the use of a multimodal approach (Griffiths et al., 2014; Knaak et al., 2014), (b) providing multiple opportunities for direct contact with individuals/families who live with these illnesses (Clement et al., 2012; Griffiths et al., 2014; Happell et al., 2014; Knaak et al., 2014;

Pinto-Foltz & Logsdon, 2009; Sadow & Ryder, 2008), (c) providing clinical skills

teaching (Stubbs, 2014) and education specific and applicable to the patient population

(Pinto-Foltz & Logsdon, 2009), and (d) an emphasis on recovery (Knaak et al., 2014;

Sadow & Ryder, 2008).

All of these factors were carefully assessed, considered, and incorporated into the

design of the psychoeducational sessions. The overall goal was to create a program that

focused on the medical-surgical nursing staff and improved the nursing care of patients

diagnosed with psychiatric illnesses. The results of this program demonstrated increased

understanding, enhanced compassionate care, and a reduction of negative attitudes

associated with caring for this population. Most importantly, the nursing staff indicated

that the program not only affected their previous attitudes and biases, but also their

clinical nursing care.

While the overall goal of the project was to improve nursing care, its effectiveness

was actually measured using an evidence-based attitudinal survey. With that being said,

the DNP student found this project to have characteristics of both quality improvement

and research. What constitutes research versus QI is a current topic of debate and the two

have overlapping characteristics. This project was a prime example of how the lines

between the two methods can become blurred.

Quality Improvement

This project initially focused on the broader notion of QI and ultimately, the

improvement of a system of nursing care within a targeted patient group (HRSA, 2011).

Quality improvement (QI) involves introspection of a health care system's delivery

process and creation of innovative actions that seek to improve overall care and patient

outcomes (HRSA, 2011). Every QI project is based on four key principles which include the following: (a) systems and processes, (b) patient needs, (c) team-based approach, and (d) data usage (HRSA, 2011).

The project began with the DNP student identifying a problem within a system that affected patient care. Evidence from the literature supported the DNP student's observations: that negative attitudes about psychiatric illnesses exist within this nursing unit, and that they could potentially result in care that precipitates negative patient outcomes (e.g. longer hospital stays, increased risk of infection).

The system where this project took place did not have a process in place (or activity/program) to improve the identified clinical problem. The DNP student used empirical evidence and a team-based approach through the use of a learning needs assessment (inputs) to design a psychoeducational program (activity/process) with effectiveness measured using an attitudinal survey (HRSA, 2011).

Finally, the project satisfied the last principle of quality improvement through the use of data (HRSA, 2011). First, a baseline stigma score was calculated for the unit using an evidence-based assessment tool. It was then re-assessed after program completion. It was through this approach that it was determined that the project influenced a lower stigma score. Nurses also indicated the perception that it increased understanding of psychiatric illnesses and the ability to provide compassionate care; however, this was not measured prior to program implementation and was the nursing staff's self-perception.

At all points in time, throughout the psychoeducational sessions, staff members were able to present and discuss their thoughts, feelings and insights in order to keep with the QI processes. The nursing staff asked the presenters questions regarding how to

clearly portray empathy and initiate discussions with patients about their mental health.

Nurses also brought patient scenarios from their experience on the unit to discuss their

initial feelings towards the patient and how they handled those feelings. They also

sought advice from the speakers on how they could have cared differently patients.

The nurses reported that they were able to reflect on their own personal biases

which could lead to the potential for increased sensitivity and self-reflection of how they

care for patients. In one instance, a staff member commented, "It encouraged me to

question my own perceptions about how I view these particular patients and to cultivate

more empathy… to avoid 'labeling' them or questioning their motives and/or intention".

Additional examples are located in Appendix 10.

Several of the responses to the qualitative question indicated that nurses also

developed a greater awareness of the lived experience of the patient rather than just the

outward signs and symptoms that may precipitate challenging behavior on the unit. One

member said, "I understand that there is always a 'story' … a reason behind the behaviors

and how physical health affects mental health." The nursing staff expressed motivation

to listen and understand patient stories or, at the very least, recognize that there is a story

that influences patient behavior. Most importantly, the staff indicated the ability to use

this newfound awareness and knowledge to specialize care and utilize innovative

interventions to improve overall patient care regardless of whether the patient has a

documented psychiatric illness. One staff member said, "I am able to set aside my

personal feelings and remember that even though I may find a patient's behavior unusual

or even frustrating, that they are suffering from a disease and as a nurse it is my job to

treat both their mental and physical health and provide a therapeutic presence."

While the post-program responses indicated the potential for behavioral change, there was no way of assessing the program's direct influence on nursing care. It can be argued that the DNP student actually tested the hypothesis that the program would result in a reduced MICA v4 score rather than improving nursing performance. For that reason, this project could also be considered the beginning of a pilot intervention.

Quality Improvement Versus Research

Both research and QI utilize systematic investigation but research analysis is based on statistical testing of a hypothesis while QI is analyzed by comparing a program or process to quality standards (The Children's Hospital of Philadelphia, 2017). After program completion, it was realized that the use of the MICA v4 to evaluate attitudinal change could have categorized the project as research rather than QI.

Additionally, the DNP student developed a program instead of testing an existing program, which could also lead one to label the project as research. However, the Institute for Healthcare Improvement now recognizes QI as the integration of both innovation and evidence based modalities to improve a system (IHI, 2017). According to IHI, QI is multi-disciplinary and contains features of research such as clinical science and statistics (IHI, 2017). This definition again blurs the line between QI and research and, as a result, the methodology of this project. This dilemma will continue to be deliberated by researchers, but it is critical that projects be carefully planned with close attention to ethical and correct methodology utilization.

Strengths and Limitations

The most notable strength of this project is its target audience and project design. Despite the prevalence of patients admitted to medical-surgical units who are also

diagnosed with behavioral health problems and psychiatric illnesses, there is a paucity of information that focuses on the attitude and perspectives of nurses and their care using a QI framework. The literature has instead focused on the negative attitudes of medical-surgical nurses and made recommendations from the perspective of the researchers. This is the first known clinically based QI project that used a systematic and team-based approach to measure stigma, implement and evaluate a specialized psychoeducational program, and examine its effect on the nursing staff's attitudes, responses and potential for behavioral change. This project encouraged the potential improvement of other outcomes which include nursing: (a) compassion, (b) understanding, (c) sensitivity, (d) and effect on future nursing care. Another strength of this project is that it focused on a healthcare model that is becoming more prevalent within the American healthcare system: integrated behavioral healthcare (Klein & Hostetter, 2014). This project was delivered in such a way that the nursing staff was encouraged to consider both the physical and mental health care needs of patients as well as using recommendations from previous research articles and projects to develop and implement the psychoeducational program.

This project did have limitations. First, the project was developed for a 'captured' target audience (medical-surgical nursing staff); therefore, the results cannot be generalized to other inpatient hospital units or nursing subspecialties. Secondly, the data collected from the nursing staff from the pre- and post-surveys was anonymous and without identifiers, so the stigma scores were interpreted as aggregate data rather than tracked individually. Although this approach worked well for this quality improvement project that focused on a healthcare system and the nursing staff as a whole, the ability to

quantifiably show the meaningfulness in difference between the pre- and post- scores is limited. Additionally, an unpaired t-test is a weaker statistical analysis.

Another limitation was the measurement of compassion and understanding. These outcomes were assessed after project completion and used as QI evaluation data of the educational sessions. Although the staff provided valuable information regarding compassion and understanding of psychiatric illnesses, the answers were based on self-perception and could represent bias. Additionally, the staff was only asked about these outcome measures after project completion rather than pre- and post-program completion. Qualitative analysis would have been stronger if answers were collected and compared from pre- to post-session completion.

Finally, there were some limitations with the use of the MICA v4 to measure attitudinal change. When the authors assessed the psychometric properties of the survey tool, they did not assess test-retest reliability (Gabbidon et al., 2013). Other stigma programs would need to assess the use of this survey to evaluate its true reliability in measuring attitudinal change. Although the survey was used to evaluate attitudinal change in nursing students who participated in stigma reduction programs, the authors mention that its use across all disciplines is still tentative and requires further testing (Gabbidon et al., 2013).

In addition to program limitations, there were also some project related logistical issues. The live educational sessions were only offered once, which made it difficult for several of the nursing staff to attend. Due to time constraints, the class dates were announced with just a three-week notice. These logistics limited the accommodation of nurses who were interested in participating but who were already scheduled to work and

could not find supplemental coverage. Although each session was recorded, the videos were available only via unit-based computers at the hospital. This was done to protect the privacy of the speakers and to ensure that the videos were made available only to the specific unit's nursing staff. All of these limitations inform suggestions for future anti-stigma programs.

Suggestions for Future Research

Future anti-stigma programs should carefully assess their stigma measurement tool and ensure its proper use as well as its psychometric properties and sensitivity to stigma interventions. Once there is more knowledge about stigma measurement tools, programs implemented in the medical-surgical setting should track individual stigma scores for a stronger data analysis. Much of the research has focused on attitudinal change and its potential to influence behavior so future studies should develop behavioral outcomes to measure its true effect on nursing care.

Another suggestion for future studies is that they include a longer follow-up period to determine whether attitudinal and/or behavioral changes persist over time. Sending out surveys at three and six months after program completion would indicate whether the program would result in long term attitudinal change and what changes need to be made to the program.

Lastly, in order to improve attendance, the staff should be made aware of the sessions more than three weeks in advance. This would allow optimal participation and adequate time for the unit to get supplemental coverage for nurses who would like to attend.

Conclusions

In conclusion, this project demonstrated attitudinal change as measured by the

pre- and post-MICA v4 scores; however, it must be noted that further research on proper

use of the MICA v4 and its sensitivity to anti-stigma interventions needs to be conducted.

The post-program evaluation indicated that nurses identified the desire to be more

compassionate towards patients. Lastly, nurses indicated an increased understanding of

psychiatric illnesses as measured by their responses to the post-program qualitative

questions. Further studies should assess the psychometric properties and sensitivity of

stigma assessment tools in order to accurately measure the effect of anti-stigma programs

and what characteristics result in the most attitudinal and behavioral change

APPENDIX 1: LEARNING NEEDS ASSESSMENT

Thank you for participating in this survey. The data you provide will be used to design an educational program to decrease stigma of and help you better care for patients with co-existing psychiatric illness. Your participation is voluntary and your answers are completely anonymous. You may skip any question you choose not to answer.

Please click the ____ button below to begin the survey.

Demographic Information

1. Highest level of education achieved:

    a. High school diploma/GED
    b. Associates Degree/Diploma in Nursing
    c. Bachelors Degree
    d. Masters Degree
    e. Other:

2. Number of years of experience as a registered nurse or nursing assistant
    a. 0-5 years
    b. 6-10 years
    c. 11-14 years
    d. 15+ years

3. Have you had any previous or current work and/or volunteer experience in psychiatry? If yes, briefly describe in what setting and for how long.
    a. No
    b. Yes

This next section focuses on better understanding your learning needs. You may skip any question that you do not feel comfortable answering.

4. In your opinion, how well did your nursing course work and/or hospital education prepare you to care for individuals diagnosed with or suffering from psychiatric illnesses?
    a. Extremely well, very well, moderately well, slightly well, not well at all

5. How confident are you in recognizing signs and/or symptoms of a psychiatric illness?
    a. Extremely confident, very confident, moderately confident, slightly confident, not at all confident

6. How confident are you in providing interventions for specific psychiatric illnesses?

a. Extremely confident, very confident, moderately confident, slightly confident, not at all confident

7. How confident are you in your ability to recognize behaviors indicating a patient may be suffering from an addiction to substances?
   a. Extremely confident, very confident, moderately confident, slightly confident, not at all confident

8. How confident are you in communicating with someone with a psychiatric illness?
   a. Extremely confident, very confident, moderately confident, slightly confident, not at all confident

9. How confident are you in your ability to explain the relationship between physical and emotional health?
   a. Extremely confident, very confident, moderately confident, slightly confident, not at all confident

10. How confident are you in your ability to gather information related to a mental status examination?
    a. Extremely confident, very confident, moderately confident, slightly confident, not at all confident

11. Based on your experience, which of the following do you believe to be associated with having a psychiatric illness? Select all that apply.
    a. Violence
    b. Inability to make healthcare decisions
    c. Non adherence to physical/mental healthcare treatment
    d. Inability to attend school
    e. Inability to handle a job
    f. Being homeless
    g. Being mentally disabled

12. To the best of your knowledge, which of the following may influence the development of a psychiatric illness?
    a. Genetics
    b. Trauma
    c. Life stressors
    d. Personality
    e. Pregnancy
    f. Birth complications
    g. Medical conditions
    h. Chronic disease
    i. Discrimination
    j. Other
    k. None of the above

13. In your experience, how much support by physicians and other caregivers has been provided when caring for someone with complex mental health needs?
    a. A great deal, a lot, a moderate amount, a little, none at all

14. As a medical-surgical nurse or nursing assistant, how important is it for you to learn about psychiatric illnesses?
    a. Extremely important, very important, moderately important, slightly important, not important at all

15. For you personally, what are the best ways to learn about caring for patients with a psychiatric illness? Choose up to 3 options.
    a. In-person education
    b. Emails
    c. Posters/brochures on unit
    d. Computer modules
    e. Videos/films
    f. Guest speakers
    g. Simulations
    h. Group discussions
    i. Other

16. During the past year, which illnesses have you seen on the unit? Select all that apply.
    a. Depression
    b. Anxiety
    c. Substance Abuse
    d. Drug and/or alcohol withdrawal
    e. Bipolar disorders
    f. Delirium
    g. Dementia
    h. Post Traumatic Stress Disorder (PTSD)
    i. Borderline Personality Disorder
    j. Schizophrenia
    k. Suicide
    l. ADD/ADHD
    m. Other

17. Which illnesses do you want to learn more about?
    a. Depression
    b. Anxiety
    c. Substance Abuse
    d. Drug and/or alcohol withdrawal
    e. Bipolar disorders
    f. Delirium
    g. Dementia

h. Post Traumatic Stress Disorder (PTSD)
i. Borderline Personality Disorder
j. Schizophrenia
k. Suicide
l. ADD/ADHD
m. Other

18. Please list any other questions or comments that you may have.

APPENDIX 2: STIGMA INFLUENCES

Factors that Contribute to Negative Attitudes Towards Patients Diagnosed with Psychiatric Illnesses	Statements that Assess these Factors
Not having the clinical skills	• In your opinion, how well did your nursing and organizational coursework prepare you to care for individuals diagnosed with or suffering from psychiatric illnesses? • How confident are you in providing interventions for specific psychiatric illnesses? • How confident are you in communicating with someone with a psychiatric illness? • How confident are you in your ability to gather information related to a mental status examination?
Not having enough knowledge about psychiatric illnesses	• How confident do you feel in recognizing signs and/or symptoms of a psychiatric illness? • How confident are you in your ability to recognize behaviors indicating a patient may be suffering from an addiction to substances? • How confident are you in your ability to explain the relationship between physical and emotional health? • Based on your experience, which of the following do you believe to be associated with having a psychiatric illness? • To the best of your knowledge, which of the following may

	influence the development of a psychiatric illness?
Fear	• How confident do you feel communicating with someone with a psychiatric illness?
Negative attitudes	• Based on your experience, which of the following do you believe to be associated with having a psychiatric illness?
Not feeling supported in their job to adequately care for these patients	• In your experience, how much support by physicians and other caregivers has been provided when caring for someone with complex mental health needs?
Not feeling it's their job to attend to mental health care needs of patients	• In your opinion, how related are physical and mental health? • As a medical-surgical nurse or nursing assistant, how important is it for you to learn about psychiatric illnesses?

APPENDIX 3: MENTAL ILLNESS: CLINICIANS' ATTITUDES SCALE v4

Mental Illness: Clinicians' Attitudes Scale

MICA-4

Note to researchers distributing this scale: please only use after reading instructions in "Manual for Researchers".

Instructions: for each of questions 1-16, please respond by **ticking one box only**. Mental illness here refers to conditions for which an individual would be seen by a psychiatrist.

		Strongly agree	Agree	Somewhat agree	Somewhat disagree	Disagree	Strongly disagree
1	I just learn about mental health when I have to, and would not bother reading additional material on it.						
2	People with a severe mental illness can never recover enough to have a good quality of life.						
3	Working in the mental health field is just as respectable as other fields of health and social care.						
4	If I had a mental illness, I would never admit this to my **friends** because I would fear being treated differently.						
5	People with a severe mental illness are dangerous more often than not.						
6	Health/social care staff know more about the lives of people treated for a mental illness than do family members or friends.						
7	If I had a mental illness, I would never admit this to my **colleagues** for fear of being treated differently.						
8	Being a health/social care professional in the area of mental health is **not** like being a real health/social care professional.						
9	If a senior colleague instructed me to treat people with a mental illness in a disrespectful manner, I would **not** follow their instructions.						

Mental Illness: Clinicians' Attitudes Scale

MICA-4

Note to researchers distributing this scale: please only use after reading instructions in "Manual for Researchers".

Instructions: for each of questions 1-16, please respond by **ticking one box only**. Mental illness here refers to conditions for which an individual would be seen by a psychiatrist.

		Strongly agree	Agree	Somewhat agree	Somewhat disagree	Disagree	Strongly disagree
10	I feel as comfortable talking to a person with a mental illness as I do talking to a person with a physical illness.						
11	It is important that any health/social care professional supporting a person with a mental illness also ensures that their physical health is assessed.						
12	The public does **not** need to be protected from people with a severe mental illness.						
13	If a person with a mental illness complained of physical symptoms (such as chest pain) I would attribute it to their mental illness.						
14	General practitioners should **not** be expected to complete a thorough assessment for people with psychiatric symptoms because they can be referred to a psychiatrist.						
15	I would use the terms 'crazy', 'nutter', 'mad' etc. to describe to colleagues people with a mental illness who I have seen in my work.						
16	If a colleague told me they had a mental illness, I would still want to work with them.						

Thank you very much for your help.

Kassam A., Glozier N., Leese M., Henderson C., Thornicroft G. (2010) Development and responsiveness of a scale to measure clinicians' attitudes to people with mental illness (medical student version). Acta Psychiatrica Scandinavica 122(2), 153-161.

APPENDIX 4a: PERMISSION TO USE MICA V4

Thornicroft, Graham <graham.thornicroft@kcl.ac.uk>

Thu 9/1/2016 3:40 AM

Mark as unread

To: ☐ Danielson, Brittany;

Cc: ☐ Stacey, Jessica <jessica.stacey@kcl.ac.uk>; ☐ Evans-Lacko, Sara <sara.evans-lacko@kcl.ac.uk>;

● You forwarded this message on 9/1/2016 9:13 PM.

Thanks Brittany
Yes you have our permission
Please contact Jessica for details

best wishes

graham

graham.thornicroft@kcl.ac.uk

@ThornicroftG on Twitter

SurveyMonkey Inc. [US] | https://www.surveymonkey.com/r/stigmascalesregistration?sm=uPsXCMTmwr%2fCA7DpkUJTLnp1O2TDV1R9HmLdD0qAA...

KING'S
College
LONDON
University of London

Questionnaire to register use of the the KCL stigma and discrimination measures

Thank you for completing our survey!

To access the scales:
Return to http://www.indigo-group.org/stigma-scales/
Select the scale you with to use
Enter the password

Please make a note of this password, and do not share it with anyone whose details have not been entered into this survey.

Done

APPENDIX 4b: PERMISSION TO USE MICA V4

Dear Brittany,

Many thanks for your email and for your interest in the MICA. All current details about the stigma measures and MICA (including the psychometric paper) can be found here:
http://www.kcl.ac.uk/ioppn/depts/hspr/research/ciemh/cmh/CMH-Measures.aspx.
Regarding use of the scale, we have now created an automated system for registering use of the stigma measures. This automated registration is in place of contacting us by email for permission to use the scales. If you are planning to use any of these measures in your research or anti-stigma work we would really appreciate it if you would complete the short registration questionnaire by clicking here
https://www.surveymonkey.com/s/stigmascalesregistration
The registration takes about 5 minutes to complete. The data you enter will let us know how many people are using the scales we have produced, and in which contexts, as we sometimes need to report on this to our funders or as an indicator of the impact of our work. It will also enable us to contact scale users by email with updates about the scales and about possible future research. The data you enter will not be passed on to any third party. The data will be held in confidence and will be accessible only to Professor Thornicroft and his research team.
Apologies for the delay in my response (I work part time). Please don't hesitate to get back in touch with any questions.
Best wishes,
Jessica
Jessica Stacey, PhD
Section Administrator, Service User Research Enterprise (SURE) and Administrative Assistant, INDIGO Network
Health Service and Population Research Department
PO34 Institute of Psychiatry, Psychology & Neuroscience
King's College London
De Crespigny Park
London SE5 8AF

New telephone number: (0)20 7848 0047

APPENDIX 5: PERMISSION TO CONDUCT PROGRAM FROM CHIEF NURSING OFFICER

UNC REX HEALTHCARE

September 13, 2016

Brittany Danielson
63 Radcliffe Court
Clayton, NC 27527

Dear Ms. Danielson:

Congratulations on making progress towards the Doctor of Nursing Practice (DNP) degree at The University of North Carolina at Chapel Hill.   We appreciate your support of our patient care principles on 7 East.

On behalf of Patient Care Services at UNC REX Healthcare I am providing you with permission to conduct a quality improvement project on 7 East that aims to reduce nursing stigma of patients diagnosed with psychiatric illnesses. I understand the objectives of the project are:

(a) To increase medical-surgical nurses' understanding of psychiatric illnesses
(b) To empower nurses to provide compassionate, nonjudgmental care
(c) To decrease the negative attitudes associated with patients who have comorbid medical and psychiatric illnesses in the acute care setting

I understand the quality improvement project will include the following:
(a) A learning needs assessment to gather information about the nursing and nursing assistants' self-reported learning needs as it relates to caring for patients diagnosed with psychiatric illnesses
(b) A 4-week, interactive psychoeducational intervention
(c) Booster modules
(d) Measurement of negative attitudes using an evidence-based stigma scale

Please continue to work closely with Dr. Julia Aucoin and Stacey Thompson for the details of project execution.   Should you require any further information, please do not hesitate to contact me.   Upon completion of the study, I will enjoy reading the project report.

Sincerely,

Joel Ray, MSN, RN, NE-BC
Vice President Patient Care Services and Chief Nursing Officer

4420 Lake Boone Trail
Raleigh, NC 27607-6599
(919) 784-3100
rexhealth.com

chosen for excellence

84

APPENDIX 6: POST-PROJECT EVALUATION QUESTIONS

Q2 Which session(s) did you attend and/or view online. Select all that apply.
- ❑ Session 1: Implicit Bias by Mimi Alvarez
- ❑ Session 2: Bipolar Disorders by Shannon Gallagher
- ❑ Session 3: Addiction by Bonnie
- ❑ Session 4: Caring for Patients with Mental Health Care Needs on the Medical Surgical Unit by Brittany Danielson
- ❑ None of the sessions

Q3 The educational sessions enhanced my ability to provide compassionate care to patients with psychiatric illnesses.
- ❍ Strongly agree
- ❍ Agree
- ❍ Neither agree nor disagree
- ❍ Disagree
- ❍ Strongly disagree
- ❍ Not applicable: I did not attend or view any of the educational sessions

Q4 The educational sessions improved my understanding of psychiatric illnesses.
- ❍ Strongly agree
- ❍ Agree
- ❍ Neither agree nor disagree
- ❍ Disagree
- ❍ Strongly disagree
- ❍ Not applicable: I did not attend or view any of the educational sessions

Q5 The Implicit Bias presentation by Mimi Alvarez allowed me to reflect about personal biases I have about patients with psychiatric illnesses.
- ❍ Strongly agree
- ❍ Agree
- ❍ Neither agree nor disagree
- ❍ Disagree
- ❍ Strongly disagree
- ❍ Not applicable: I did not attend or view this presentation

Q6 The Bipolar Disorders presentation by Shannon Gallagher improved my attitude about families who have a loved one with bipolar disorder.
- ❍ Strongly agree
- ❍ Agree
- ❍ Neither agree nor disagree
- ❍ Disagree
- ❍ Strongly disagree
- ❍ Not applicable: I did not attend or view this presentation

Q7 The Addiction presentation by Bonnie increased my sensitivity towards patients who have an addiction to substances.
○ Strongly agree
○ Agree
○ Neither agree nor disagree
○ Disagree
○ Strongly disagree
○ Not applicable: I did not attend or view this presentation

Q8 The "Caring for Patients with Mental Health Needs on a Medical-Surgical Unit" presentation by Brittany Danielson improved my attitude towards patients with psychiatric illnesses.
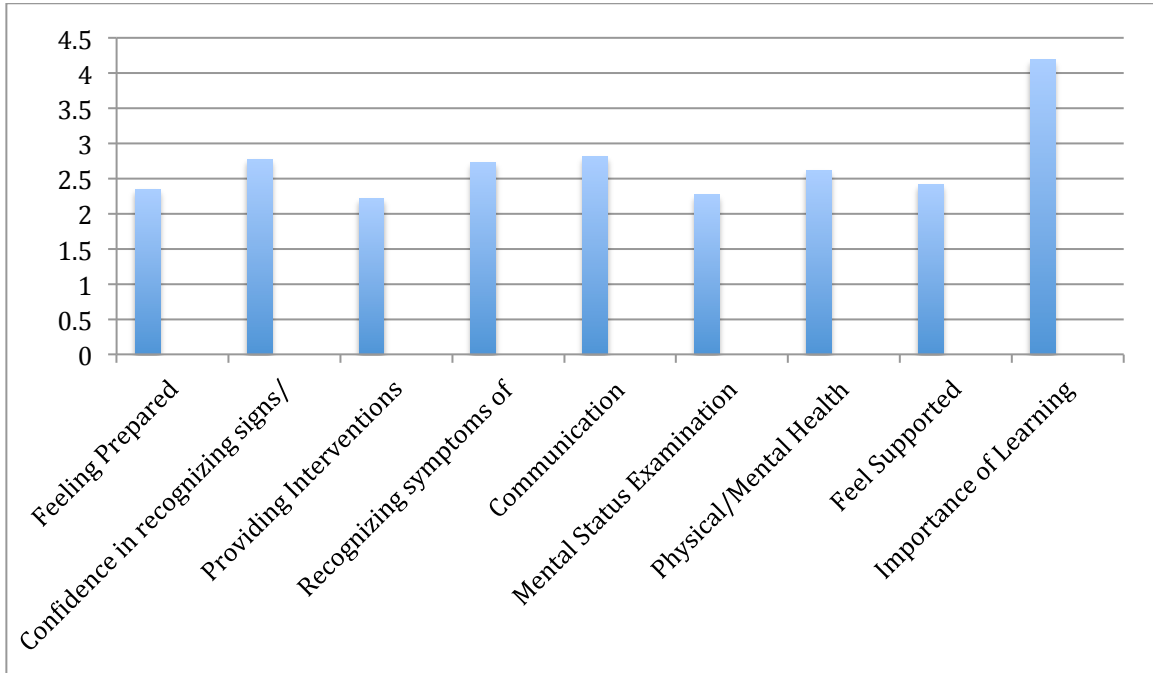○ Strongly agree
○ Agree
○ Neither agree nor disagree
○ Disagree
○ Strongly disagree
○ Not applicable: I did not attend or view this presentation

Q9 How has your ability to care for patients with psychiatric illnesses changed?

APPENDIX 7: CHARACTERISTICS OF RESPONDENTS

| Characteristic (Total responding)		n	(%)
Highest Level of Education Received	High School Diploma/GED	10	19.23%
	Associate Degree/Diploma in Nursing	11	21.15%
	Bachelor's Degree	29	55.77%
	Master's Degree	2	3.85%
Years of Experience as Nurse or Nursing Assistant	0-5 years	25	48.08%
	6-10 years	7	13.46%
	11-15 years	4	7.69%
	15+ years	16	30.77%
Psychiatric Work/Volunteer Experience	Yes	14	26.92%
	No	38	73.08%

APPENDIX 8: INFLUENCES OF STIGMA

Theme	Responses
1. Recognition of a Human Being	"Learn their story" "The need to remember that they were a person prior to the addiction." "We need to remember that everyone has a life history we do not know about the effects or how they handle things in their lives. We need to show compassion and do what we can to help them."
2. Awareness of Biases and Increased Empathy	"To be more sensitive to what might be going on with patients." "It has made me think twice about how my patient may be feeling about certain situations." "Caused me to be more open minded, less judgmental." "Encouraged me to question my own perceptions about how I view these particular patients and to cultivate more empathy. To avoid labeling them ore questioning their motives and/or intentions." "I better understand that I myself have biases towards patients which has improved the way I view and care for them."
3. Improved ability to care for patients with psychiatric illnesses	"Being more compassionate and patient" "I take more time to evaluate what will be best for each patient I care for." "I now have a better understanding which has allowed me to see my patients not only as surgical patients with medical need but also seeing their emotional and psychological components of care."

APPENDIX 10: PRE- AND POST- PROGRAM MICA V4 SCORE DISTRIBUTIONS

Pre-Program MICA v4 Scores

Post-Program MICA v4 Scores
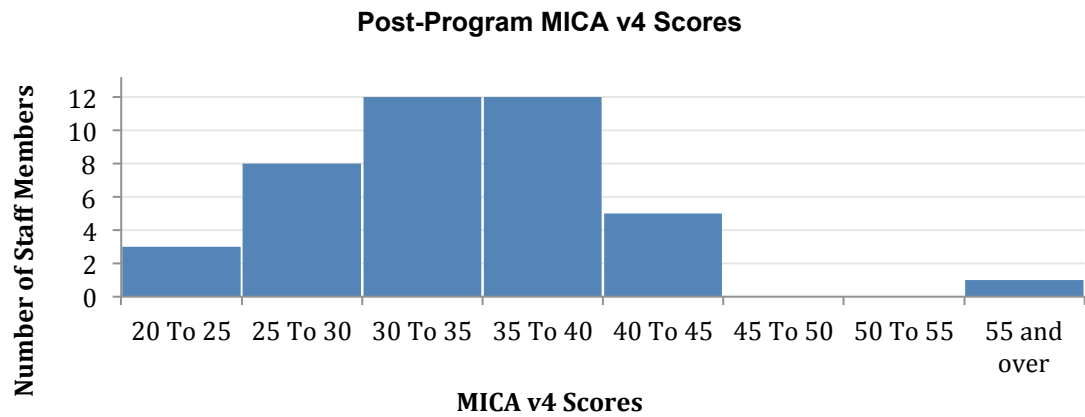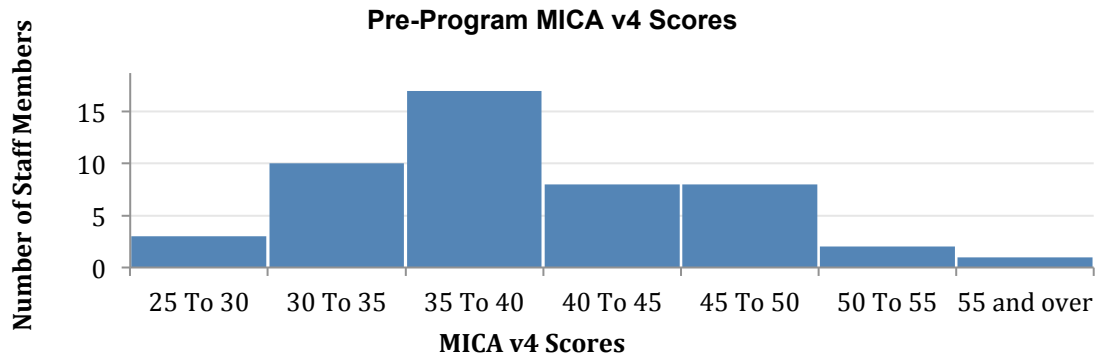
REFERENCES

American Psychiatric Association (2013). *Diagnostic and statistical manual-V.* Washington, D.C.: American Psychiatric Association.

Atkin, K., Holmes, J., & Martin, C. (2005). Provision of care for older people with co-morbid mental illness in general hospitals: General nurses' perceptions of their training needs. *International Journal of Geriatric Psychiatry, 20*(11), 1081-1083. doi:10.1002/gps.1414 [doi]

Bjorkman, T., Angelman, T., & Jonsson, M. (2008). Attitudes towards people with mental illness: A cross-sectional study among nursing staff in psychiatric and somatic care. *Scandinavian Journal of Caring Sciences, 22*(2), 170-177. doi:10.1111/j.1471-6712.2007.00509.x [doi]

Brohan, E. & Thornicroft, G. (2010). Stigma and discrimination of mental health problems: workplace implications. *Occupational Medicine, 60*(6), 414-420. doi: 10.1093/occmed/kqq048

Buechter R, Pieper D, Ueffing E, & Zschorlich B. (2013). Interventions to reduce experiences of stigma and discrimination of people with mental illness and their caregivers. *Cochrane Database of Systematic Reviews 2013*, Issue 2. Art. No.: CD010400. DOI: 10.1002/14651858.CD010400.

Children's Hospital of Pittsburgh. (2017). Quality improvement versus research. Retrieved from https://irb.research.chop.edu/quality-improvement-vs-research

Clement, S., van Nieuwenhuizen, A., Kassam, A., Flach, C., Lazarus, A., de Castro, M., . . . Thornicroft, G. (2012). Filmed v. live social contact interventions to reduce stigma: Randomised controlled trial. *The British Journal of Psychiatry : The Journal of Mental Science, 201*(1), 57-64. doi:10.1192/bjp.bp.111.093120 [doi]

Collins, R.L., Wong E.C., Cerully, J.L., Schultz, D., & Eberhart, N.K. (2012). Interventions to reduce mental health stigma and discrimination: a literature review to guide evaluation of california's mental health prevention and early intervention initiative. *The RAND Corporation*. Retrieved from http://www.rand.org/content/dam/rand/pubs/technical_reports/2012/RAND_TR1318.pdf

Cook, J. E., Purdie-Vaughns, V., Meyer, I. H., & Busch, J. T. (2014). Intervening within and across levels: A multilevel approach to stigma and public health. *Social Science & Medicine (1982), 103*, 101-109. doi:10.1016/j.socscimed.2013.09.023 [doi]

Corbiere, M., Samson, E., Villotti, P., & Pelletier, J. F. (2012). Strategies to fight stigma toward people with mental disorders: Perspectives from different

stakeholders. *Thescientificworldjournal, 2012*, 516358. doi:10.1100/2012/516358 [doi]

Corrigan, P. W. (2000). Mental health stigma as social attribution: Implications for research methods and attitude change. *Clinical Psychology: Science and Practice, 7*(1), 48-67. doi:10.1093/clipsy/7.1.48

Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry : Official Journal of the World Psychiatric Association (WPA), 1*(1), 16-20.

Corrigan, P., Markowitz, F. E., Watson, A., Rowan, D., & Kubiak, M. A. (2003). An attribution model of public discrimination towards persons with mental illness. *Journal of Health and Social Behavior, 44*(2), 162-179.

Corrigan, P. (2015). Do the effects of antistigma programs persist over time? findings from a meta-analysis. *Psychiatric Services (Washington, D.C.), 66*(5), 543; 543.

Cox, K. (2015). *Managing psychiatric symptoms and challenging behaviors in the medical-surgical patient: Evidence-based strategies and tools for your trade.* [PowerPoint slides].

Dalky, H. F. (2012). Mental illness stigma reduction interventions: Review of intervention trials. *Western Journal of Nursing Research, 34*(4), 520-547. doi:10.1177/0193945911400638 [doi]

Davey, G. (2013). Mental health and stigma. *Psychology Today*. Retrieved from https://www.psychologytoday.com/blog/why-we-worry/201308/mental-health-stigma

Desai, M. M., Rosenheck, R. A., Druss, B. G., & Perlin, J. B. (2002). Mental disorders and quality of diabetes care in the veterans health administration. *The American Journal of Psychiatry, 159*(9), 1584-1590. doi:10.1176/appi.ajp.159.9.1584 [doi]

Doherty, A. M., & Gaughran, F. (2014). The interface of physical and mental health. *Social Psychiatry and Psychiatric Epidemiology, 49*(5), 673-682. doi:10.1007/s00127-014-0847-7 [doi]

Donabedian, A. (1980). *The definition of quality and approaches to its assessment*. Ann Arbor, Mich.: Health Administration Press.

Farley-Toombs, C. (2012). The stigma of a psychiatric diagnosis: Prevalence, implications and nursing interventions in clinical care settings. *Critical Care*

Nursing Clinics of North America, 24(1), 149-156.
doi:10.1016/j.ccell.2012.01.009 [doi]

Fishbein, M. (2010). *Predicting and changing behavior : the reasoned action approach*.
New York: Psychology Press.

Gabbidon, J., Clement, S., van Nieuwenhuizen, A., Kassam, A., Brohan, E., Norman, I.,
& Thornicroft, G. (2013). Mental illness: Clinicians' attitudes (MICA) scale-
psychometric properties of a version for healthcare students and
professionals. *Psychiatry Research, 206*(1), 81-87.
doi:10.1016/j.psychres.2012.09.028 [doi]

Giandinoto, J. A., & Edward, K. L. (2015). The phenomenon of co-morbid physical and
mental illness in acute medical care: The lived experience of australian health
professionals. *BMC Research Notes, 8*, 295-015-1264-z. doi:10.1186/s13104-015-
1264-z [doi]

Gill, K. J., Murphy, A. A., Zechner, M. R., Swarbrick, M., & Spagnolo, A. B. (2009).
Co-morbid psychiatric and medical disorders: Challenges and strategies. *Journal
of Rehabilitation, 75*(3), 32-40. Retrieved
from https://auth.lib.unc.edu/ezproxy_auth.php?url=http://search.ebscohost.com/l
ogin.aspx?direct=true&db=aph&AN=45463596&site=ehost-live&scope=site

Griffith, J. L., & Kohrt, B. A. (2015). Managing stigma effectively: What social
psychology and social neuroscience can teach us. *Academic Psychiatry : The
Journal of the American Association of Directors of Psychiatric Residency
Training and the Association for Academic Psychiatry,* doi:10.1007/s40596-015-
0391-0 [doi]

Griffiths, K. M., Carron-Arthur, B., Parsons, A., & Reid, R. (2014). Effectiveness of
programs for reducing the stigma associated with mental disorders. A meta-
analysis of randomized controlled trials. *World Psychiatry : Official Journal of
the World Psychiatric Association (WPA), 13*(2), 161-175.
doi:10.1002/wps.20129 [doi]

Goffman, E. (1963). *Stigma : Notes on the management of spoiled identity*. New York: J.
Aronson. Retrieved
from http://search.lib.unc.edu.libproxy.lib.unc.edu?R=UNCb1239853

Happell, B., Byrne, L., Platania-Phung, C., Harris, S., Bradshaw, J., & Davies, J. (2014).
Lived-experience participation in nurse education: Reducing stigma and
enhancing popularity. *International Journal of Mental Health Nursing, 23*(5),
427-434. doi:10.1111/inm.12077 [doi]

Health Resources and Services Administration (HRSA). (2011). Quality improvement. Retrieved from https://www.hrsa.gov/quality/toolbox/508pdfs/qualityimprovement.pdf

Henderson, C., Noblett, J., Parke, H., Clement, S., Caffrey, A., Gale-Grant, O., . . . Thornicroft, G. (2014). Mental health-related stigma in health care and mental health-care settings. *The Lancet.Psychiatry,1*(6), 467-482. doi:10.1016/S2215-0366(14)00023-6 [doi]

Institute for Healthcare Improvement. (2017). Science of improvement: How to improve. Retrieved from http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx

Institute of Medicine. (2007). Improving the quality of healthcare for mental health and substance use conditions: quality chasmseries. *The National Academies Press*. Retrieved from http://www.nap.edu/read/11470/chapter/7#222

Klein, S. & Hostetter, M. (2014). In focus: Integrating behavioral health and primary care. *Quality matters: Innovations in health care quality improvement*. Retrieved from http://www.commonwealthfund.org/publications/newsletters/quality-matters/2014/august-september/in-focus

Knaak, S., Modgill, G., & Patten, S. B. (2014). Key ingredients of anti-stigma programs for health care providers: A data synthesis of evaluative studies. *Canadian Journal of Psychiatry.Revue Canadienne De Psychiatrie, 59*(10 Suppl 1), S19-26.

Lambert, K.D. & Salmon, N. (2014). Caring for patients with mental health disorders. *AMN Healthcare Education Services*. Retrieved from http://lms.rn.com/getpdf.php/2018.pdf?Main_Session=10b0920c6ef9e9ffe098e9b17cbc07a0

Livingston, J. D., Milne, T., Fang, M. L., & Amari, E. (2012). The effectiveness of interventions for reducing stigma related to substance use disorders: A systematic review. *Addiction (Abingdon, England),107*(1), 39-50. doi:10.1111/j.1360-0443.2011.03601.x [doi]

Lobo, D.M. & Agius, M. (2012). The mental illness spectrum. *Psychiatria danubina, 24*(1), 157-160.

Mather, B., Roche, M., & Duffield, C. (2014). Disparities in treatment of people with mental disorder in non-psychiatric hospitals: A review of the literature. *Archives of Psychiatric Nursing, 28*(2), 80; 80.

McDonald, D. D., Frakes, M., Apostolidis, B., Armstrong, B., Goldblatt, S., & Bernardo, D. (2003). Effect of a psychiatric diagnosis on nursing care for nonpsychiatric

problems. *Research in Nursing & Health,26*(3), 225-232. doi:10.1002/nur.10080 [doi]

Mental Health Commission of Canada. (2013). *Opening minds: Interim reports*. Retrieved from http://www.mentalhealthcommission.ca/English/system/files/private/document/opening_minds_interim_report.pdf

Munro, A., Watson, H. E., & McFadyen, A. (2007). Assessing the impact of training on mental health nurses' therapeutic attitudes and knowledge about co-morbidity: A randomised controlled trial.*International Journal of Nursing Studies, 44*(8), 1430-1438. doi:S0020-7489(06)00229-X [pii]

NIMH. (2014). *Any mental illness among adults*. Retrieved from https://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-adults.shtml

Oliveira, M. C., Martins, L.F., Richter, K., & Ronzani, T.M. (2013). Evaluation of an intervention to reduce health professional stigma toward drug users: A pilot study. *Journal of Nursing Education and Practice, 3*(5), 138; 138.

Outlaw, H.O., Bradley, P.K., & Davis-Williams, M. (2014). Achieving mental health parity. In Mason, D.J., Leavitt J.K., & Chaffee, M.W. (6th ed), *Policy and Politics in Nursing and Health Care* (pp. 220-224). St. Louis, MS: Elsevier Saunders.

Pinto-Foltz, M. D., & Logsdon, M. C. (2009). Reducing stigma related to mental disorders: Initiatives, interventions, and recommendations for nursing. *Archives of Psychiatric Nursing, 23*(1), 32-40 9p. doi:10.1016/j.apnu.2008.02.010

Pozuelo, L. (2009). Depression and heart disease: What do we know, and where are we headed? *Cleveland Clinic Journal of Medicine January*, *76* (1): 59-70. Retrieved from http://www.ccjm.org/index.php?id=107937&tx_ttnews[tt_news]=361481&cHash=c44fbd01b47bf5061d206ccc48809ed4

Reed, F., & Fitzgerald, L. (2005). The mixed attitudes of nurse's to caring for people with mental illness in a rural general hospital. *International Journal of Mental Health Nursing, 14*(4), 249-257 9p. Retrieved from https://auth-lib-unc-edu.libproxy.lib.unc.edu/ezproxy_auth.php?url=http://search.ebscohost.com.libproxy.lib.unc.edu/login.aspx?direct=true&db=rzh&AN=106403152&site=ehost-live&scope=site

Ross, C. A., & Goldner, E. M. (2009). Stigma, negative attitudes and discrimination towards mental illness within the nursing profession: A review of the literature. *Journal of Psychiatric and Mental Health Nursing, 16*(6), 558-567. doi:10.1111/j.1365-2850.2009.01399.x [doi]

Rutledge, D. N., Wickman, M. E., Cacciata, M., Winokur, E. J., Loucks, J., & Drake, D. (2013). Hospital staff nurse perceptions of competency to care for patients with psychiatric or behavioral health concerns. *Journal for Nurses in Professional Development, 29*(5), 255-262. doi:10.1097/01.NND.0000433150.18384.1c [doi]

Sadow, D., & Ryder, M. (2008). Reducing stigmatizing attitudes held by future health professionals: The person is the message. *Psychological Services, 5*(4), 362-372. doi:10.1037/1541-1559.5.4.362

Stubbs, A. (2014). Reducing mental illness stigma in health care students and professionals: a review of the literature. *Australasian Psychiatry, 22*(6), 579-584. doi: 10.1177/1039856214556324.

Thornicroft, G., Rose, D., & Kassam, A. (2007). Discrimination in health care against people with mental illness. *International Review of Psychiatry (Abingdon, England), 19*(2), 113-122. doi:777684844 [pii]

Traniello, V. (2014). Hysteria and the wandering womb. Retrieved from http://academic.mu.edu/meissnerd/hysteria.html

UNC Rex Healthcare. (2016). *Nursing excellence*. Retrieved from http://www.rexhealth.com/rh/about/nursing-excellence/

Ungar, T., Goldman, S., & Marcus, M. (2013). Reversed shared care in mental health: Bringing primary physical health care to psychiatric patients. *Canadian Journal of Community Mental Health, 32*(3), 1-16. doi:10.7870/cjcmh-2013-022

U.S. Department of Health and Human Services. (1999). *Mental health: A report of the surgeon general—Executive summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental health Services Administration, Center for Mental health services, National Institute of Health, National Institute of Mental Health. Retrieved from http://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/NNBBHS

van Boekel, L. C., Brouwers, E. P., van Weeghel, J., & Garretsen, H. F. (2013). Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review. *Drug and Alcohol Dependence, 131*(1-2), 23-35. doi:10.1016/j.drugalcdep.2013.02.018 [doi]

Viron, M. J., & Stern, T. A. (2010). The impact of serious mental illness on health and healthcare. *Psychosomatics, 51*(6), 458-465. doi:10.1176/appi.psy.51.6.458 [doi]

Watson, J. (2012). *Human caring science: A theory of nursing.* Sudbury, MA: Jones & Bartlett Learning.

Wilrycx, G. K., Croon, M. A., van den Broek, A. H., & van Nieuwenhuizen, C. (2012). Mental health recovery: Evaluation of a recovery-oriented training program. *Thescientificworldjournal, 2012*, 820846. doi:10.1100/2012/820846 [doi]

Wong, E.C., Collins, R.L., Cerully, J.L, Roth, E., Marks, J.S., & Yu, J. (2015). Effects of stigma and discrimination reduction trainings conducted under the California mental health services authority: An evaluation of the national alliance on mental illness adult programs. *RAND Corporation.* Retrieved from http://www.rand.org/content/dam/rand/pubs/research_reports/RR1200/RR1247-1/RAND_RR1247-1.pdf

World Health Organization. (1946). *Constitution of the world health organization.* Retrieved from http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1

World Health Organization. (2008). *Integrating mental health into primary care: A global perspective*. Singapore: Wonca College of Medicine Press

Zolnierek, C. D. (2009). Non-psychiatric hospitalization of people with mental illness: Systematic review. *Journal of Advanced Nursing, 65*(8), 1570-1583. doi:10.1111/j.1365-2648.2009.05044.x [doi]