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Dissertation

Direct Practice Improvement Project Proposal Improving Patient Satisfaction Scores by Reducing Mental Health Stigmas of Health Care Professionals

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Abstract

Stigma, a mark of disgrace associated with a particular person, can leave a negative impact on a patient. Current literature indicates that stigmas towards mental illness are global in nature and are a threat to public, societal, and individual health. This project aimed to increase the quality of patient care delivery and outcomes by identifying the attitudes and beliefs towards mental illness of the health care professionals and how the patients reported how they were treated on the patient satisfaction surveys. The setting was at an inpatient psychiatric hospital where the staff were administered a MICA -4 questionnaire to measure stigma rates based on self-disclosure of the answers, followed by reading a preexisting hospital policy on the nurse/patient relationship and re-administration of the MICA -4. The project also sought to determine the possibility in increasing patient satisfaction scores by decreasing stigmas in staff. Results demonstrated that with the selected intervention that stigmas amongst healthcare professionals were reduced by nearly 50%. Patient satisfaction scores were not positively impacted by this intervention. Health care organizations can address mental health stigmas during the orientation process and throughout an employees' tenure by increasing awareness and by conducting regularly trainings. Findings of this project will help future researchers on their own research and thereby support the mental health community.

Keywords: Attitudes; Health Care Professional; Mental Health; Mental Health Patient Care Delivery; Mental Health Patient Outcomes; Stigmas

Introduction to the Project

The intent of this Direct Practice Improvement (DPI) project was to improve patient care delivery and patient outcomes for those diagnosed with mental illness as evidenced by improvement in patient satisfaction scores. This was accomplished by reviewing and analyzing the attitudes and beliefs towards mental illness of health care providers and then providing an intervention and analyzing attitudes and beliefs towards mental illness after the intervention. The intervention consisted of reading a pre-existing hospital policy on the nurse patient relationship: Interpersonal

Relations Between Staff and Patients (Appendix C). Current research has identified a bias problem regarding the attitudes and beliefs towards mental illness by those who provide care to the mentally ill and how those attitudes and beliefs impact patient care delivery and outcomes [1,2].

According to current empirical research, health care providers may have negative attitudes or beliefs towards mental illness, referred to as a bias or a stigma [3-8]. Negative attitudes and beliefs impact patient care delivery and outcomes, at times evidenced by poor patient satisfaction scores [9,10]. Each hospital creates or adopts their own version of the patient satisfaction survey. The inpatient mental health unit where this DPI project was done entitled their patient satisfaction survey as a DHS Consumer Survey (Appendix B). The patient satisfaction survey

at the hospital this DPI project was conducted at uses 32 question quantitative survey that captures the perception of the patient on the interaction they had with staff and the quality of care they perceived that they received. Quality improvement in patient outcomes as evidenced by patient satisfaction scores for those with mental illness is often correlated to the attitudes and beliefs of the health care professionals who are caring for them [11,12].

The United States has current legislation, including Healthy People 2020, to reduce health care disparities for the mentally ill population (Agency for Healthcare Research and Quality [AHRQ], 2014) [13]. Understanding the level of stigmas that mental health care professionals have as well as the level of care that patients perceive they were given by these professionals will enhance scientific knowledge and help to reduce health disparities. Current empirical research has demonstrated that stigmas towards mental health can negatively impact the quality of care that those with mental illness receive and is reflected in patient satisfaction scores [7,10,14]. Reducing disparities is important as it aims to produce equality of care to all patients, despite their illness [15].

This DPI project was driven by reviewing current empirical literature and was completed by collecting data regarding the attitudes and beliefs of health care professionals from a multidisciplinary sample of health care professionals. Statistical analysis was used to understand the relationship between nature of the attitudes and beliefs of health care professionals and patient satisfaction scores [16,17]. As an intervention, an existing hospital policy on therapeutic nurse/patient relationships that focuses on anti-stigma rhetoric and attitudes was reviewed with staff. Patient satisfaction scores, both pre and post intervention were evaluated. Stigma levels of the health care professionals was measured using a pre-existing tool entitled the Mental Illness Clinicians' Attitude Scale (MICA -4) (Appendix A).

When people do not meet societal standards, society tends to respond with negative terms to describe these people, which are referred to as stigmas [16,18]. In ancient societies, marks were often burnt into the flesh of slaves, criminals, and those who were found to be societal deviants, including those with mental illness [19-21]. Current society still labels those with mental illness as people who are dangerous, cannot obtain recovery, and have unpredictable behaviors that eliminate them from working and engaging with society [22,23]. Branding and assignment of stigmas negatively impacts patient care, patient care delivery, and patient outcomes [15,24]. Stigmas are often reflected in patient satisfaction surveys as the patient reports the care they received while in an inpatient psychiatric unit [9,10]. Stigmas have been shown to promote negative expectations about the person who exhibits a mental illness, as prejudiced attitudes lead people into discrimination of others [16,25].

Examples of having negative expectations would be the

healthcare professional assuming the patient does not want to change, or assuming they are not able to change, or becoming frustrated with the patient and communicating to the patient that their multiple admissions is tiresome for staff [16]. The health care professional is often unaware of the negative attitudes and beliefs that they have towards mental illness [26]. Stigmas include attitudes and beliefs that degrade another person [27]. Some of these beliefs and attitudes may include believing that most patients with mental illness are dangerous, that they are drug seeking, that they can never recover enough to have a good quality of life, and by using terms such as crazy or nuts to describe the mentally ill patient [28]. Chapter 1, summarizes the following information for this DPI project: (a) a problem statement and purpose, (b) clinical questions, (c) how this project intends to advance scientific knowledge, (d) terminology defined, (e) nature of the project, (f) a summary of the theoretical foundations, (g) addressing assumptions, limitations, and delimitations, and (h) a succinct summary.

Background of the Project

The history of mental illness dates back at least to the early Roman Empire [29]. Mental health remains essential to a person's well-being, healthy relationships, and ability to be a successful member of society [6,30]. Mental illness is addressed by nursing theorists including Peplau [31] and Barker [29] as they recognize the impact that mental health has on a person and society, along with the role of the nurse-patient relationship. Mental health has far-reaching effects on the public health of a community [6,30]. Mental health disorders are often concurrent with physical disorders, such as diabetes and heart disease which impact the overall physical health of a society [32]. Mental illness has been negatively impacting society for many years with these patients declining in recent years after discharge from a psychiatric inpatient hospital [16,19,33]. Declines include having to return within thirty days for the same condition, increase in physical disease, and early death [16,33]. Reducing health disparities for those with mental illness is an integral part of the Federal initiative entitled Healthy People 2020 [34]. Healthy People 2020 was first drafted by the United States Office of Disease Prevention and Health Promotion (USODPHP) in 2010 as ten-year national target for improving the physical and mental health of all Americans [34]. The Joint Commission requires hospital compliance with the standards for treatment plans, care given, and outcomes of those with mental illness concerns [22]. Patient satisfaction surveys help determine if those with mental illness were responsive to the care they received while in an inpatient psychiatric unit [9,10].

Current empirical research suggests bias promotes stigmas which in turn promote negative expectations about the person who exhibits a mental illness [10,35]. For example, the nurse of a patient with a substance abuse disorder may expect that patient to just stop drinking, as the nurse educated them to the last time they were in the emergency room and may score their level of intoxication

differently due to their view of the patient not following their patient care objectives [1]. Prejudiced attitudes lead people into discrimination of others including not listening to the physical complaints of a suicide attempt patient because the professional has stigmas against those who try to end their own life [16]. It is reported in current empirical research studies that healthcare professionals who harbor stigmas often treat those with mental illness without positive regard [14,19,35,36]. Patient satisfaction surveys often reflect negative responses to questions regarding the patients' perception of how they were respected by those who provided care for them [10]. Chen and Chang [16] suggested that a reduction in stigmas would help to improve patient satisfaction scores.

Healthy People 2020 calls for an end to mental health disparities and for the treatment of this vulnerable population to be of the highest quality [34]. As accreditation agencies and the federal government seek to improve patient outcomes with the mentally ill population, the necessity of exploring the causes of the patient care delivery problems and lower patient outcomes become evident [16,37]. This DPI project will begin with those who provide care for the mentally ill and their belief systems towards mental illness [16,30,36]. Based on theoretical foundations for mental health nursing, this DPI project focused on the attitudes and beliefs of those caring for this vulnerable population and how patient care delivery and outcomes could be negatively impacted, as evidenced by patient satisfaction survey scores [10,24,29,38].

Statement of the Problem

It is not known if and to what extent patient satisfaction scores are impacted by healthcare professionals who have bias towards mental health while providing care for those with mental illness [16,30,39]. Further research indicates that the outcomes of patients diagnosed with mental illness decrease when they receive care by someone who has negative attitudes or beliefs towards mental illness [40-42]. The quality of patient care delivery and patient anticipated after-care results are often reflected in patient satisfaction surveys which are completed upon discharge from an inpatient psychiatric unit [10]. It is within these patient satisfaction surveys that the patient is allowed to anonymously provide feedback as to how they were treated and the level of care they received while a patient [26]. These quantitative surveys do not include the patient's name, date of birth, address, or any other personal identifying information [30]. The broad population affected by mental health disparities include anyone suffering from a mental illness, including anxiety, depression, and substance abuse [43]. This DPI project was needed to help reduce disparities for the mentally ill as they seek treatment for medical or psychiatric illnesses [40-42]. Current literature reviews support this DPI project topic as a quality improvement measure to improve patient outcomes for those with mental illness as evidenced by improved

patient satisfaction survey scores [10,14,39,44,45]. The DPI project made a positive contribution to reducing disparities and improving patient outcomes for the vulnerable population of those diagnosed with mental illness [16,39-41].

Purpose of the Project

The purpose of this quantitative DPI project was to improve patient care delivery and outcomes by identifying negative attitudes and thoughts of the health care workers utilizing the MICA -4 (Appendix A), providing an intervention of reviewing an existing policy on the nurse/patient relationship (Appendix C), and then re-measuring the level of stigma using the MICA -4. The effectiveness of this intervention was measured by evaluating the pre and post intervention patient satisfaction scores (Appendix B). The specific population group for this DPI project included unlicensed mental health care professionals, mental health technicians and mental health counselors, and licensed mental health care professionals, registered nurses and physicians. All participants were employees of the inpatient psychiatric unit where the DPI project was investigated. All participants were known to have at least an associate level degree in nursing, counseling, criminal justice, and/or psychology. The participants were men and women from a variety of ethnic and religious background having various years of experience. They were between 21 and 65 years of age, as the inpatient psychiatric unit does not currently have any staff over 65.

The data collection tool selected for this project was the Mental Illness: Clinicians' Attitudes Scale: (MICA - 4) [28]. The MICA -4 was described in Chapter 3 and can be found in Appendix A. Permission was granted to this investigator to use the MICA -4 (G. Thornicroft, personal communication, October 10, 2016). The MICA -4 focused on the attitudes and beliefs of those who provided care for the mentally ill, assessed their attitudes and beliefs towards mental illness and the impact of these attitudes and beliefs on patient care delivery and outcomes [5,28,46]. The MICA -4 is a questionnaire that was completed by mental health care professionals before and after the review of the inpatient psychiatric hospitals' policy on therapeutic nurse/patient relationships, which enforces anti-stigmas rhetoric. The MICA -4 has been deemed to be both valid and reliable [5,28,46]. The impact of the MICA -4 on reducing stigmas of mental health care providers as seen by improving patient satisfaction scores was demonstrated by a review of the patient satisfaction scores for 30 days before administration of the MICA -4 and then again 30 days after.

Quantitative analysis was chosen for this DPI project as it provides tools to help observe, interpret, and explain what may happen in a given scenario based on numbers [47]. Data obtained from the output measures of the tool being used (Appendix A) and the review of the patient satisfaction survey scores was statistically

analyzed and a reasonable understanding was reached. It was the goal of this investigator that in this pattern, to with certainty predict what will happen if a similar study were conducted elsewhere as well as the impact that this DPI project would have on current evidence-based processes [47]. Although quantitative research involves the study of behavior and the reasons behind those behaviors, there is sufficient empirical evidence that already saturates this as related to this DPI project.

The participants were randomly selected from a list of potential subjects provided by the nursing director of the inpatient psychiatric unit. Staff who worked on Unit A and Unit B were chosen, as the Director of Nursing preferred for the other units of the hospital to not participate due to the intensity of their units. The participants were contacted by this investigator via encrypted email, inviting them to participate in the DPI project via an in-person group conference. A conference was conducted on December 12, 2016 at 0630-0700 and December 13, 2016 at 1430-1500. The conference took place in Conference Room 203 at the inpatient psychiatric hospital. The location and time was confirmed with the inpatient psychiatric hospital. Up to 50 participants could sit comfortably around tables in the conference room.

Prior to the meeting, the patient satisfaction survey results for the past 30 days were reviewed by this investigator. These scores are obtained by the inpatient psychiatric unit nursing director. The inpatient psychiatric unit agreed to have these scores available for this investigator to review and to provide statistical analysis of these scores again in January 2017. Participants of the December 12 meeting were provided with a paper copy of the MICA -4 which they were asked to complete after explanation of the DPI project and the volunteer nature of their participation, which included a signed informed consent. Participants were given a number to protect their identity and this number was placed on their MICA -4. After completion of the MICA -4, participants were handed a paper copy of the inpatient psychiatric unit recent policy change on therapeutic nurse/patient relationships, which promotes anti-stigma rhetoric, attitudes, and beliefs by health care professionals. After reading of the policy, participants were asked to again complete another paper copy of the MICA -4, including their personalized number on the top of the form. Participants were dismissed. On January 14, 2017, patient satisfaction survey scores (obtained by the inpatient psychiatric unit nursing director) were reviewed by this investigator. The inpatient psychiatric unit agreed to have these scores available for this investigator to review and to provide statistical analysis of these scores. Statistical analysis of the MICA -4 (pre and post policy reinforcement) was conducted. Statistical analysis of the patient satisfaction survey results (pre and post intervention) was conducted. Data analysis and results are recorded in Chapter 4. A summary of the DPI project, conclusions, and recommendations is included in Chapter 5.

Chapter 3 elaborated on the quantitative methodology of this DPI project. The basic pretest posttest design allowed there to be focus on the intervention while assessing group differences and change within the group. Chapter 3 elaborated on this quantitative basic pretest posttest design as it detailed the (a) individualized informed consent including the purpose of the DPI project, (b) what is expected of the participant, (c) any expected risks and benefits, including psychological and social impacts, (d) the fact that participation was voluntary and that one could withdraw at any time, or choose not to participate, without any repercussions, (e) how confidentiality was protected, (f) the name and contact information of the investigator of the DPI project, (g) and contact information of the chair of the DNP program [48]. Statistical analysis and reporting will be conducted utilizing IBM SPSS Statistics software [48]. As this DPI project addressed concepts of Healthy People 2020 and other federal and local initiatives to reduce disparities to those with mental illness, this DPI project positively contributed to scientific knowledge [8,49,50]. Although this DPI project was limited to one inpatient psychiatric unit in the Chicago area, it has the potential of exciting readers and encouraging them to conduct similar studies within their hospitals and geographical locations [16].

Clinical Question

The identified problem for this DPI project was that the negative attitudes and beliefs of health care professionals towards mental illness negatively impacts patient care delivery and outcomes [1,45]. A lack of quality in patient care delivery and outcome planning is problematic for those diagnosed with mental illness [29,31]. The clinical questions that guide this DPI project were as follows:

- What is the correlation between mental health patient satisfaction scores before and after intervening to reduce bias held by the mental health care providers? The intervention was re-introducing an existing hospital policy on the therapeutic nurse/patient relationship?
- What is the correlation between the amount of mental health bias held by a healthcare professional before and after re-introducing an existing hospital policy on the therapeutic nurse/patient relationship?

P -Population/Patient problem: Health care providers on an inpatient psychiatric unit who harbor mental health stigmas as evidenced on MICA -4 scores, have low patient satisfaction scores, as evidenced by patient satisfaction scores for 30 days, pre-intervention. Any participant who demonstrated no stigma was still included in this DPI project.

I - Intervention: Mental health stigmas can be reduced by reintroducing a pre-existing hospital policy on the therapeutic nurse/patient relationship.

C - Comparison: Comparison will include patient satisfaction scores pre and post intervention as well as stigma scores pre and post intervention.

O - Outcome: The desired outcome is a reduction in mental health stigmas as evidenced by an improvement in both MICA -4 survey results and patient satisfaction scores.

T - Time: MICA -4 survey scores will improve immediately after the intervention, and this will be evidenced by an improvement in patient satisfaction scores over the next 30 days.

Advancing Scientific Knowledge

A current gap in published literature exists in reducing disparities towards those with mental illness, which is that of determining the level of mental health stigmas by those providing care for the mentally ill and determining if an intervention will decrease those stigmas, as evidenced by an increase in patient satisfaction scores [14,16,18,21,27]. This DPI project advanced scientific knowledge by improving patient care delivery and outcomes for those with mental illness by addressing the attitudes and beliefs towards mental illness by health care professionals [8,51]. This quantitative DPI project was unique in that it was limited to one psychiatric inpatient hospital in the Chicago area. Similar projects have been conducted in other countries including, Taiwan, Canada, and European countries [16,27,52]. The stakeholders were informed of the outcomes of this DPI project.

Theoretical foundation: This DPI project was built on the theoretical foundations of mental health leaders: the theories of Peplau [31], the curative factors developed by Watson [53], and the most recent theoretical foundations of Barker [29]. All three of these theorists focus on the need for care of the mentally ill to be provided in a patient-centered approach that is free of stigmas and bias, while entering into the patients' story and understanding their projected outcomes through the development of curative, therapeutic interpersonal relationships [43,54,55]. All three theorists support stigma reduction and provide an understanding of why those who harbor stigmas towards the mentally ill impair patient care delivery and hinder patient care outcomes [29]. In 2001, Barker introduced the tidal model: A mid-range nursing theory for mental health nursing. This theory is based on the therapeutic nurse/patient relationship, which is built on trust. This trust is established through the nurse who genuinely listens and engages with the patients' personal story without judgment, bias, or stigma [29]. The mid-range nursing theory by Barker has been adopted as a recovery method for those working with patients on an inpatient psychiatric unit [29].

The works of Peplau [31] are often considered to be the foundation of psychiatric nursing and are often turned to when developing policies for working with the mentally ill population

[43]. This includes when developing therapeutic interventions for those with mental illness as well as when identifying the dynamic role that the clinical nurse plays in healing for those with mental illness [39]. Peplau identified the seven most common roles of nursing and the necessity within these roles or providing the best care possible in order to help speed along treatment and recovery [55]. The curative factors developed by Watson [53] focus on the nurse/patient relationship and the curative factor that this relationship has. Watson emphasized that this relationship has to be built on trust and must be free of nurse bias and stigmas for the relationship to have curative factors [53]. This patient-centered approach taught by Watson has been adopted in the psychiatric field and is the basis for the recovery of the mentally ill patient [55]. Watson encourages nurses to examine their own thoughts, feelings, and beliefs before providing care to someone with mental illness. The project added to understanding these important theorists and support their work by demonstrating the connection between the therapeutic relationship of the health care provider and the mentally ill patient being impacted by stigmas [14,38,43,44]. This was shown by evaluating the rise or fall in patient satisfaction scores post intervention. Although this project was limited to the one inpatient psychiatric hospital in the Chicago area, it had the potential of exciting readers and encouraging them to conduct similar studies within their hospitals and geographical locations [4,16,56].

Significance of the Project

This DPI project was needed because the mentally ill population is often cared for by health care professionals who harbor stigmas against them, and these stigmas reduce patient care delivery and impede patient outcomes [5,16,27,28,57]. As found in studies in other countries, health care workers are often unaware of these stigmas nor the phenomenon of how these attitudes and beliefs are negatively impacting their patients [7,35,44,58]. These stigmas are sensed by the patients and most often reflected in patient satisfaction surveys, where the patient can reminisce about the care they received while on an inpatient psychiatric unit [26,10]. This DPI project complemented current literature and research by adding additional support to what has already been investigated while offering insight into whether an intervention for the healthcare workers reduces stigmas and results in higher patient satisfaction scores [10,59]. The concepts of identifying the negative stigmas of health care providers has been studied in Africa [60], Australia [12], Canada [35], Europe [21], Haiti [17], India [40], Nigeria [44], Sweden [58], and Taiwan [16]. Many researchers have studied these stigmas and how they impact patient care delivery and outcomes [9,40,49,59]. A replication study serves to advance the current international research while ultimately reducing health care disparities and improving patient care delivery and outcomes in Chicago are inpatient psychiatric hospital [3,8,26].

Bail, et al. [3] reported on the impact that negative mental health stigmas from providers have on migrant farm workers in Georgia. Reeves et al. [22] addressed the mortality component of mental illness in the United States and the necessity for health care workers to address this growing concern. Meanwhile, Michaels et al. [18] connected the reader to the impact that stigmas have on the healing process for those with mental illness and the impact that care given by those harboring stigmas has on patient satisfaction surveys. Researchers have identified that stigmas harbored by health care providers negatively impact the care those with mental illness receive. A study to determine the effectiveness of an intervention for mental health care providers has not been conducted in the past five years in the Chicago area [18,57,61,62]. This DPI project helps those who work with patients diagnosed with mental illness provide a higher standard of care for those patients as stigmas are acknowledged and reduced so that patients can receive the highest level of quality care [26,49,63].

Opportunities to improve patient care delivery and outcomes as evidenced by improved patient satisfaction surveys are consistent with current federal and local initiatives and with current researchers [7,8,24,44,64]. It is difficult to reduce health care disparities towards the vulnerable population of the mentally ill while personal stigmas towards mental illness exist in those who provide care for these patients [8,17,29,62]. Reducing health care disparities is consistent with the theoretical underpinnings of mental health care and consistent with improving the health of those with mental illness, which in turn promotes the health of a community and society [8,11,22,29,53,62]. One step to reducing the disparities is to reduce the stigmas that health care professionals have towards mental illness so that they can provide their patients with the highest level of care and patient care delivery [8]. This DPI project accomplished these proposed goals without studying or interviewing individuals from the vulnerable population, only in part and with limited generalizability. The goals of this DPI project were accomplished by obtaining survey results from health care professionals who work with the mentally ill populations (Appendix A). As the correlation between the attitudes and beliefs of health care workers towards the mentally ill and patient care outcomes, (as evidenced by patient satisfaction scores), was demonstrated, future researchers will have sound reasoning to further reduce disparities towards patients diagnosed with mental illness [22].

Rationale for Methodology

After careful review of the quantitative and qualitative designs, a quantitative analysis was utilized for this DPI project. The quantitative methodology established statistical findings from a representative sample of the population studied [47]. This quantitative pretest-posttest design DPI project established relationships between the independent variable (mental health

stigma survey) and the dependent variable (patient satisfaction scores) as an intervention was offered and measured [47]. A qualitative methodology would have been chosen if it had aligned with the identification, descriptions exploration, and explanation of a phenomenon [47]. The flow of activities in a qualitative study is more flexible and less linear [47]. Because qualitative research designs are inductive in nature and describe an event in its natural setting, it is more subjective in nature, and therefore, was not chosen as the methodology for this DPI project [47]. Further rationale for the choice of the methodology will be detailed in Chapter 3.

Established researchers have determined that search criterion is critical to a successful project [47]. For this DPI project searches were conducted using the Grand Canyon University online library with the keywords, health care professional, mental health, stigmas, attitudes, mental health patient care delivery, mental health patient outcomes. Inclusion criteria included articles that were directly related to the research question, empirical articles, and articles that had been peer-reviewed and that specifically focused on adult populations. Articles published from 2000-2016 were reviewed for their relevancy. Exclusion criteria included articles that were published prior to the year 2000 and theorists who did specifically impact psychiatric nursing. All of the articles were evaluated for empirical evidence and compared using a comparison matrix. Qualitative and quantitative studies were selected including descriptive, quasi-experimental, historical, case studies, grounded theory research, and phenomenological studies. Theoretical foundations were limited to three key mental health theorists: Peplau, Watson, and Barker [22].

Nature of the Project Design

The selected design for this DPI project is a quantitative methodology that is rooted in reliability and validity [50]. This investigator believed that the quantitative design was an excellent design to prove or disprove a hypothesis with statistical analysis [47]. This quantitative basic pretest-posttest designed DPI project established relationships between the independent variable (mental health stigma survey) and the dependent variable (patient satisfaction scores) as an intervention was offered and measured [47]. The aim of this investigator was to use quantitative methodology and correlational design to determine the relationship between the independent variable (intervention: nurse/patient relationship policy) and the cause and effect on the dependent variable (MICA-4 and the patient satisfaction surveys) in a population of mental health care providers and patients. Quantifying these relationships was critical and was done with careful statistical analysis using SPSS software. This software has been proven reliable and valid and used for mental health quantitative projects [47,50]. This DPI project enhanced the theoretical underpinnings of mental health while explaining an intervention that lead to increased patient care and outcomes; hence, the investigator sought publication in mental

health related nursing journals.

Definition of Terms

Terms and definitions that will be used in this DPI project include the following:

Behavioral Health: An inclusive word that includes methods to promote well-being by preventing mental illness or intervening when a mental illness is diagnosed. This term may have fewer stigmas associated with it as compared to mental health yet does not imply root causes for the behaviors being treated [65].

Licensed Health Care Professional: Professionals who provide care to those with mental illness, and have a license to perform within the field of medicine. This includes a registered nurse, psychologist, medical doctor, social worker, and/or professional counselor [65].

Mental Health: A person's condition in regard to their psychological and emotional well-being: level of psychological well-being [65].

Mental Illness: A term that groups the terms behavioral health, mental health, and psychiatric, into one word that is understood by health care professionals to refer to all mental disorders with definable diagnoses [65]. This includes disorders that are manifested with significant dysfunction and may be the result of biological, developmental, or psychological disturbances in mental functioning [65].

Psychiatric: Relating to mental illness or its treatment [65].

Psychiatric Mental Health Nurse: A core mental health profession that employs a purposeful use of self as its art and a wide range of nursing, psychosocial, and neurobiological theories and research evidence as its science [29]. The psychiatric mental health nurse was the primary licensed health care professional in this DPI project [5].

Stigmas: Negative words (i.e., crazy, lunatic, untamed, untreatable, etc.) and attitudes (i.e., those with mental illness are not recoverable; those with mental illness are dangerous etc.), that are used to describe mental illness [14,16,66].

Unconscious Bias: Attitudes and beliefs that lead to unintended discrimination against or degradation of those who are socially marginalized in society [65]. The word bias and stigma are used interchangeably in this project as they are used interchangeably throughout psychiatric nursing [29].

Unlicensed Health Care Professionals: Professionals who provide some level of care to those diagnosed with mental illness, but are not licensed as a registered nurse, psychologist, social worker, psychiatrist, or other licensed health care professional [65]. This can include mental health technicians, behavioral health technicians and patient care technicians [65].

Assumptions, Limitations, and Delimitations

Assumptions: Identification of assumptions, limitations, and delimitations help to strengthen a project and therefore, they are included here. Assumptions in this DPI project were:

- Survey participants will be objective and honest with their answers [28]. This is a standard assumption in quantitative delimitations [47].
- Negative attitudes and beliefs towards mental illness and those diagnosed with mental illness exist in the Midwest [5]. This assumption is based on global empirical research that identifies these negative attitudes and beliefs across the globe [16,27,52].
- This project will be an accurate representation of the attitudes and beliefs towards mental illness and those diagnosed with mental illness exists in the Midwest, by licensed and unlicensed health care professionals who work with the mentally ill [5,28].
- There will be a connection between the level of health care professionals' stigmas and patient satisfaction scores [5,28].

Limitations: Limitations of this project were observed to be the self-reporting and anonymous nature of the survey. However, similar studies have been conducted by numerous researchers, and they have been found to be very effective [14,39,45]. The sample size had to be large enough to detect the smallest worthwhile effect or relationship between the variables, and this could pose a limitation [28]. There is no evidence to support that these limitations will negatively impact the results of this DPI project with a plethora of researchers demonstrating similar limitations with positive results [12,19,27,34,45,57,60].

Delimitations: The major delimitation noted was that the project only included results from one inpatient psychiatric hospital in the Midwest region of the United States [47]. Although this is a delimitation, it is normal to conduct a project within a specific geographical region and there was no evidence to support that this delimitation will negatively impact the DPI project or its results [3,12,27,45,57].

Summary and Organization of the Remainder of the Project

Mental health was identified as being a public health concern that the U.S. government and accreditation agencies are focusing on for Healthy People 2020. This unique DPI project, yet based on a plethora of literature reviews, sought to investigate the relationship between these stigmas and patient care delivery and outcomes as evidenced on patient satisfaction surveys [26,58,60]. Reducing disparities and improving outcomes for this vulnerable population is of concern to individuals with mental illness, their

families, their immediate societal members, and the public health of their communities [19,21]. Improving patient care delivery and patient outcomes, for those diagnosed with mental illness, by addressing the attitudes and beliefs towards mental illness of the health care professionals is quality care improvement that can be done without disturbing or studying the individual members of the mentally ill population [21,22,45].

Assumptions, limitations, and delimitations were addressed to ensure the reader of the legitimacy, validity, and reliability of this project [21]. The conclusion was that the mental health population is vulnerable and deserves to receive care with the same standards of dignity, respect, and evidence-based care delivery and outcome planning that those with medical problems receive [16,17,19,29]. The following chapter includes a literature review of 50 peer-reviewed empirical articles that support this DPI project. Chapter 2 will provide the reader a comprehensive literature review of current empirical studies that support and lead credence to this DPI project. Chapter 3 will describe in detail the methodology for this DPI project. This will include (a) the clinical questions, (b) project methodology, (c) project design, (d) population and sample selection, (e) sources of data (including the scale chosen and rationale for choosing that scale), (f) validity, (g) reliability, (h) data collection procedures (i) ethical considerations, and (j) limitations.

Literature Review

The intent of this DPI project was to improve patient care delivery and patient outcomes for those diagnosed with mental illness by investigating the attitudes and beliefs of the health care providers towards mental illness. This improvement of a reduction in stigmas by the health care providers should be evidenced by an increase in the patient satisfaction scores [6]. Current research has identified the negative impact on patient care and outcomes for patients diagnosed with a mental illness when they are cared for by a health care professional who has negative attitudes or beliefs towards mental illness itself or towards the patient with mental health problems [3,18,24,36]. Quality improvement in patient outcomes for those with mental illness is directly correlated to the attitudes and beliefs of the health care professionals who are caring for them [11]. Therefore, this DPI project was based on studying the attitudes and beliefs of health care professionals from a multidisciplinary sample, with studying individuals from the vulnerable population only in part and with limited generalizability.

Mental health stigmas were found to negatively impact the health and outcomes of those with mental illness. Empirical literature indicated that mental health stigmas can be reduced in a variety of methods including having policies that enforce treating people without preconceived notions about the person or their illness influencing the care given to the patient [36]. Patient

satisfaction surveys are uniquely tied to patients being treated with bias due to the mental health providers' attitudes and beliefs towards mental illness [9,10]. This chapter served as a means of communicating the methodology of the literature review, the theoretical foundations on which this DPI project is built, a review of the literature, and a summary of the information presented.

The DPI project was based on primary sources by searching for references in bibliographic databases. Searches were conducted through the Grand Canyon University (GCU) online library, EBSCO host, and CINAHL, using the keywords, health care professional, mental health, stigmas, attitudes, mental health patient care delivery, mental health patient outcomes. Boolean operators were used to expand and delimit a search. Articles were screened to ensure that the reference was accessible and filed in a computer database program to permit easy access. Critiquing questions included if the title suggested key phenomenon, was the abstract clearly written, was the problem statement unambiguously noted, were the questions clearly stated, was the information summarized appropriately, were the rights of the subjects safeguarded, and if the literature gave opportunities to capitalize on understandings of the phenomenon. Inclusion criteria included articles that were directly related to the questions, empirical articles, and articles that had been peer-reviewed and that specifically focused on adult populations. Articles that have been published from 2000 to 2016 were reviewed for their relevancy to the question, how do the negative attitudes and beliefs of health care professionals towards those diagnosed with mental illness impact patient care delivery and outcomes compared to those receiving care from a health care professional who has a positive regard for those diagnosed with mental illness? Exclusion criteria included articles that were published prior to the year 2000 and theorists who did not specifically impact psychiatric nursing. All of the articles were evaluated for empirical evidence and compared using a comparison matrix. Qualitative and quantitative studies were selected, including descriptive, quasi-experimental, historical, case studies, grounded theory research, and phenomenological studies. Theoretical foundations were limited to three key mental health theorists.

Background of the Problem

Mental health is essential to a person's well-being, healthy relationships, and ability to be a successful member of society [16,30]. Yet, mental health is often characterized by negative attitudes and beliefs [22]. Mental health disorders are often concurrent with physical disorders, such as diabetes and heart disease, but they also have far reaching effects on a person's social group as well as on the public health of a community [11]. Therefore, reducing health disparities for those with mental illness is an integral part of the federal initiative entitled Healthy People 2020 [22]. Healthy People 2020 was first drafted by the ODPHP in 2010 as ten-year national objectives for improving the physical

and mental health of all Americans United States Office of Disease Prevention and Health Promotion [34]. The Joint Commission Top Compliance Issues [64] also addresses concerns with health disparities of the mentally ill. According to Reeves et al., the Joint Commission is requiring hospital compliance in the standards for treatment plans, care given, and outcomes of those with mental illness concerns.

Unfortunately, mental illness has become associated with negative words, referred to as stigmas. In ancient societies, marks were often burnt into the flesh of slaves, criminals, and those who were found to be societal deviants [18]. This branding of a person's perceived social worth is the origin of our current word, stigma [18]. Bail, et al. [3] reported that mental health stigmas are negative attributes that devalue a person by marking them with disgrace and reproach. According to Corrigan and Rao [35], these stigmas when believed by the individual are referred to as self-stigmas, and when believed by the general public, are referred to as public stigmas. Stigmas, according to Corrigan and Rao, include negative expectations about the person who exhibits a mental illness as prejudice attitudes that lead to discrimination of these people. Healthy People 2020 calls for an end to mental health disparities and treatment of this vulnerable population to be the highest priority and of the highest quality. As accreditation agencies and the Federal government seek to improve patient outcomes with the mentally ill population [13]. One place to begin is with those who provide care for the mentally ill and their belief systems towards mental illness [16,30,36]. Based on theoretical foundations for mental health nursing, this project focused on the attitudes and beliefs of those caring for this vulnerable population and how these attitudes and beliefs impacted patient care and outcomes [23,24,29,31].

Theoretical Foundations and/or Conceptual Framework

Over the years, many theorists have evolved who place an emphasis on the needs of compassionate care and treatment that is free of negative stigmas for those with mental illnesses. Peplau [31] addressed the interpersonal relationship that is required between the nurse and the mental health patient, in order for healing to occur. Peplau identified the vulnerable population of mental health patients and introduced the paradigm shift from a medical treatment based to interpersonal relational based. Watson [53] reported curative factors as the philosophical foundation for the science of caring and working with those diagnosed with mental illness. Watson stressed that effective caring promotes patient health and patient outcomes. Curative caring includes the practice of loving-kindness and equanimity, authentic presence, cultivation of one's own spiritual practice toward wholeness of mind/body/spirit, openness to the unexpected, and a reflective/meditative approach to nursing care that increase consciousness and presence to the humanism of self and other [53]. This human caring model

has been instrumental for mental health/psychiatric nursing [29]. The curative factors identified by Watson include formation of humanistic-altruistic system of values, instillation of faith/hope, development of helping/trusting nurse/patient relationships, promotion and expression of both positive and negative feelings, creation of a supportive environment for healing, and allowance for existential/phenomenological/spiritual forces [45].

In 2001, Barker published a mid-range nursing theory entitled Tidal Model for Recovery. This seminal mid-range nursing theory for the care of the mentally ill, emphasized the role of the health care professional/patient relationship, and the necessity of providing patient care without having personal negative stigmas towards mental illness. This empirical article provides both a theoretical and a practical basis for the implementation of the Tidal Model of Recovery to the psychiatric and mental health nursing profession [29]. The philosophical approach to psychiatric and mental health nursing is explained. Barker provides comprehensive literature reviews and clinical experience to support the hypothesis for this recovery model. According to Barker, the Tidal Model assists the nursing professional in changing their perspective on psychiatric mental health nursing, and focuses on the patient being part of the solution. Emphasis is given to the patient and their story during the healing process. The Tidal Model promotes the paradigm shift of Peplau as well as the caring model established by Watson [45].

This DPI project was built on the theoretical foundations of mental health leaders: the theories of Peplau the curative factors developed by Watson [53] and the most recent theoretical foundations of Barker [29]. For example, caring for a patient without having stigmas against them supports the curative caring, authentic presence, and wholeness of mind/body/spirit, that was taught by Watson [53]. Peplau [31] taught nurses of the necessity of a paradigm shift when caring for those with mental illness. Peplau focused on interpersonal relational based care for those with mental illness and this DPI project emphasizes the importance of relational care. Finally, Barker [29] introduced nurses to listening to a patient's story and identifying the mental health patient as a person with a mental illness not as a mentally ill person. Barker emphasized that this switch in thinking would improve patient care outcomes. This DPI project supports Barker as it is demonstrated that mental healthcare providers do often have stigmas towards patients with mental illness. This project increased understanding of these important theorists and supported their work by demonstrating the connection between the therapeutic relationship between the health care provider and the patient, while identifying underlying stigmas that may be impacting these outcomes (14,39,44,45).

This DPI project aligned with other empirical literature based on the same theoretical foundations. For example, Boyle, et al. [67] reported that negative attitudes by health care professionals impact the quality of care, range of services offered, and hinder the

development of a therapeutic relationship. These negative attitudes were concluded after a convenience study of undergraduate students enrolled in the first, second, and third years of an undergraduate nursing program were administered a reliable scale to self-report attitudes and beliefs towards mental illness. Boyle et al. concluded that there was virtually no regard for patients with substance abuse problems. Therefore, identifying and correcting the negative beliefs and attitudes was seen as paramount to improving patient care for those suffering with mental illness [67]. The nursing theorists have determined that identification of negative beliefs and attitudes towards those diagnosed with mental illness is imperative to improving patient care and patient outcomes [7,31,53].

Review of the Literature

The relationship associated with this project is how the attitudes and beliefs of health care workers impact patient care delivery and outcomes. This DPI project answered the clinical questions. The DPI project was firmly based on current literature [58,61] and theoretical foundations [29,31], while providing new answers to the clinical questions for those in the Midwest region of the United States [8]. The project was conducted based on the PICOT question. Seventy-five articles and two books were evaluated with 50 articles being determined as meeting the methodology requirements and contributing to the clinical questions. Works describing the theoretical foundations of three key mental health theorists were also studied. References to government initiatives to improve mental health delivery and outcomes have been made. All 50 articles that were evaluated had a common theme of reduced patient care delivery and reduced patient care outcomes amongst those diagnosed with mental illness when care was provided by a health care professional having negative stigmas towards mental illness. Relationships were drawn between theoretical foundations for patient care, established from the early 1950s through the present.

Gaps that were most often noted included studies that were conducted in one specific geographical location without repeating the same study in another location [16]. Culture and ethnicity of the respondents were not consistently reported. Most of the current literature focused on the nurse/patient relationship, despite researchers identifying that negative stigmas towards mental health reached through all areas of medical and mental health professions [67]. Finally, methodology to improve patient care delivery and outcomes was limited to addressing the attitudes towards mental health of the registered nurse (RN), the quality of care they provide to those with mental health disorders, and the direct role of the nurse/patient relationship to client outcomes [61]. This DPI project was conducted based on the PICOT question.

Attitudes and beliefs of health care professionals: The empirical study of Corrigan and Rao [35] concluded that negative stigmas, whether individualized or societal, give rise to diminished

hope, decreased self-confidence, and foreclosure of important life goals on the part of the person diagnosed with mental illness while increasing social withdrawal and hopelessness. Corrigan and Rao had no clear bias and reported the limited geographical area as a limitation of the study. The researchers suggested that others conduct investigations to determine if these same social stigmas and self-stigmas are consistent amongst other ethnic groups and in various economic groups as well. Media, in modern society, is of the methods by which stigmas are developed and passed onto those in the society, via music, art, and movies (theater). In an empirical systematic literature review, Sharac, et al. [23] concluded that those with mental illness are portrayed by the media as dangerous, violent, and severely disturbed. This study by Sharac et al. determined that the public has a higher regard for the health and well-being of those with physical problems than those with mental health problems. The attitudes of society as a whole trickle down to the basic units of society. Balahara and Mathur [40] identified the attitudes of nursing students towards psychiatric nursing. Because psychiatric nurses are an integral component of a multidisciplinary mental health-care team, a question as to the attitudes of nursing students towards psychiatric nursing arose. The empirical article by Balahara and Mathur revealed a fear among nursing students of the mentally ill and a perception that psychiatric nursing would be boring and unfulfilling. Balahara and Mathur had a sample population of 166 nursing students in India. No information was provided on what their nursing specialty choice was, nor was information regarding any personal or prior experience with patients who were mentally ill.

Yet Balahara and Mathur found that reducing fear of the mentally ill community improves the care that these patients receive. Stigma, according to Chambers, et al. [9] has been linked to negative outcomes in both mental and physical health and may contribute to the burden of illness, social morbidity, and a decrease in patient outcomes. This is consistent with the findings of other empirical literature, including that from DeHert, et al. [32]. DeHert et al. proposed that the lifespan of those with severe mental illness is shorter than that of the general public, and this is most often due to physical illnesses that accompany the mental health disorders. The researchers with DeHert et al. were concerned about nutritional, metabolic, and cardiac diseases amongst those with mental illness. After a quasi-experimental study was conducted, it was concluded that those with mental illness often have their physical symptoms not taken as seriously, or the physical symptoms are assessed as being part of the mental illness. According to DeHert et al. these patients live for a shorter period of time and have decreased patient outcomes from their counterparts who lack the mental illness component. The researchers with DeHert et al. determined that further investigative study is required to identify the reasons why health care providers do not take the medical complaints of the mentally ill as seriously as they do of their counterparts. It

was proposed that this is due to ingrained stigmas against mental illness and its patients [32].

Measuring stigmas amongst mental health care providers. Mental health stigmas can be created and generated by society [20]. The development of mental health stigmas by health care professionals was addressed by Stefanovics, et al. [1] conducted a quantitative study that compared beliefs regarding how negative stigmas towards mental health develop in health care professionals [1]. This study is of particular interest because it was conducted in five countries and had 952 participants. Confirmatory factor analysis by Stefanovics et al. confirmed the hypothesized model, and four factors of causation were identified. These factors included socialization, normalization, curses and witchcraft, and the health care workers' belief in the bio-psycho-social causes of mental illness. Stefanovics, et al. [1] appeared to have no biases that impacted the study, and addressed gaps by including respondents from several different global regions. Stefanovics et al. concluded that the more developed a country, the greater was the level of mental health stigmas. According to Stefanovics et al., increasing empathy and compassionate care for this population will lead to improvements in care, care delivery, and patient outcomes. Conclusions by Stefanovics et al. included that the negative attitudes and beliefs can be due to the many challenges faced on an inpatient psychiatric setting, as well as non-compliance issue with the stigmatized patients [1]. The results were similar to that of Gateshill, et al. [62] and that of the peer-reviewed, qualitative research of Iheanacho et al. [43].

It was proposed by Evans-Lack, et al. [52] that it is often difficult to differentiate between internal stigmas and societal stigmas [2,52]. The lack of defining terms such as labeling and stigma, as well as them being associated with vignette characters and not actual people from respondents participating in the surveys posed a limitation of the studies [12]. Although health care professionals have been identified as part of the problem of mental health stigmas, few improvement strategies have been suggested or tested. The study by Gabbidon, et al. [28] provided a tool to measure mental health stigmas. This tool (The Mental Health Clinician's Attitude Scale: MICA -4) was later proven valid and reliable by Foster [5]. Interventions such as providing information on stigmas or enforcing a no-stigma policy in the workplace was discussed as options for providing those with mental illness a higher standard of care [28].

Identification of the need to improve patient care delivery and outcomes. The first theme that emerged was the identification of the need to improve patient care and outcomes of the mentally ill. The AHRQ [13] released a program brief that expresses the necessity of improving quality, safety, efficiency, and effectiveness of mental health care services through research and transforming that evidence into practice. The AHRQ reported that nearly one-

third of the adults in the United States have been diagnosed with either a mental illness or a substance abuse disorder. Access to quality mental health care services remains an ongoing problem, with the AHRQ reporting an increase in mental health disorders, a decrease in quality mental health services, and an increase in readmissions within thirty days for mental health services. Finally, patient satisfaction scores have been decreasing for mental health patients. It is, therefore, necessary to research why the quality of care for mental health patients continues to lag despite advances in providing health care insurance to this vulnerable population. Crothers and Dorrian [61], determined that as society develops its definitions of what is socially acceptable and what is not socially acceptable, stigmas develop.

Those things that are not deemed socially acceptable quickly develop into stigmas. These stigmas become negative beliefs and attitudes of the population of a given society. Schomerus, et al. [68] conducted a systematic review of two years of studies on mental illness-related attitudes and beliefs in the general population. A limitation of this study was that there was no way to know if a respondent, although part of the general population, had a job working with people diagnosed with mental illness. This knowledge could have helped to interpret the results more soundly. Schomerus et al. concluded that there was some positive regard for mental illness, but that over the two years of their research, they saw a decline in the attitudes and beliefs of the population towards people with mental illness. This study brought awareness to the negative media personification that has created stigmas that reach far into society and into the hearts of those who care for this vulnerable population. This includes cartoons that exaggerate emotions of anger and sadness, movies that depict those with mental illness as unable to control their behaviors, and news clips that show individuals acting out when their mental illness is exacerbated (such as holding a person hostage or running in front of a moving train, thus disrupting rush hour traffic).

According to Chen and Chang [16], the attitudes of psychiatric hospital health care providers towards patients are critical to the quality of mental health care. Chen and Chang's study was aimed at exploring the attitudes of those who work in psychiatric hospitals towards mental illnesses. Chen and Chang utilized self-report questionnaires that were shown to be reliable as evidenced by Corrigan and Rao's research on the self-stigma reporting that was limited to Taiwan [16]. The article concluded that although many hospital employees in Taiwan had positive regard for people with mental illness, they did not hold that same positive regard for mental health patients who were living in the community or seeking social relationships. Chen and Chang concluded that in theory there was positive regard for people, but negative attitudes and beliefs towards people with mental illness who are living and working in the community. Therefore, these people, according to Chen and Chang, are less likely to seek help until they reach a

psychiatric crisis. By itself, this decreases patient outcomes, as early treatment is always better for the mental health patient [16].

While the federal government is calling for immediate improvement to care and outcomes for those diagnosed with mental illness, researchers are not avidly exploring the issue [30]. The AHRQ [13] reports that multiple studies have been done to determine the reasons for the existence of these disparities for this vulnerable population. Balahara and Mathur [40] reported that nurses historically have negative attitudes towards the psychiatric patient yet they are an integral component of the multidisciplinary team [29,31,53]. Balahara and Mathur conducted their study by using a questionnaire that had been proven to be reliable [28]. The conclusions drawn by Balahara and Mathur were that nursing students have varying negative attitudes and beliefs to mental illness and the field of psychiatry. These attitudes and beliefs, if not addressed, will carry over into stigmatized care for the mental health patient [40]. Danda [30] revealed that the negative stigmas towards patients who have mental health problems (including chronic substance abuse) are deeply embedded in our society and in hospitals that treat the mentally ill. The research instrument used by Danda had been shown to be reliable by Svensson [2]. As an example of the negative stigmas, when clients present with both substance abuse issues and psychiatric symptoms the patient is motivated to access care. Yet health care professionals often revert to negative attitudes of not believing the patient is serious about getting help, or not believing that the patient will ever regain their mental health [30]. These negative attitudes and beliefs were found to create barriers to care that are both covert and overt, while negatively impacting not only patient care but also the mere understanding of the entire problem at hand [30]. Negative attitudes identified by Danda [30] included open display of feelings of frustration, powerlessness, and even resentment to the mental health/psychiatric patient. The conclusion was that the staff working in psychiatric inpatient environments must learn to balance responsibilities, with empathy, compassion, and recovery-focused interventions [30].

Attitudes and beliefs of healthcare workers towards mental illness. The second theme that emerged was that of the stigmas health care workers often have toward mental health disorders. As health care providers seek to improve patient care and outcomes for those with mental illness, it is imperative that one assesses the attitudes and beliefs of the health care workers towards mental health disorders [29]. International qualitative and quantitative research highlights the negative effects on patient outcomes when care for those with mental illness is delivered by providers who harbor negative stigmas towards mental illness [3,9,27]. Rusch et al. [21] was aimed at identifying the attitudes of health care professionals toward mental illness directly and how these attitudes impacted patient care and outcomes. The researchers of Rush et al. determined that interventions to reduce the negative effects

of psychiatric admission, needed to include stigma by staff, as a stressor for the mental health/psychiatric patient. The limitation to the study by Rush et al. is the lack of suggestions for implementing this important factor into care for the hospitalized mental health patient.

Researchers have identified that negative attitudes and beliefs towards mental illness exist globally [16,27,52]. Gateshill et al. [62] compared the attitudes towards mental disorders and empathetic care amongst health care professionals. The respondents reported feeling sympathetic towards those with mental illness and favored them being cared for within the community. However, it was also revealed that less than 60% of the respondents felt that mental illness should be covered by insurance and many responded that they believe that people with mental health disorders are dangerous and unpredictable [62]. Because the questionnaire used was not standardized, this limitation should be taken into consideration. Because participants were especially selected to participate and were not randomly chosen, there is concern that a bias could be present. A descriptive, quantitative study was conducted by Wynaden et al. [39]. In this study, it was found that undergraduate nursing students and staff of universities have negative stigmas towards mental health issues. Wynaden et al. found that these negative stigmas keep students from seeking help as they fear discrimination and negative stigmas from their professors. Wynaden et al. sought to identify the attitudes of nurses towards mental illness before they graduated. The conclusion by the Wynaden et al. team was that these negative attitudes could be partly caused by society, by inadequate psychiatric clinical rotations, or by prior personal experience with someone who had a mental illness.

A limitation of the study by Wynaden, et al. [39] was that the prior knowledge of mental illness was not addressed, nor were the students' clinical rotations. Therefore, the reader did not know if the students had successfully completed their psychiatric mental health rotation prior to completing the survey. It is possible for the reader to wonder had a student had a poor preceptor for this experience, or if they did not pass this rotation if this would have impacted their answers on the questionnaires that were utilized. Evans-Lacko, et al. [52] linked two large international databases to explore the concept of public stigmas towards mental illness in 14 European countries as well as using individual reporting. They concluded that because social inclusion is central to mental health recovery, it is imperative to reduce the stigmas so that those who need mental health assistance feel safer obtaining services. The limitation of this study was targeting such a mass of people in the general public without engendering any public stigma that may have existed. The final conclusion of Evans-Lacko et al. was that stigmas towards mental health may be improved by facilitating access to information regarding mental illness, facilitating access to care, and delivering care with compassion and empathy. This

study by Evans-Lacko et al. mirrored the results and conclusion of that conducted by Crothers & Dorrian [61]. Although both studies noted cultural and ethnic diversities as being part of the cause of stigmas towards mental illness, both groups also concluded that those with mental illness deserve to be treated with compassion and ethical care in order to promote healing and wellness [61,52].

Attitudes and beliefs of healthcare workers towards patients with a mental illness. Once the attitudes and beliefs of health care workers towards mental illness are identified, then one can move forward to identifying their attitudes and beliefs towards the actual patients with mental illness [30]. Researchers have established the stigmas towards mental illness. Further investigation leads to a number of researchers who also studied the attitudes and beliefs of health care workers towards patients, as individuals, when they are diagnosed with a mental illness. Iheanacho et al. [43] conducted qualitative research on the attitudes of health care professionals towards people with mental illness. This study was limited to Nigeria, yet the conclusions were similar to other international studies, including that by Stefanovics, et al. [1] and Wynaden et al. [39]. Stefanovics, et al. explained that mental illness is attributed to causative factors or as being the architect of their own misfortune. Therefore, in Nigeria mental health is seen as a spiritual problem and their cultural practices negatively impact mental health. Stefanovics, et al. [1] also concluded that because of the spiritual component to their beliefs in mental illness, those being treated in hospitals are treated with discrimination, disdain, and with a lower quality of care. Iheanacho et al. [43] concluded that the attitudes of professionals who care for those with mental illness need to be improved and that their attitudes negatively impact a persons' self-perception while seeking mental health care. According to Rusch, et al. [21], this is directly opposite of what the theoretical foundations of Peplau, Watson, and Barker taught. Danda [30] conducted a mixed method research study in Canada on staff attitudes towards those with concurrent medical and mental health disorders. The research indicated that those suffering from mental health and physical disorders received poorer treatment outcomes, worsening of psychiatric symptoms, poor social outcomes and negative impacts on career and family. Crothers and Dorrian [61] conducted a multivariate analysis of nurse attitude scores towards caring for a patient diagnosed with alcoholism. There was a gap in the research between personal characteristics (such as age) and attitudes towards those with substance abuse issues. However, it was determined by Crothers and Dorrian that the attitudes and beliefs of health care professionals towards mental illness are very complex and include societal attitudes towards mental health problems and erroneous stereotypes towards the individuals who suffer from mental illness. Health care providers were reported to perceive those with mental health problems as uncooperative, unpleasant, difficult, and unrewarding to care for [61].

A cross-sectional study was conducted by Hansson, et al.

[58] which explored the attitudes of mental health professionals towards people who are diagnosed with mental illness. Amongst the 281 participants, it was found that negative attitudes and beliefs towards those diagnosed with mental illness were prevalent amongst the mental health professionals. Statistical analysis was correctly applied to the survey results, and the unconscious harboring of stigma and discrimination towards the mentally ill was brought to light. Hansson et al. concluded that health care providers should be examples to others, and therefore, attitudes towards people with mental illness need to be addressed. Hansson et al. brought up concerns that if a health care professional has a particular bias against a person, then it does not seem possible that they are able to provide the same standard of care to that person. Kapungwe, et al. [60] conducted a quantitative research study to explore and document the attitudes and beliefs of health care providers towards patients with mental illness. The researchers were able to collect data from 111 respondents in a pilot tested structured questionnaire format. The results were astounding as they revealed the widespread stigmatizing and discriminatory attitudes of licensed health care professionals toward those patients who have been diagnosed with a mental illness. The researchers of Kapungwe, et al. acknowledged the limitation of the study as it was carried out in only two areas of Zambia, yet recognized the universal negative attitudes found in other international studies on the same topic. Going one step further, Kapungwe, et al. suggested that this is not only a problem in Zambia, but one that affects patients and their families around the world. Treatment options for the mentally ill were found to be often punitive and discriminatory, and therefore a far cry from what the global standard should be. Kapungwe, et al. called for international research, advocacy, and policies to be developed globally to stop mental health stigma, so that patient care and outcomes could be improved.

Some researchers focused on the attitudes and beliefs towards people who suffer from one specific mental health disorder. Negative attitudes and beliefs towards patients diagnosed with schizophrenia were identified by Svensson, et al. (2014) [69] in a quantitative cross-sectional research study. This project was conducted outside of the United States, yet evidence for the need to conduct it in several other countries, including the United States, was presented. Reliable research methods were utilized with results showing that stigmas towards mental health disorders negatively impact the care that patients receive. The researchers utilized a tool that had been shown to be reliable with a similar tool used by Linden and Kavanagh [19] to measure stigmas. The final focus of the article by Svensson et al. was that of improving undergraduate nursing educational programs to include sensitivity and compassion training, involving care delivery to those with mental illnesses. Nursing education that includes sensitivity training is consistent with the theoretical foundations for mental health nursing [29].

Similarly, Mesa and Tsakanikos [66] conducted empirical research using a between-subject design and self-administered postal questionnaires to determine attitudes towards patients with intellectual disabilities in acute psychiatric wards in London. The participants were randomly assigned to two different research groups, thus increasing the validity of the study. The small response rate and sample size were obvious limitations of this study. The findings were similar to other international studies, such as Linden and Kavanagh [19] that determined that mental health stigmas exist amongst health care professionals and negatively impact patient care. There was no statistically significant difference between the two groups in the Mesa and Tsakanikos study. The conclusion by Mesa and Tsakanikos was that even those who have a positive regard for mental illness hold to stigmas. The researchers noted no declaration of interest or bias within their study.

Impacts of stigmas on patient care delivery and outcomes. Once the attitudes and beliefs were clearly identified towards mental illness and the patients diagnosed with mental illness, the next theme that emerged was the impact that stigmas have on patient care delivery and outcomes. Simply, this refers to how those who are providing care view the patient, treat the patient, and react to the patient. The empirical study of Chambers et al. [9] focused on the impact of stigma on lung cancer patient outcomes. Although the study focused on a physical condition and not a mental illness, the implication of negative stigmas and patient outcomes was well-established. Chambers et al. found significant data to support that the patients' perspective stigmas being present by those who care for them resulted in the patient having lowered outcomes for their own health. Societal views on lung cancer negatively impacted the view these patients had towards themselves, feeling as if they were a burden and the disease process was their fault [9]. Chambers, et al. [9] went on to report that patients pick up on negative attitudes and beliefs of those who care for them, and these negative attitudes and beliefs are internalized by the patient, leading to shame and guilt that negatively impact the patients drive for a good outcome. Chambers et al continued to report that shame and guilt hamper healing and outcomes while contributing to lower patient satisfaction scores. The impact of ones' emotions on their healing process is true for physical and mental health [29].

Similar studies were conducted by Michaels, et al. [18] where they compared the constructs and concepts which comprise the stigmas of mental illness. Michaels, et al. [18] reported that a cross-cultural study of employers' attitudes demonstrated that employers did not look favorably on people with mental illness; they were less likely to hire someone with a mental illness, and often found reasons to discharge those who worked there and had sought help for a mental illness. Michaels et al. concluded that stigma impedes treatment seeking; it also impedes adherence to treatment plans and medication regimens, and therefore makes it

difficult for the person diagnosed with a mental illness to regain health. Michaels, et al. [18] concluded that although there are many factors which contribute to negative mental health stigmas, the stigmas negatively impact patient care and outcomes. The study was limited by the number of participants and geographical restrictions. The researchers identified the gap in understanding how to effectively debunk public stigmas towards mental illness, as well as improving the attitudes and beliefs of health care professionals towards those with mental illness. Michaels et al. did conclude that stigmas impede healing for those with mental illness, a theme that is recurrent internationally. Brener, Von Hippel, Kippax, and Preacher [70] demonstrated that when health care providers have negative stigmas towards the mentally ill patients, disparities are developed. The aim of the study by Brener et al. was to examine the inter-relationships among variables. The researchers used path analysis to review the statistical information. Conclusions were consistent with predictions and demonstrated strong stigmas amongst health care workers who were assigned to provide care to mental health patients who were also injecting drug users. Brenner et al. acknowledge that the study was limited by its exploratory nature. The researchers noted it was a first step to reducing mental health stigmas. The data itself was cross-sectional and relied on the self-report of health care workers with no objective measure. This limitation was also noted and considered when selecting this article for review. Because there was no declared interest, and no apparent biases, the study was chosen for inclusion as it offered valuable insight into the research question.

Stigmas can create not only problems with patient care delivery and outcomes, but they can also create disparities and discrimination towards the mentally ill. Chen and Chang [16] reported that mental health disparities include lack of access to quality care, lack of quality of treatment delivered, and poor patient outcomes. Poor patient care delivery contributes to decreased patient outcomes and is evidenced by patient satisfaction surveys [10,16]. These disparities are discussed in every layer of health care, including by accrediting agencies, the Department of Health and Human Services, state and local mental health organizations, and even within the treatment teams of mental health facilities [32]. According to Jansen and Venter [55] quality of care improvement for the mentally ill is of interest based on national quality standards. Their study was of interest as it sampled 27 final year nursing students from a school that represented students from the United Kingdom, New Zealand, and Australia. The respondents to the Jansen and Venter [55] study represented each of their countries and the conclusions were representative of the three countries. Jansen and Venter concluded that mental health stigmas exist and impact the nursing path choice of new nurses as well as the care given to mental health patients. The study by Jansen and Venter utilized scales that have been shown to be reliable as it was a similar tool used by Gateshill, et al. [58,62].

Patients with mental health disorders come to health care providers for help to cope and live with their mental illness, and to make an effort to live a normal life [8]. Researchers studied the impact that mental health stigmas have on a patient's physical health as well. After reviewing 138 empirical articles that were quantitative population-based studies of self-reported racism and health, Paradies proposed that because those with mental illness also have physical ailments, disparities reach deeply into the community of medical health providers as well. Paradies reported that the strongest and most consistent findings were with regard to adverse mental health outcomes and health-related behaviors for those patients who had a mental illness, and received care by a health care professional with stigmas towards mental illness. Paradies realized some of the limitations of his study and therefore suggested that future studies were needed to examine the psychometric validity of the stigma and racism instruments along with how to score them objectively. It is necessary to ensure the quality of such studies and Paradies expressed that the quality of the studies is only as good as the reliability of the instruments and scoring techniques.

Nurses are continually seeking best practices that are based on current evidence [29]. Researchers Hansson et al. [58] provided strong evidence which suggested that the negative attitudes and beliefs towards those diagnosed with mental illness negatively impacts treatment, the development of evidence-based practices, and the implementation of evidence-based practices in care for the mentally ill. Hansson et al. [58] aimed to investigate the attitudes of mental health professionals towards people with mental illness and compare them with the attitudes of patients who are seeking mental health help. Hansson et al. conducted a cross-sectional study of 140 staff and 141 patients, who were willing volunteers, had signed disclosures, and proper approvals for the study. Hansson et al. utilized a questionnaire that was proven reliable, that covered the beliefs and devaluation/discrimination towards people with mental illness. The results of the study were that negative attitudes and beliefs towards those with mental illness were prevalent among staff [58]. The patients' attitudes were negative in the same areas that the staff attitudes were negative. The need for recovery-oriented staff and strong therapeutic relationships with the patient was concluded as key to improving the care delivery and outcomes for the mentally ill [58].

Patient satisfaction surveys and the outcomes of those with mental illness are of particular interest to many local, state, and Federal agencies, as reported in the AHRQ [13]. Brissos, Balanza-Martine, Dias, Carita, and Figueira [71] studied the social functioning and subjective quality of life in seventy-six patients diagnosed with schizophrenia, who reside within the community. Brissos et al. found in this ethical, mixed-methods study, that those patients who identify with stigmas have decreased patient outcomes and more return visits to mental health institutions. The

results suggested that the constructs of the study may need to be studied independently of each other in the future [71]. The gaps identified were that this was only done in one geographical location, and no information was provided about the type of schizophrenia that the patient was diagnosed with, the length of time they had been diagnosed, or what their social support system looked like. However, the conclusions of the research by Brissos et al. support the proposed need to reduce stigmas in order to improve patient outcomes.

Improving patient care delivery and outcomes by identifying stigmas. The question as to whether or not addressing the attitudes and beliefs of those who care for the mentally ill towards mental illness and its patients was also studied. The next theme to emerge was that of how patient care delivery and outcomes can be improved for the mentally ill by identifying negative attitudes and beliefs of the health care worker towards their illness and their personhood. Empirical literature and validity of previous studies and surveys demonstrate that identification of mental health stigmas towards patients with mental illness assists in promoting patient care delivery and patient outcomes [16]. According to Chambers, et al. [9] and Thoreson [10], improved patient care delivery translates into improved patient satisfaction scores. The study conducted by Chen and Chang [16] was undertaken in Taiwan, thus limiting the study; however, the instrument used was proven to be reliable, and the data analysis was accurate and based on one-way Analysis of Variance (ANOVA). The results were consistent with other peer-reviewed articles from multiple countries. For example, Heyman [33] reported that health care professionals report having a fear or dislike for caring for those diagnosed with mental illness. Sun, et al. [51] suggest that it is important to re-identify ones' biases towards mental illness and that identification can improve patient outcomes whether or not it demonstrates statistical significance. Corrigan and Rao [35] reported that stigmas inhibit recovery as they chip away at the patient's own self-meaning and hope for the future. The clinical implications of the study by Corrigan and Rao included that stigmas can significantly impact overall health outcomes, and techniques and interventions have been developed to help reduce stigmas, but with limited studies to validate their effectiveness.

It is important for health care providers to continually assess their personal attitudes and beliefs towards those who they care for so they can provide empathetic, compassionate care that positively impacts patients [29]. According to Chu and Galang (2013), when health care providers are unaware of their negative stigmas towards mental health, inadvertent discrimination, distancing of care, lack of patient-client relationship, and poor patient teaching occurs. Chu and Galang conducted a cross- sectional survey study in Toronto at a major university-affiliated urban hospital. Chu and Galang used a reliable instrument for measurement of the therapeutic attitudes of 102 nurses and had obtained written permission to utilize that tool.

The study by Chu and Galang was approved by an ethics. Chu and Galang were able to statistically conclude that negative attitudes towards patients with mental illness or substance abuse issues, can adversely affect the therapeutic nurse/patient relationship, resulting in suboptimal patient care. Concluding that people are unaware or unmotivated by the phenomenon of the impact of stigmas on patient care delivery and outcomes within the mental health field, a change was sought [27]. Chambers, et al. [9] and Thoreson [10] suggest that improving patient care delivery will improve patient satisfaction surveys.

According to Barker [29], mental health has come a very long way since the days of Hildegard Peplau and her work that was published in the 1950s. However, researchers determined that stigmatizing beliefs towards mental illness and its patients can serve as a culprit for discrediting valuable contributions of mental health nurses and other health care professionals who work with the mentally ill populations. The narrative review of current stigma discourse by Arboleda-Florez and Stuart [57] has similar results to the study by Alexander and Link [72] thus contributing to the reliability of both projects. Arboleda-Florez and Stuart aimed to test the link between contact with the mentally ill and stigmas towards the mentally ill. Arboleda-Florez and Stuart collected data from 1507 respondents to a telephone poll on attitudes towards homelessness and homeless people diagnosed with mental illness. The conclusion by Arboleda-Florez and Stuart was that more studies are needed to provide strong evidence for the link between exposure to mental illness and stigmatizing attitudes, along with the potential usefulness of stigma reduction interventions. The study by Arboleda-Florez and Stuart appeared to be void of bias and declared no special interests.

Researchers also addressed the long-term impacts that the stigmas have on the mentally ill patient. Girma et al. [6] conducted a cross-sectional study to determine the long-term impact that stigmas have on the mental health patient. The conclusion of the study by Girma et al. was that non-adherence to psychiatric plans of care, decreased hope, decreased social integration, and a decrease in the quality of life, is consistently noted in mental health patients who believe societal stigmas on mental illness. A lack of compliance creates a self-fulfilling prophecy as the patient seeks mental health treatment while demonstrating resistance to treatment [30]. According to Wynaden et al. [39], the patient demonstrates thoughts and behaviors that are consistent with the stigmas, thus increasing confirmation of those stigmas by the mental health caregivers. The result is care being delivered with stigmas toward the patient and their mental illness [73], which in turn result in decreased patient outcomes [6]. Thornicroft et al. [42] in a mixed- methods study also concluded that stigmas impact patient care delivery. However, the study by Thornicroft et al. did not draw clear parallels between the proposed changes and the direct positive impact that those changes would have.

Not only do the negative stigmas affect patient care and outcome, but they also impact the lifespan of those patients, according to Yap, et al. [12]. The conclusion of the cross-sectional investigation by Yap et al. was that stigmas contribute to adverse physical and mental outcomes of those diagnosed with mental illness; Australians aged 15-25 years were among the over two thousand participants. Limitations of the study include its cross-sectional design that had a potential for social desirability bias in the stigma measure. Although the study by Yap et al. was only conducted in one area of Australia, several references were directly tied to other international researchers, who determined similar conclusions [20,24,73]. The sample provided by Yap, et al. [12] indicated that the respondents had negative attitudes toward mental illness in relation to stereotypes, separatism, and pessimism regarding the possibility of positive outcomes for these patients. Yap et al. concluded that these negative stereotypes need to be addressed to ensure that this vulnerable population is receiving the highest quality of care that fosters positive life- long outcomes. The results of Yap et al. are mirrored by Balahara and Mathur [40] when they concluded that psychiatric nurses are an integral component of the multidisciplinary care team. It is important to identify the attitudes and beliefs of the nurse towards the mentally ill patient, to help ensure the highest quality of care [14,69,74].

It has been established that mental health stigmas negatively impact patient care delivery, mental health outcomes, and physical outcomes [14,69,74]. Negative attitudes and beliefs towards mental illness keep patients from seeking help until they are in crisis, or then they stop seeking help altogether [69]. Wynaden, et al. [39] emphasized that public stigmas towards mental health keep college students from seeking mental health services. His survey of college students was conducted with proper ethics approval and using a reliable tool. With 108 respondents, the sample size did not demonstrate any statistical significance but it does have practical significance. According to Wynaden et al., because college students were afraid of having mental health stigmas attached to them, they refrained from obtaining mental health services even when they thought they needed mental health assistance. Therefore, interventions were not typically sought until after a major psychological crisis [39]. This, according to Crowe [73] and Wynaden et al. decreases patient outcomes as early intervention is the key to mental health concerns. Wynaden et al. continued in their quantitative empirical research to conclude that stigmas not only impact current patients who receive mental health services but prevent many from seeking help. This is consistent with the theoretical foundations of Barker [29].

Tang and Wu [74] in their qualitative study on the quality of life and self- stigmas for those diagnosed with schizophrenia collaborated with previous research studies that have similar implications for healthcare professionals. Tang and Wu studied the impact that stigmas have on the personal life of a person diagnosed

with schizophrenia. The study was very sobering in the graphic descriptions of how those diagnosed with schizophrenia have to not only battle the mental health illness, but also the self-stigmas and societal stigmas associated with the disorder. Those who could not overcome the stigmas, had poor health outcomes and well as diminished mental health outcomes and reported feeling discriminated against by caregivers [74]. Once mental health stigmas are identified in those who provide care for this vulnerable population, the stigmas need to be addressed [71]. Heyman [33] suggested that to reduce mental health stigmas, health care providers need to promote mental health and well-being while challenging the inequalities and discrimination that currently exists. The conclusions remain consistent with other projects across the globe [16,30,72]. Heyman [33] concluded that perceptions of undergraduate nursing students towards mental illness and the people diagnosed with mental illness can be positively impacted while the students are still in an undergraduate program. Heyman also concluded that it is necessary to reduce these stigmas before the students become actual nurses. According to Hyman, stigma reduction will help improve the mental health of the community and reduce the discrimination that those with mental health issues often face in a hospital setting. Danda stresses that one can safely conclude that negative stigmas towards mental illness impede the development of a therapeutic relationship thus reducing patient care delivery and outcomes. Hyman concluded similar results, thus giving credence to the legitimacy and accuracy of these two valuable studies.

Improving patient care delivery and outcomes. The final theme to emerge was that of improving patient care delivery and outcomes for those with mental illness. There are gaps in the literature related to how organizational cultures contribute to the attitudes, behaviors, and perceptions that the impact of a change from negative to positive typing of those with mental health issues would have [4,71,74]. Crowe [73] reported in a cross-sectional methodological study that a therapeutic relationship between the care provider and the patient is critical for the effective care and outcomes for the mentally ill population. Slade and Longden [26] used qualitative methods to study the parallel between stigmatization and status processes. It was determined that stigmas towards mental illness are interpersonal, intrapersonal, and detected at the macro-level process as well. Slade and Longden concluded that mental health stigmas may be a fundamental cause of mental health inequalities. Although the Slade and Longden study was limited by the number of participants, the interview data is consistent with other peer-reviewed articles that studied the adverse impacts of mental health stigmas [67,70]. The results were also consistent with other studies that report a connection between the health care provider/patient relationship and outcomes, for those diagnosed with mental illness [72].

The founding theorists of mental health nursing stressed

the caring attitude compassion, empathetic care, and the nurse/patient therapeutic relationship being crucial to successful care for those with mental illness [29,31]. Heyman [33] agrees that the responsibility for challenging negative mental health stigmas lies with each member of the health care community. According to Heyman, the introduction of a mental health nursing theory can positively impact the negative attitudes of those caring for the mentally ill. Grist and Cavanagh [75] conducted a meta-analysis and a systematic review of computerized cognitive behavioural therapy, and found that the lack of a therapeutic relationship negatively impacted the mental health patients attempting to receive therapy via computer. Peer-reviewed, reliable evidence of the importance of a therapeutic relationship to mental health care delivery and patient outcomes was provided by Grist and Cavanagh. It was acknowledged by Grist and Cavanagh that computerized care is becoming more common. Grist and Cavanagh also determined that the nurse/patient therapeutic relationship was vital to the positive outcomes of those with mental illness, which high-quality computerized care may be lacking. The importance of the nurse/patient relationship is consistent with the theoretical foundations of Barker [29], Peplau [31], and Watson [53].

Barker [29] identified that the therapeutic relationship is critical to outcomes and can be inhibited by computerized care or in-person care by one with negative stigmas towards mental illness. The need for a therapeutic nurse/patient relationship was part of the outcomes of the study by Grist and Cavanagh [75]. One limitation by Grist and Cavanagh was that little advice was provided on how to differentiate the motives of those caring for the mentally ill while having negative attitudes and beliefs towards them. The cross-sectional descriptive design by Grist and Cavanagh posed no other obvious gaps or limitations. A study by Kourkouta and Papathanassiou's [76] emphasized that a therapeutic relationship needs to include positive communication skills, genuinely providing emotional support, conveying understanding and empathy, non-judgemental attitudes towards the expression of thoughts and feelings, and being able to strive to understand and ascribe meaning to behaviours of the person diagnosed with a mental illness. The need for positive communication between the nurse and the patient is consistent with the findings of Keys, et al. [17] and the theoretical foundations of Peplau [31] and Watson [53]. Keys et al. encouraged readers to conduct a similar study in their geographical location and suggested that the results would be closely duplicated. The findings of Kourkouta and Papathanassiou's are consistent with the theoretical teachings of Barker [29] as he teaches that the most vital part of caring for a patient with mental illness is the nurse/patient relationship. The therapeutic relationship between the nurse and the patient was established by theorists [29] and continues as part of current nursing education [43,72]. Grist and Cavanagh [75] emphasized that this therapeutic relationship is often halted by negative attitudes and beliefs on the part of the

health care provider.

Person-centered care is part of the nursing process in the United States (AHRQ) [13]. Doherty and Thompson [43] published a paper on the necessity of a nurse/patient therapeutic relationship in order to develop person-centered care, despite the complexity of the care that is required. Doherty and Thompson reported that this nurse/patient relationship has significant implications for patient experiences and outcomes. Although this study is limited by the small geographical location in which it was conducted, the study is specific to mental health and consistent with the theoretical foundations established by Barker [29], Peplau [31], and Watson [53]. Access to quality mental health services is also part of Healthy People 2020. A quantitative, mixed-methods study by Keys, et al. [17] again demonstrates the perceived discrimination and stigmas contribute to a decrease in mental health outcomes and increase the limitation of access to quality health care [75]. The study by Keys et al. had a unique perspective as it sought to examine the discrimination that occurs towards Haitian migrants who came to the United States, who have mental health disorders. Keys et al. utilized both qualitative and quantitative methods to generate a hypothesis that was found to be statistically significant. The conclusion by Keys et al. was that both qualitative and quantitative methods demonstrated that the stigmas toward those with mental illness limited their access to health care and increased personal levels of humiliation. Both these conclusions, although real, are in direct opposition to the AHRQ [13] and the Healthy People 2020 initiative. Keys et al. encourages international investigations that would further evaluate the associations between migrants and mental health issues, and identify pathways for proper treatment, as well as the reduction of discrimination-related health factor risks.

A plethora of international projects suggested that it is imperative for societies both independently and as part of a global society to work diligently in order to reduce mental health stigmas [2,33,43,72,74]. By decreasing discriminatory and stigma-related factors, those who need mental health treatments would be more likely to seek it early, and those receiving them, would have improved care delivery and better outcomes [14,17,29,74]. Lin et al. [14] studied the discriminatory and mental health stigma-related experiences in relation to the mental health status of rural-to-urban migrants in China. The cross-sectional study by Lin et al. collected data from 1,006 rural-to-urban migrants in Beijing. The mental health scale that was chosen for the Lin et al. study had been proven reliable and is an instrument used in other multiple international studies [5,28,47]. The study of Lin et al. used multivariate analyses to test the impact that mental health stigmas and discrimination that were perceived by the migrants. Lin et al. reported that these migrants, who were diagnosed with mental health problems, faced daily discrimination due to social stigmas to the extent that it forced the respondents to become

migrants, seeking a place where they could find hope, healing, and a positive atmosphere. The study of Grist and Cavanagh [75] and that of Kourkouta and Papathanassiou [76] strongly echo the same conclusion that mental health stigmas negatively impact the care these patients receive as well as their outcomes.

The mixed-methods study of Murray, et al. [77] was conducted as a model and case presentation containing guidelines for how to train, supervise, and sustain a high-quality level of mental health care delivery. This was done by Murray et al. with 100 lay mental health counselors in 12 different countries. The basis of the study from Murray et al. is the problem statement of this DPI project. Murray et al. proposed developing and testing a plausible solution to the negative attitudes and beliefs of health care workers towards mental illness and towards the patient diagnosed with mental illness to improve patient outcomes and thereby create healthier societies [45]. The research team of Murray et al. did not indicate the validity of the proposed intervention tool. There were no grants or funding reported, and no obvious bias was apparent in the Murray et al. study.

Summary

The literature reviewed provided a plethora of information regarding the impact that attitudes and beliefs toward mental illness or those with mental illness have on the care and outcomes for those diagnosed with mental illness. It has been established that mental health theorists have been calling for compassionate and equal treatment for those with mental illness, while more recent theorists even call for the development of a positive nurse/patient relationship as part of the therapeutic healing process for the patient [12,14,29,66]. Researchers have shown that these negative attitudes towards mental illness are global in nature and pose a threat to public health, societal health, and individual health of people [16,17,27,77]. It was also identified that stigmas are populated through a society by media and health care professionals [19,45]. It is important that health care providers be aware of negative attitudes or beliefs that they have towards those they are caring for or the illnesses they have [12,39]. This is consistent with the theoretical foundations of mental health nursing and current health care initiatives from the Federal Government [8,13,29,72].

Mental health was identified as a public health concern, and negative stigmas can impact patients seeking mental health care [1,22]. Seeking mental health care only after a crisis impedes the outcome for that individual and is a common problem, especially in colleges, due to the stigmas that are attached to mental health [14,18,21]. It was also determined that not caring for those with mental illness can be costly to society financially as societal members decrease in mental and physical health, and have limited capacity for gainful employment [3,4,43,45]. Finally, researchers demonstrated that patient care delivery and patient outcomes can be improved by identifying and addressing mental health stigmas

[8,11,14,22,57,78]. These findings give credence to the necessity of this DPI project. Although some limitations and gaps were found throughout the projects, the conclusions were that those with mental health problems are vulnerable, and therefore deserve to be treated with the same level of care, respect, and with the same evidence-based practices of those who only have medical conditions [14,39,44,45]. Other investigators demonstrated the economic impact on society when they disregard those with mental illnesses and how discriminating against them can actually cause them to migrate elsewhere to try to find hope and healing [3,72,77]. Identifying the attitudes and beliefs of the health care workers towards mental illness and caring for patients diagnosed with mental illness is the key in producing a higher standard of patient care and the realistic opportunity for improved outcomes [12,22,24,29,39,66].

The next chapter provides the methodology of the DPI project. This will include (a) the clinical questions, (b) project methodology, (c) project design, (d) population and sample selection, (e) sources of data (including the scale chosen and rationale for choosing that scale), (f) validity, (g) reliability, (h) data collection procedures (i) ethical considerations, and (j) limitations.

Methodology

The purpose of this chapter was to describe how the DPI project will be designed and implemented. This included a restatement of the problem statement from Chapter 1, restating of the clinical question from Chapter 1, and approaches that were used to collect the data to answer the clinical questions. Specific project design was also addressed in this chapter.

The intent of this DPI project was to improve patient care delivery and patient outcomes for those diagnosed with mental illness by investigating the attitudes and beliefs towards mental illness of the health care providers [22,49]. Determining a statistical relationship between the level of mental health stigmas that health care providers have and patient satisfaction scores was important. Empirical literature and validity of previous studies and surveys demonstrate that identification of mental health stigmas towards patients with mental illness assists in promoting patient care, delivery of care, and patient outcomes [18]. Existing evidence has identified the negative impact on patient care and outcomes for those patients who are diagnosed with a mental illness when they are cared for by a health care professional who has negative attitudes or beliefs towards mental illness [3,18,24,36]. The impact that these stigmas have on patient satisfaction scores has also been established in the literature [37,49,59].

Quality improvement in patient outcomes for those with mental illness has been shown to be directly correlated to the attitudes and beliefs of the health care professionals who are caring for them [11]. This DPI project was based on investigating

the attitudes and beliefs of health care professional from a multidisciplinary sample, with no research being conducted on the vulnerable population of the mentally ill. The goal of this project was to increase the quality of patient care delivery and patient outcomes by identifying the attitudes and beliefs towards mental illness of the health care professionals. A full explanation of the methodology for the DPI project will include (a) the clinical questions, (b) project methodology, (c) project design, (d) population and sample selection, (e) sources of data (including the scale chosen and rationale for choosing that scale), (f) validity, (g) reliability, (h) data collection procedures (i) ethical considerations, and (j) limitations.

Statement of the Problem

It is not known if and to what extent patient satisfaction scores are impacted by healthcare professionals who have bias towards mental health while providing care for those with mental illness [16,30,39]. Further literature indicates that the outcomes of patients diagnosed with mental illness decrease when they receive care by someone who has negative attitudes or beliefs towards mental illness [40-42]. The quality of patient care delivery and patient anticipated after-care results are often reflected in patient satisfaction surveys which are completed upon discharge from an inpatient psychiatric unit [10].

Prior studies have identified the negative impact on patient care and outcomes for those patients who are diagnosed with a mental illness when they are cared for by a health care professional who has negative attitudes or beliefs towards mental illness [40-42]. Investigators have shown that these negative attitudes towards mental illness are global in nature and pose a threat to the public health, societal health, and individual health of people [16,17,27,77]. Health care providers should be self-assessing for negative attitudes or beliefs that they have towards those they are caring for [12,27,39]. Self-assessment is consistent with the theoretical foundations of mental health nursing and current health care initiatives from the federal Government and the intentions of this DPI project [8,13,29,72].

Clinical Questions

The identified problem for this DPI project was that the negative attitudes and beliefs of health care professionals towards mental illness can negatively impact patient care delivery and outcomes [1,45]. A lack of quality in patient care delivery and outcome planning is problematic for those diagnosed with mental illness [29,31]. The clinical questions that guided this DPI project are as follows:

- What is the correlation between mental health patient satisfaction scores before and after intervening to reduce bias held by the mental health care providers? The intervention was re-introducing an existing hospital policy on the therapeutic

nurse/patient relationship?

- What is the correlation between the amount of mental health bias held by a healthcare professional before and after reintroducing an existing hospital policy on the therapeutic nurse/patient relationship?

P -Population/Patient problem: Health care providers on an inpatient psychiatric unit who harbor mental health stigmas as evidenced on MICA -4 scores, have low patient satisfaction scores, as evidenced by patient satisfaction scores for 30 days, pre-intervention. Any participant who demonstrated no stigma was still included in this DPI project.

I - Intervention: Mental health stigmas can be reduced by reintroducing a pre-existing hospital policy on the therapeutic nurse/patient relationship.

C - Comparison: Comparison will include patient satisfaction scores pre and post intervention as well as stigma scores pre and post intervention.

O - Outcome: The desired outcome is a reduction in mental health stigmas as evidenced by an improvement in both MICA -4 survey results and patient satisfaction scores.

T - Time: MICA -4 survey scores will improve immediately after the intervention, and this will be evidenced by an improvement in patient satisfaction scores over the next 30 days.

The data collection tool selected for this project was the MICA - 4 [28]. The MICA -4 focused on the attitudes and beliefs of those who provided care for the mentally ill, assessed their attitudes and beliefs towards mental illness and the impact of these attitudes and beliefs on patient care delivery and outcomes [5,28,46]. The MICA -4 is a questionnaire that was completed by mental health care professionals before and after the review of the inpatient psychiatric hospitals' policy on therapeutic nurse/patient relationships, which enforces anti-stigmas rhetoric. Foster [5] and Gabbidon, et al. [28] deemed the MICA -4 to be both valid and reliable. The impact of the MICA -4 on reducing stigmas of mental health care providers as seen by improving patient satisfaction scores was demonstrated by a review of the patient satisfaction scores for 30 days before administration of the MICA -4 and then again 30 days after.

There are multiple interventions offered on-line to assist in reducing mental health stigmas in a given population [28]. For this DPI project, a current policy at the inpatient psychiatric hospital where the DPI project was completed was chosen as the intervention. In 2006, an Interpersonal Relations Between Staff and Patients policy was put into practice (Appendix C). The hospital policy was written specifically for the inpatient psychiatric hospital and was adopted into practice in 2006. The instrument chosen to collect patient satisfaction scores was the inpatient psychiatric hospitals

DHS Consumer Survey (Appendix B). This 32-question survey is administered by the inpatient psychiatric hospital to all patients upon discharge. There is no patient identifying information on the survey and completion of the survey is optional for each patient being discharged. Patient satisfaction surveys are a recognized instrument by which to collect information as to how the patient perceived the care they received [26].

Project Methodology

The project methodology that has been chosen for this DPI project is quantitative in nature and experimental as the subjects will not just be observed, but an intervention will be offered and measured [4]. Quantitative analysis was chosen because it establishes a statistical significance as a sample of the population that is studied.

Qualitative design is inductive in nature and describes an event in its natural setting [47]. Therefore, a qualitative design was not chosen.

Many current empirical investigators have also used a quantitative design. Several who used a quantitative design include Charles (2015) [4], Chen and Chang (2016) [16], Doherty and Thompson (2014) [43], Mesa and Tsakanikos (2014) [66], Stefanovics, et al., (2016) [1], and Thornicroft, Wyllie, Thornicroft and Mehta (2014) [42].

Project Design

The selected design for this DPI project is quantitative methodology. This quantitative basic pretest-posttest designed DPI project established relationships between the independent variable (mental health stigma survey) and the dependent variable (patient satisfaction scores) as an intervention was offered and measured [47]. This investigator was working with a sample of subjects from an inpatient psychiatric unit of a hospital that is located in the Chicago area; the full population of health care providers at that hospital were not studied. It is understood that a high compliance rate was important to avoid bias [47]. Specific instruments that were used was the MICA -4 to determine the level of stigma that the mental health care worker reported (Appendix A). Also, the inpatient psychiatric hospitals copy of the patient satisfaction survey was used (Appendix B). Finally, the inpatient psychiatric unit's policy on the nurse/patient relationship was read as the intervention (Appendix C).

The aim of this investigator was to use quantitative methodology and correlational design to determine the relationship between the independent variable (intervention: nurse/patient relationship policy) and the cause and effect on the dependent variable (MICA-4 and the patient satisfaction surveys) in a population of mental health care providers and patients [43]. Quantifying these relationships was critical and was done with

careful statistical analysis using SPSS software. This software has been proven reliable and valid and used for mental health quantitative projects [47,50].

Population and Sample Selection

The target population for this DPI project was that of licensed and unlicensed health care professionals who have worked with the mentally ill population. According to the American Psychiatric Nurses Association [79], the psychiatric mental health nurse is a core mental health profession and employs a purposeful use of self as its art and a wide range of nursing, psychosocial, and neurobiological theories and literary evidence as its science [29,79]. Specific demographic information for a psychiatric mental health nurse is not available, other than that the individual has graduated from a school of nursing and is licensed in the state they practice in. The psychiatric mental health nurse was the primary licensed health care professional in this DPI project [5]. The demographics and descriptive characteristics of a mental health nurse in this project are registered nurses who have earned a baccalaureate degree or higher in nursing [29].

The unlicensed health care professionals will include mental health technicians, mental health care technicians, and resident doctors [30,43]. The demographics and descriptive characteristics of those who could participate include those who work in a mental health setting and are above 21 years of age. The unlicensed health care professionals have high school diplomas and a baccalaureate degree. Those with associate or baccalaureate degrees had degrees in criminal justice, nursing, medicine, or psychology. Unlicensed health care professionals had to complete extensive hospital-based training in mental health before they were able to work on a mental health unit. Those employees who worked on Unit A or Unit B were selected for the project as the other units had staff not employed by the hospital, but rather by the state.

Participants were contacted by this investigator via encrypted email, inviting them to participate in the DPI project via an in-person group conference. This conference was conducted on December 12, 2016, at 0630-0700 and December 13, 2016, at 1430-1500 to ensure availability of the staff. The conference took place in Conference Room 203 at the inpatient psychiatric hospital. The location and time were confirmed with the inpatient psychiatric hospital. This was a conference room where up to 50 participants could sit comfortably around tables. Before the meeting, the patient satisfaction survey results of the past 30 days were reviewed by this investigator. These scores were obtained by the inpatient psychiatric unit nursing director. The inpatient psychiatric unit had agreed to have these scores available for this investigator to review and to provide statistical analysis of these scores.

A to Z-score table was used to determine an appropriate sample size. With a confidence level of 99% a confidence interval

of 50, and a population of 100 (the total number of licensed and unlicensed health care professionals who are employed at the inpatient psychiatric hospital), the minimum sample size needed was 30. To achieve a confidence level of 99%, with a sample size of 30 out of a population of 100, the confidence interval is 19.8. Confidence intervals are affected by sample size, percentage, and population size [5]. However, the calculated sample size for correlation with acceptable absolute precision is 19 ($\alpha = .05$ and acceptable absolute error is .5).

According to the Z-score table the sample size for the MICA -4 should have been a minimum of 30 participants for pre and post intervention. With a mean of 30 and a standard deviation of 2, according to Cohen's d , the effect size is 10. Participants were provided with a paper copy of the MICA -4, which they were asked to complete after explanation of the DPI project and the volunteer nature of their participation, which included a signed informed consent. Participants were given a number to protect their identity, and this number was written by them on their MICA -4. After completion of the MICA -4, participants were handed a paper copy of the inpatient psychiatric units' recent policy change on therapeutic nurse/patient relationships, which promotes anti-stigma rhetoric, attitudes, and beliefs by health care professionals. Participants were asked to again complete another paper copy of the MICA -4, including their personalized number on the top of the form, after the reading of the hospital policy. Participants were dismissed.

On January 14, 2017, patient satisfaction survey scores (obtained by the inpatient psychiatric unit nursing director) were reviewed by this investigator. The inpatient psychiatric unit had agreed to have these scores available for this investigator to review and to provide statistical analysis of these scores. Statistical analysis of the MICA -4 (pre and post policy reinforcement) was conducted. Patient satisfaction survey results (pre and post-DPI conference meeting) were statistically analyzed. Data analysis and results is recorded in Chapter 4. A summary of the DPI project, power calculations, conclusions, and recommendations is included in Chapter 5.

Instrumentation

A tool that was used in current empirical literature to identify mental health stigmas is the Mental Illness Clinicians Attitude Scale: MICA -4 [5] (Appendix A). The MICA -4 is a 16 item questionnaire that participants mark as strongly agree, agree, somewhat agree, somewhat disagree, disagree, or strongly disagree. The MICA -4 was administered before the re-introduction of a company policy on the therapeutic nurse/patient relationship that supports anti-stigma rhetoric and beliefs. After re-introduction of the pre-existing company policy (Appendix C) on the therapeutic nurse/patient relationship, which focuses on anti-stigma rhetoric and attitudes, the MICA -4 was given to the participants again

to be completed. The MICA -4 does not ask any demographic information from those completing it, other than if they consider themselves to be licensed or unlicensed health care professionals. One completes the MICA -4 questionnaire with paper and pencil.

The hospital had a pre-existing patient satisfaction survey that all patients are given to complete voluntarily, upon discharge from the inpatient psychiatric unit. This questionnaire consisted of 32 questions that the patient marks as strongly agree, agree, neutral, disagree, or strongly disagree (Appendix B). The questions that are asked to the patient include questions regarding if they were treated with respect, if they received the help they were seeking upon admission, and if they were given a discharge plan that they had participated in developing. Patient satisfaction surveys were completed with paper and pencil and contains no demographic information or identifying patient information. The scores from the patient satisfaction surveys were tallied by the director of nursing at the hospital. These scores were examined for the 30 days prior to the intervention of this DPI project and then for 30 days after the intervention to determine if the intervention (and reduction of stigmas) impacted the patient satisfaction scores or not. Once the data was collected, the investigator organized the responses that were received. Data analysis was used to organize the results, to summarize them, and to do an exploratory analysis of the data. This information was communicated in Chapter 4 of the DPI project using tables, graphical displays, and summary statistics. Cause and effect of the variables was addressed.

Validity

Quantitative studies determine the external validity or the extent to which the results of a study can be generalized beyond the sample to a larger population [47]. Internal validity was a concern as consistency and dependency of the measure is needed so that the project can be repeated with similar results in a different setting [47]. The internal consistency of the MICA -4 was $\alpha .79$ and had a split correlation of .73 and a test-retest reliability of .80 [5]. Statistical conclusion validity was demonstrated as the conclusions reached about the relationships in the data were reasonable. Internal validity was demonstrated to the extent where a causal connection between variables can be inferred was accurate and repeated by other investigators [5]. External validity was reached because the generalizability of the results was accurate and repeated by other investigators while construct validity demonstrated as generalizations from the program study measures to the concept of the program study measures (labeling) was accurate [5]. The findings were proven to be believable by the convergence of multiple sources compared with the evidence of respondent evaluations. Evidence was gathered to support the claims of the DPI project, this lending to dependability [47]. Finally, the investigator remained neutral and objective, thus reducing bias and proving confirmability [47].

Reliability

The MICA -4 was found to be reliable by Foster [5]. The MICA -4 had an internal consistency of $\alpha .79$ and has a split correlation of .73 [5]. The internal consistency was evaluated with Cronbach's alpha, where a normal range is between .00 and +1.00. With the MICA -4 having a .79 and a split correlation of .73, it is shown to be highly reliable. The test-retest reliability of the MICA -4 was found by Foster [5] to be .80. Again, according to Cronbach's alpha, this demonstrates high reliability. The investigator of this DPI project demonstrated effort in following the guidelines of a quantitative DPI project to prove reliability [47]. Internal validity was necessary so that the project can be repeated in successive trials with similar results. This was enforced by assuring external validity, as the investigator will show that the results of this DPI project can be applied beyond the sample population [47]. In October of 2016, permission was granted to use the MICA -4 for this project, via personal communication.

Data Collection Procedures

Data collection of the MICA -4 involved answering the second clinical question. Can mental health bias amongst mental health care professionals be reduced as evidenced by improvement in patient satisfaction scores, by re-introducing an existing hospital policy on the therapeutic nurse/patient relationship? This will be measured by comparing patient satisfaction scores pre and post intervention. The data will be collected following strict guidelines to ensure accuracy and validity. Activities that will take place prior to data collection include obtaining informed consent, preparing clean copies of the MICA -4 (Appendix A) preparing clean copies of the current hospital policy on therapeutic nurse/patient relationships (Appendix C), providing writing material that work, and preparing notecards with numbers on them, to assign each participant a number. The informed consent was a standard form that is provided by this doctorate program and the permission to obtain this informed consent is part of the IRB approval (Appendix D).

The meeting room was opened 15 minutes ahead of time, ensuring that informed consents were explained and signed, and answering questions from the staff. Secret numbers were handed to each participant that they wrote on their survey. Quality control occurred throughout the interview by the investigator maintaining confidentiality of the participants, collecting each MICA -4 with it clearly being labeled pre or post, along with the participants' secret number. Clear instructions were given with participants having time to ask clarification of the directions prior to beginning the survey. The participants were given fifteen minutes to answer the questions on the MICA-4 pre survey and everyone completed the survey in 9 minutes. Then a hospital policy on nurse/patient relationship was read as the intervention and the second MICA -4 was given to participants. Participants were instructed to put their

same secret number and the word post on the top of their survey. The time allotted to complete the MICA -4 was fifteen.

All documents were collected as participant's finish and papers placed in a manila envelope. Data was transported by the investigator to a locked vehicle and driven to a private office where they will be stored securely in a locked cabinet. The investigator transferred the data into a computer that was encrypted, and statistical software was used to analyze that data. Informed consents are kept in a locked cabinet for a period of two years. This all served to preserve data integrity. Only this investigator had a key for access to the locked cabinet. The same quality controls were used when handling the patient satisfaction scores (Appendix B), with only the scores being recorded by the investigator and the original forms remained at the hospital in their locked storage. Patient personal identifying information was not available and therefore not collected. The results of the surveys remained private with the investigator and only the necessary portions of the surveys were translated into statistical data for the DPI project.

The master list linking participant names to the participant numbers was maintained by this investigator and secured in locked a cabinet, in a locked office, and on a password-protected computer that can only be accessed by this investigator. Data entered into the project dataset only identified a participant via the study ID code. All communications among DPI project personnel relative to individual DPI project participants was conducted via the pre-identified study ID. The DPI project database met GCU requirements for data security and confidentiality, including the use of anti-virus software and protection against unauthorized access.

- Staff working on Unit A and Unit B were invited to participate. Staff working on other units were employed by the State of Illinois and not the mental health hospital, therefore, they were not asked to participate. The participants were contacted by this investigator via encrypted email, inviting them to participate in the DPI project via an in-person group conference.
- This conference was conducted on December 12, 2016 at 0630-0700 and December 13, 2016 at 1430-1500. The date was flexible, per the inpatient psychiatric facility, and could be adjusted based on the date the IRB approval is granted from Grand Canyon University.
- The conference took place in Conference Room 203 at the inpatient psychiatric hospital. The location and time was confirmed with the inpatient psychiatric hospital. Up to 50 participants can sit comfortably around tables in the conference room.
- Prior to the meeting, the patient satisfaction survey results for the past 30 days were reviewed by this investigator. These scores are obtained by the inpatient psychiatric unit nursing

director. The inpatient psychiatric unit has agreed to have these scores available for this investigator to review and to provide statistical analysis of these scores.

- Participants were provided with a paper copy of the MICA -4 which they were asked to complete after explanation of the DPI project and the volunteer nature of their participation, which included a signed informed consent.
- Participants were given a number to protect their identity and this number was placed on their MICA -4.
- After completion of the MICA -4, participants were handed a paper copy of the inpatient psychiatric unit recent policy change on therapeutic nurse/patient relationships, which promotes anti-stigma rhetoric, attitudes, and beliefs by health care professionals.
- After reading this policy, participants were asked to again complete another paper copy of the MICA -4, including their personalized number on the top of the form.
- Participants were dismissed.
- Statistical analysis of the MICA -4 (pre and post policy reinforcement) was conducted.
- Data analysis and results are recorded in Chapter 4.
- A summary of the DPI project, conclusions, and recommendations is included in Chapter 4.

Data Analysis Procedures

The data was collected using the following steps, beginning with obtaining the data. Addressed first is the data analysis procedures for the mental healthcare professionals. This quantitative pretest-posttest design DPI project established relationships between the independent variable (mental health stigma survey) and the dependent variable (patient satisfaction scores) as an intervention was offered and measured [47]. This information sought to answer the first clinical question: What is the correlation between mental health patient satisfaction scores before and after intervening to reduce bias held by the mental health care providers? The intervention was re-introducing an existing hospital policy on the therapeutic nurse/patient relationship.

The data from the MICA -4 that was to be analyzed was the pre and post intervention level of stigmas on the part of the healthcare professional. The quantitative method established statistical findings from a representative sample of the population studied and established relationships between the independent variable (mental health stigma survey) and the dependent variable (patient satisfaction scores) as an intervention was offered and measured [47]. Data from the patient satisfaction surveys that was to be analyzed were the ordinal numbers that indicated their level of satisfaction with the care they received while on the inpatient

psychiatric unit. When data analysis began, the manila envelope was opened and data sat into groups of completed MICA -4 pre-intervention, completed MICA -4 post-intervention, and informed consents. Informed consents were placed back into the envelope, sealed, and stored in a locked cabinet in the investigators office. Both sets of the MICA -4 were organized in numerical order, according to the secret number placed on the top of the form by the participant. Ordinal measurement was used to analyze the data from the MICA -4 [5]. Data tabulation (frequency distributions and percent distributions) procedure was used to determine the narrative that the data is telling. A frequency distribution was used to organize tabulation. This assisted in determining if the scores are entered correctly, if the scores are high or low, how many were in each category, and the spread of the scores [5].

With statistical analysis, the investigator was looking to see if there is any significance in the results. Pearson correlation was used to find a correlation between continuous variables. The value should like between 0.00 (-1 to +1) and 1.00 (perfect correlation). The alpha level (ρ level) was set at 0.05. The groups completing the pre- intervention and post-intervention MICA -4 were related as they are the same group but completing pre-intervention and post-intervention questionnaires. Data analysis for the first clinical question followed strict statistical procedures and utilized SPSS software [48]. Data collected from those who were being discharged from the inpatient mental health unit was completed as follows. Patients were not interviewed by this author nor was any patient identifying information provided to this author. This data was collected to answer the second clinical question: What is the correlation between the amount of mental health bias held by a healthcare professional before and after re-introducing an existing hospital policy on the therapeutic nurse/patient relationship? This will be measured by comparing patient satisfaction scores pre and post intervention.

- The patient satisfaction survey was administered and collected by the registered nurse on duty when a patient was discharged from the in-patient mental health hospital. These surveys were written in English and completed with a pencil while the patient sat in a common group area.
- Completed surveys were stored in a sealed manila envelope in the nursing station and transported to the director of nursing's office during the day shift.
- These surveys were then tabulated by the hospital statistician and the results were provided to this investigator. The results were stored in a sealed manila envelope in the director of nursing's office.
- On January 14, 2017, patient satisfaction survey scores (obtained by the inpatient psychiatric unit nursing director) were reviewed by this investigator. The inpatient psychiatric

unit agreed to have these scores available for this investigator to review and to provide statistical analysis of these scores.

- This investigator was handed the sealed envelope. It was stored in a locked car during transport to the office of the investigator. Then the results were opened and scanned into an electronic file on an encrypted computer. The original paper sheet was shredded. The file remains in a password protected file on an encrypted computer for the duration of time required by Grand Canyon University.
- Statistical analysis of the patient satisfaction survey results (pre and post intervention) was conducted.
- Data analysis and results are recorded in Chapter 4.
- A summary of the DPI project, conclusions, and recommendations is included in Chapter 4.

Data from the patient satisfaction surveys that was to be analyzed were the ordinal numbers that indicated their level of satisfaction with the care they received while on the inpatient psychiatric unit. The quantitative method established statistical findings from a representative sample of the population studied and established relationships between the independent variable (mental health stigma survey) and the dependent variable (patient satisfaction scores) as an intervention was offered and measured [47]. Ordinal measurement was used to analyze the data from both the patient satisfaction surveys [5]. A frequency distribution was used to organize tabulation. This assisted in determining if the scores are entered correctly, if the scores are high or low, how many were in each category, and the spread of the scores [5]. The aim of the data analysis was to generate a sample that allows understanding of the DPI study questions [80]. The alpha level (ρ level) was set at 0.05. Pearson correlation was used to find a correlation between two continuous variables. The value should be between 0.00 (-1 to +1) and 1.00 (perfect correlation). Therefore, the level for statistical significance was appropriate. Data analysis followed strict statistical procedures and utilize SPSS software [48].

Ethical Considerations

Confidentiality was protected by the investigator avoiding any inconsequential information from one participant to another. No identifying information was gathered other than if the participant identifies as a licensed or unlicensed health care professional. Consent forms were electronically stored on an encrypted, password-protected server, with nothing connecting the consent form to the respondents' responses to the questionnaire.

This investigator underwent ethics training from the U.S. National Institutes of Health and all aspects of ethics and confidentiality was upheld. Only this investigator identified the responses of the individual subjects. Identifying information was

not essential to the DPI project protocol and was not collected. Data analysis followed strict statistical procedures and utilized SPSS software [48]. There was reduced harm to humans because no vulnerable population were studied, nor did they participate in the survey [47]. There were no anticipated risks to the participants and no benefits other than contributing to a project that seeks to improve care for those with mental illness. No ethical conflicts arose. No questions were asked by the participants. Each participant completed both the pre and post MICA -4 and listened to the reading of the hospital policy on the nurse/patient relationship, which served as the intervention. Although there may have been a conflict between the investigators' role as a board-certified psychiatric nurse and also as the person who gathered the data, appropriateness of the literary design, the methodological design, and the behaviors in reporting has been evaluated and was found not to be an ethical consideration. MICA -4 pre and post intervention form data was transferred to an Excel spreadsheet and the actual forms were stored in manila envelopes in a locked cabinet in the investigators office for the duration of time required by Grand Canyon University. The Excel spreadsheet was stored on the investigators computer, in a password protected file. This was the only information that was shared with the statistician and only included their participant number and response to each question. Data analysis for the second clinical question followed strict statistical procedures and utilized SPSS software [48].

Limitations

All studies have limitations [47]. The literature review section (Chapter 2) provides the reader with great insight as to the limitations of the literature review. This section will provide the reader with limitations of this DPI project. The first limitation of this study was that of self-reporting. Limitations Self-reporting refers to data being obtained about the individual from the individual's own perspective [47]. Self-reporting has the limitation of self-deception enhancement (the individual unconsciously has a distorted perception of how they answer the questions) and faking "better" or "worse" in regards to answering the questions [5]. The limit of this project being conducted in one geographical location is the second limitation of the project. Limiting the DPI project to one hospital, in one geographical location was necessary for this DPI project. However, it did pose a limitation as the results contained information that is limited to one location. The perception of the investigator could have posed another limitation, as the investigator was a board-certified psychiatric nurse. Therefore, the perception of the investigator was different than those who are not board certified in psychiatric nursing. Many have studied how the affective influences on processing interact with results and the investigator aimed to remain flat in affect to not sway participant responses by displaying positive or negative affect and emotion [81].

The fourth limitation was that of patients' satisfaction surveys being included in the January statistics whose staff did not participate in the December meeting. This was a completely unforeseen circumstance that resulted from unaware staff collecting all of the surveys and storing them together without separating them by unit as they had done in the past. Patient satisfaction scores from Unit A, Unit B, Unit C, and Unit D were all put together without any way of separating out the ones from Unit A and Unit B, which were the only units whose staff participated in this project. Fifthly was the limitation of generalizability. Generalizability refers to findings from this project being generalizable to other similar psychiatric inpatient hospitals. Two broad inferences were able to be drawn. First, mental healthcare professionals often are unaware of their attitudes and beliefs towards mental illness. A second broad inference that could be drawn is that patient satisfaction scores reflect how the patient perceives they were treated while in the hospital. These two inferences are based on the findings of this project and are supported by current empirical literature.

The existing limitations were unavoidable due to the purpose of the DPI project and the problem statement that was being studied. The limitations were well noted and taken into account when interpreting the findings. There was no evidence to support that any of the limitations negatively impacted the results of the DPI project [28,47,54]. On the contrary, it was hypothesized that the results of the DPI project, although impacted by limitations, encouraged others to conduct similar studies in their geographical locations. This same encouragement was indicated in similar studies conducted across the globe, by DeHert, et al. [32], Evans-Lacko, et al. [52], Arboleda-Florez, et al. [57], Kapungwe, et al. [60], and Rusch, et al. [21].

Summary

It is important to define methodology for all projects. This DPI project sought to provide the highest possible standards for both [47]. Five limitations were observed as explained above: self-reporting, a single geographical location, the perception of the investigator, patient satisfaction scores being included from patients whose staff did not participate in the project, and generalizability. The limitations were not found to produce negative impacts on this project, rather they were expected to encourage other investigators to conduct similar studies within their hospital or geographical location to help improve patient care delivery and outcomes for those diagnosed with mental illness [8,72].

Ethical considerations must be observed in qualitative and quantitative research [82]. Part of that included data collection and data analysis procedures. The standard collection of data was utilized including informed consent, data storage tools, and data destruction methodology [82]. Data analysis followed strict statistical procedures and utilized SPSS software [48]. Overall, this

was an exciting project with the goal of helping those diagnosed with mental illness achieve high patient outcomes and receive quality patient care delivery, by assessing the attitudes and beliefs of those who care for them. Although this DPI project was limited to the Midwest, it had the potential of exciting readers and encouraging them to conduct similar studies within their hospitals and geographical locations [21,32,52,58,60]. This DPI project had every intention of being published so as to address concepts of Healthy People 2020 and other federal and local initiative to reduce disparities to this precious, yet vulnerable population of those with mental illness [14,18,21]. In Chapter 4, reports on the data analysis and the results. This will be followed by descriptive data, data analysis procedures, results and a summary. Chapter 5 will include a summary of the entire DPI project. The reader can expect to also read a summary of the finding and conclusion, followed by theoretical, practical and future implications.

Recommendations for future projects and for current practice will conclude Chapter 5.

Data Analysis and Results

The purpose of this chapter was to review the problem statement, methodology, and clinical questions used in this DPI project. Chapter 4 will then provide a narrative summary of the population of the participants in the project. Data analysis procedures will be described, and data will be organized by patterns. The results were presented in a non-evaluative, unbiased organized manner. Finally, a summary of the project was provided. Current literature has identified the negative impact on patient care and outcomes, for those patients who are diagnosed with a mental illness when they are cared for by a health care professional who has negative attitudes or beliefs towards mental illness [40-42]. Investigators have shown that these negative attitudes towards mental illness are global in nature and pose a threat to public health, societal health, and individual health of people [16,17,27,77]. Health care providers should be self-assessing for negative attitudes or beliefs that they have towards those they are caring for [12,27,39]. This is consistent with the theoretical foundations of mental health nursing and current health care initiatives from the Federal Government and the intentions of this DPI project [8,13,29,72]. Finally, these stigmas impact patient satisfaction scores [16,42].

The identified problem for this DPI project was that the negative attitudes and beliefs of health care professionals towards mental illness negatively impacts patient care delivery and outcomes [1,45], and are evidenced by patient satisfaction scores. A lack of quality in patient care delivery and outcome planning is problematic for those diagnosed with mental illness [29,31]. The clinical questions that guided this DPI project were:

- What is the correlation between mental health patient satisfaction scores before and after intervening to reduce bias

held by the mental health care providers? The intervention was re-introducing an existing hospital policy on the therapeutic nurse/patient relationship?

- What is the correlation between the amount of mental health bias held by a healthcare professional before and after re-introducing an existing hospital policy on the therapeutic nurse/patient relationship?

The intent of this DPI project was two-fold, based off the clinical questions that guided this project. Therefore, the intent of this DPI project was (a) to improve patient care delivery, and (b) to improve patient outcomes for those diagnosed with mental illness by investigating the attitudes and beliefs towards mental illness of the health care providers [49,22]. Mental health providers were given the MICA -4 to measure their bias rates towards mental illness. A hospital policy on the nurse/patient relationship was read as an intervention. Following the reading of the policy, mental health providers were then given the MICA -4 again to assess their level of stigmas towards mental illness. The project methodology was quantitative in nature and experimental as the subjects were not just observed, but an intervention was offered and measured [4].

Descriptive Data

Licensed and unlicensed health care professionals from the inpatient psychiatric hospital on the two civil units were invited to participate in the DPI study via the informed consent (Appendix D). Out of the 40 who were invited, 30 participated out of which 20 were women and 10 were men. Fifteen of the participants reported to be unlicensed, which included behavioral health counselors, medical students, and support staff. The other 15 participants were reported to have either an RN license or a doctorate degree in psychiatry (Ph.D.). The age of the individuals was not asked, however, due to state hiring laws and regulations for the facility, all subjects were over the age of 21. The oldest was a psychiatrist who had been practicing for over 35 years. The others were a mix of individuals who appeared to be in their late-twenties to mid-fifties. Information was provided by the participants as to the number of years they have worked with patients who are mentally ill (Table 1).

	Under 5 Years in Mental Health	5-10 Years in Mental Health	20 Years or More in Mental Health
Unlicensed Healthcare Professionals	8	5	2
Licensed Healthcare Professionals	3	9	3

Table 1: Years' Experience in Mental Health.

The inpatient psychiatric hospital where this DPI project took place, had four distinct units. Between December 2016 and January 2017, the nature of these units changed. There are now two units for patients who are incarcerated and two units for patients who are free citizens. The staff for these units changed as well, with some of the staff being state hospital employees and other staff being from the Department of Corrections. This DPI project did not include any of the staff from the Department of Corrections, as although they are on the physical grounds of the inpatient psychiatric hospital, they are not employed by the psychiatric hospital. Therefore, these staff were not included in the intervention.

More specifically, this DPI project was completed at an inpatient psychiatric facility located in the Chicago area, which was owned by the State of Illinois. The psychiatric hospital had four units which comprise 112 beds. Two of the units were forensic in nature, meaning that they provide psychiatric treatment for those individuals who are criminally insane and for those individuals who are awaiting psychiatric clearance in order to stand trial [83]. The psychiatric facility was run by state employees who are typically limited to a five-year assignment to the psychiatric facility. Although as of January 2017, some of the employees are from the Department of Corrections and were not included in this DPI project.

Setting: The setting for this project was a psychiatric hospital outside of Chicago that was built in 1852. First, the completion of the MCIA -4 (Appendix A) was done in a conference room at the facility by mental healthcare workers. The setting also involved the patients completing the patient satisfaction survey (Appendix B). This survey was provided by hospital staff to each patient during the discharge process from the inpatient psychiatric unit. The patients were given the survey along with a short pencil and asked to complete the survey at a table in the commons area of the unit. The commons area is in the center of the milieu and is where most interaction with staff and peers occurs.

When a patient is discharged, they are instructed by the staff to complete a patient satisfaction survey and then place it in an envelope which is then sealed. These sealed envelopes were stored in a locked box in the nursing station and collected weekly by the director of nursing. These surveys did not contain any patient identifying information. After collection, it was impossible to even know what unit the patients were on who completed the surveys. The director of nursing holds the surveys in a locked office, in a filing cabinet which is also locked. Although the administration has a key to the office of the director of nursing, only the director of nursing has a key to the locked cabinet where the patient satisfaction surveys are stored.

The patient satisfaction surveys were reviewed in December 2016, to determine the scores prior to the intervention, and then

again 30 days after the intervention. These scores were reviewed by the director of nursing in an office. The scores were tallied by the hospital staff with those final tallies being supplied to this investigator, along with a blank copy of the patient satisfaction survey. The patient satisfaction survey collection process did not positively change between December 2016 and January 2017, yet the population of the hospital drastically changed with the introduction of criminals from the Department of Justice onto two of the psychiatric units. Surveys of those patients from the Department of Justice were inadvertently combined with the surveys of the patients from the two civil units; the units on which staff participated in the DPI project.

Therefore, the results of the patient satisfaction surveys include responses from patients whose treatment team did not participate in the DPI project (Table 2).

Unit Census	Dec-16	Jan-17
Unit 1 (Staff Participated in DPI Project)	28	26
Unit 2 (Staff Participated in DPI Project)	28	26
Unit 3 (Staff Did Not Participate in DPI Project)	28	30
Unit 4 (Staff Did Not Participate in DPI Project)	28	30

Table 2: Unit Census.

The patient satisfaction scores were reviewed and returned to the director of nursing for storage as per hospital policy. No patient identifying information was provided nor seen by this investigator. The diagnosis of the patients completing the surveys was not collected. The director of nursing reported that that on January 1, 2017 65% of the population was admitted for psychosis, 25% for depression, and 10% for anxiety. The population in December was different from other months in that 75% of the patients had been hospitalized for a minimum of 60 days prior to discharge, and they were discharged within a few days of each other in early January.

The patient satisfaction scores were completed by individuals who made up a group of residents who had all received treatment at the same time, for similar illnesses, and were discharged within a similar time period. This may impact the patient satisfaction scores due to very few patients having been admitted after the intervention. Those patients who were admitted prior to the DPI project questionnaire and intervention for staff may have already experienced some forms of stigma and may have reported that on their patient satisfaction surveys (Table 3). Another factor that was discussed earlier as a limitation is that patient satisfaction scores from units where the staff did not participate in this project were included. This was discussed with the director of nursing and although a limitation, the scores did not vary more than 1% than

in previous months where scores were tallied per unit and then as a whole. Therefore, the combining of scores from all the units despite who participated in this project is seen as a limitation but not a detriment to the results of this project.

	Dec-16	Jan-17
Admissions or Patients from Previous Month	105	75
Discharges	70	100

Table 3: Hospital Admissions and Discharges.

Data Analysis Procedures

Quantitative data analysis was done to help the investigator and reader to move from the data that was collected into a form of explanation, understanding, and interpretation. Conclusions will also be suggested. Data analysis also gives one a perspective on this DPI project as well as an exploration of the relationship between the variables. The aim of the data analysis was to generate a sample that allows understanding of the DPI study questions [80]. The alpha level (p level) was set at 0.05. Pearson correlation was used to find a correlation between two continuous variables. The value should like between 0.00 (-1 to +1) and 1.00 (perfect correlation). The groups completing the pre-intervention and post-intervention MICA -4 are related as they are the same group but completing pre-intervention and post-intervention questionnaires. Data analysis will follow strict statistical procedures and utilize SPSS software [48]. With statistical analysis, the investigator was looking to see if there were significance in the results. Therefore, the alpha level (p level) was set at 0.05. A T-test was utilized as variables are discrete. In the first MICA -4 the mean as 3.8, and in the second MICA -4 the means was 2.5667. Mean a -Mean b was 1.233 with a t value of +3.6 and a p one-tailed value of 0.00033. The difference between the variances of the two samples had a P score of 0.015866. The confidence interval was observed at 1.2333 (assuming equal sample variances and also when assuming unequal sample variances).

The groups completing the pre-intervention and post-intervention MICA -4 were related as they were the same group but

completing pre-intervention and post- intervention questionnaires. Data analysis followed strict statistical procedures. The MICA -4 was found to be reliable by Foster [5]. The internal consistency of the MICA -4 is α .79 and has a split correlation of .73 [5]. The internal consistency was evaluated with Cronbach's alpha, where a normal range is between .00 and +1.00. With the MICA -4 having a .79 and a split correlation of .73, it is shown to be highly reliable. The test-retest reliability of the MICA -4 was found by Foster [5] to be .80. Again, according to Cronbach's alpha, this demonstrates high reliability. The investigator of this DPI project demonstrated effort in following the guidelines of a quantitative DPI project to prove reliability [47]. Credibility, transferability, validity, and trustworthiness are all an instrumental part of the overall reliability of the project [47]. Reliability (internal validity) is necessary so that the project can be repeated in successive trials with similar results. This was enforced by assuring external validity, as the investigator demonstrated that the results of this DPI project can be applied beyond the sample population [47].

The one source of error was the patient satisfaction surveys from all 4 units being included in the results instead of the scores from only the units where staff participated in this project. This collection method by the psychiatric inpatient hospital may have impacted the results of the patient satisfaction surveys. This was the result of a change in methodology that the hospital used to collect and store patient satisfaction data. Their new methodology took place on January 1, 2017 and this change was not shared with the primary investigator until after it occurred as the primary investigator Is not a part of the management at the hospital. There were no other obvious sources of error that impacted the data.

Results

Analysis of stigma rates. (Table 4) shows descriptive statistics of the response to the 16 survey questions reflecting the presence / absence of stigma. Descriptive statistics of minimum, maximum, mean and standard deviation are reported for each question separately for before and after the intervention periods. This data is necessary to answer the second clinical question: What is the correlation between the amount of mental health bias held by a healthcare professional before and after re-introducing an existing hospital policy on the therapeutic nurse/patient relationship?

Period	Question	N	Minimum	Maximum	Mean	Std. Deviation
Before	1.00	30	2.00	5.00	3.27	1.05
	2.00	30	1.00	6.00	3.50	1.63
	3.00	30	2.00	5.00	3.40	1.04
	4.00	30	3.00	6.00	4.13	.78
	5.00	30	1.00	5.00	3.60	1.10
	6.00	30	2.00	6.00	3.70	1.02
	7.00	30	2.00	6.00	4.23	1.14
	8.00	30	3.00	5.00	4.00	.83
	9.00	30	1.00	6.00	4.40	1.48

	10.00	30	2.00	5.00	3.37	.81
	11.00	30	3.00	5.00	4.00	.83
	12.00	30	1.00	5.00	2.77	1.28
	13.00	30	2.00	6.00	4.27	1.08
	14.00	30	1.00	6.00	3.90	1.24
	15.00	30	2.00	6.00	4.53	1.01
	16.00	30	1.00	6.00	3.20	1.56
	1.00	30	1.00	5.00	2.77	.94
	2.00	30	1.00	5.00	3.07	.87
	3.00	30	2.00	6.00	4.17	1.05
	4.00	30	1.00	5.00	2.73	1.01
	5.00	30	1.00	5.00	2.93	1.11
	6.00	30	1.00	6.00	3.03	1.43
	7.00	30	1.00	6.00	2.93	1.46
After	8.00	30	3.00	5.00	3.87	.90
	9.00	30	2.00	6.00	4.63	.89
	10.00	30	2.00	6.00	4.60	.89
	11.00	30	3.00	6.00	5.00	.79
	12.00	30	2.00	6.00	4.47	1.43
	13.00	30	1.00	5.00	2.33	.88
	14.00	30	1.00	4.00	2.70	.95
	15.00	30	1.00	6.00	2.20	1.27
	16.00	30	2.00	6.00	4.43	1.04

Table 4: Descriptive Statistics of Response to Questions.

(Table 5) shows the rate of stigma as measured by the proportion of the respondents reporting stigma before the intervention, after the intervention, and the difference (reduction) in rate of stigma defined as the difference between stigma rate before and after the intervention. The overall rate of stigma across all 16 questions and for both before and after intervention periods is 42.39 %. Across all 16 questions, the rate of stigma before the intervention period was 56.5%. The rate of stigma after the intervention period is 28.3%. This indicates that after the intervention stigma rate is reduced by 28.2% which is nearly a reduction of 50% compared with the rate before the intervention. The result of the McNemar's test indicates that no significant difference in the two proportions must be rejected at .05 level of significance ($\chi^2 (1) = 77.735$, $p = <.001$). With respect to individual questions, the proportion of responses indicating stigma before and after the intervention period

did not show a significant difference for Questions 2, 6, 8, 9 and 16. The other 11 questions had a significant difference. Question 4 reported a statistically significant increase in stigma rate after the intervention as compared to before intervention period (Increase in rate = 66.7%, $p = <.001$, according to a t-Test assuming unequal sample variances). Similarly, question 12 also reported significant increase in stigma rate after the intervention compared to before the intervention period (increase in rate of stigma = 46.7, $p = .001$). Question number 13 reported the highest percentage of reduction in stigma rate after the intervention compared to the before the intervention period (Reduction in stigma rate = 80.0%, $p = <.001$). Among questions reporting statistically significant reductions in stigma rates after the intervention, Question 11 reported the least reduction (Reduction in stigma rate = 30.0%, $p = .006$).

Question		Before	Percent	After	Reduction in stigma		P value
		Frequency		Frequency	Percent		
1.00	No Stigma	19	63.3	24	80.0	--	.252
	Stigma	11	36.7	6	20.0	16.7	
	Total	30	100.0	30	100.0		
2.00	No Stigma	10	33.3	24	80.0	--	.001
	Stigma	20	66.7	6	20.0	46.7	
	Total	30	100.0	30	100.0		

3.00	No Stigma	10	33.3	25	83.3	--	
	Stigma	20	66.7	5	16.7	50.0	<.001
	Total	30	100.0	30	100.0		
4.00	No Stigma	25	83.3	5	16.7	--	
	Stigma	5	16.7	25	83.3	-66.6	<.001
	Total	30	100.0	30	100.0		
5.00	No Stigma	10	33.3	23	76.7	--	
	Stigma	20	66.7	7	23.3	42.4	.002
	Total	30	100.0	30	100.0		
6.00	No Stigma	13	43.3	20	66.7	--	
	Stigma	17	56.7	10	33.3	23.4	.119
	Total	30	100.0	30	100.0		
7.00	No Stigma	6	20.0	21	70.0	--	
	Stigma	24	80.0	9	30.0	50.0	<.001
	Total	30	100.0	30	100.0		
8.00	No Stigma	10	33.3	14	46.7	--	
	Stigma	20	66.7	16	53.3	13.4	.430
	Total	30	100.0	30	100.0		
9.00	No Stigma	24	80.0	26	86.7	--	
	Stigma	6	20.0	4	13.3	6.7	.731
	Total	30	100.0	30	100.0		
10.00	No Stigma	11	36.7	28	93.3	--	
	Stigma	19	63.3	2	6.7	56.6	<.001
	Total	30	100.0	30	100.0		

Table 5: Stigma Rates Before and After Completing the MICA -4, Reading the Hospital Policy on Nurse/Patient Relationships and Completing the MICA -4 Again (Questions 1-10).

Each question was transferred into a figure for further explanation (Figures (1-15)). The blue boxes on the graph signify no stigma and the green boxes on the graph indicate stigma. By comparing each individual question to how much stigma was reported both before and after the intervention one can clearly see the impact or lack thereof that the intervention had. For example, on question number 1 of the MICA -4, 11 respondents reported internal stigma towards those with mental illness, while 19 persons reported to not being aware of any internal stigmas. After the intervention, only six persons reported having internal stigmas with 24 reporting that they had no identifiable stigma against mental health for this question. The initial response indicates that mental health stigmas do exist in healthcare providers who provide care for those with mental illness while the second survey demonstrate that a simple intervention can help to reduce stigmas.

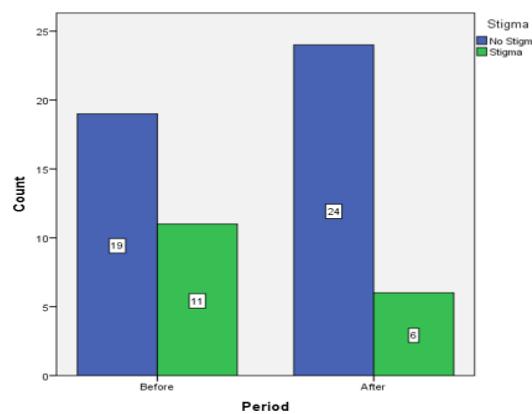


Figure 1: Cluster bar chart for stigma before and after periods for Question 1.

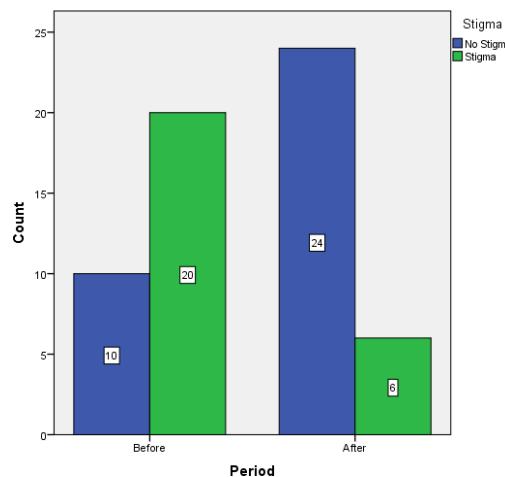


Figure 2: Cluster bar chart for stigma before and after periods for Question 2.

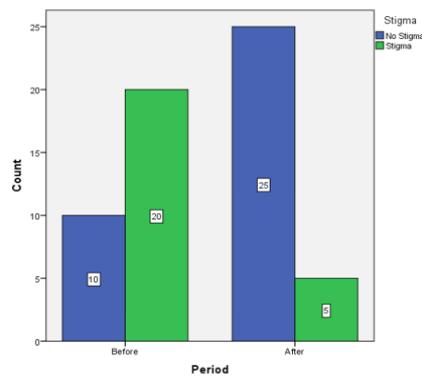


Figure 3: Cluster bar chart for stigma before and after periods for Question 3.

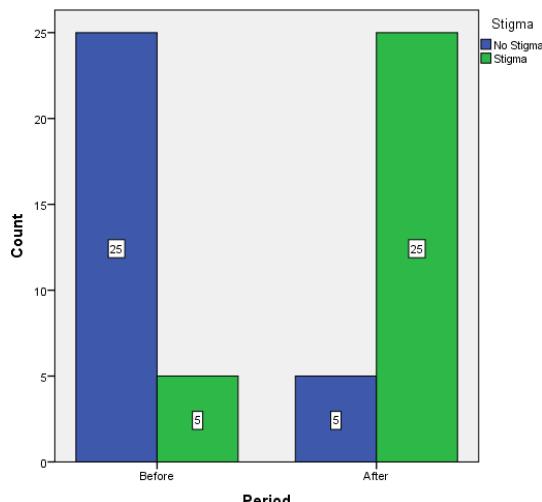


Figure 3: Cluster bar chart for stigma before and after periods for Question 4.

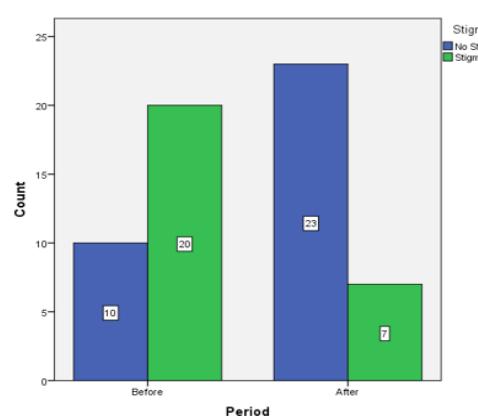


Figure 4: Cluster bar chart for stigma before and after periods for Question 5.

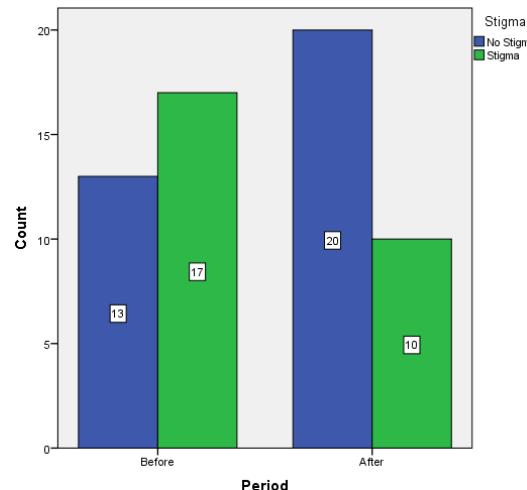


Figure 5: Cluster bar chart for stigma before and after periods for Question 6.

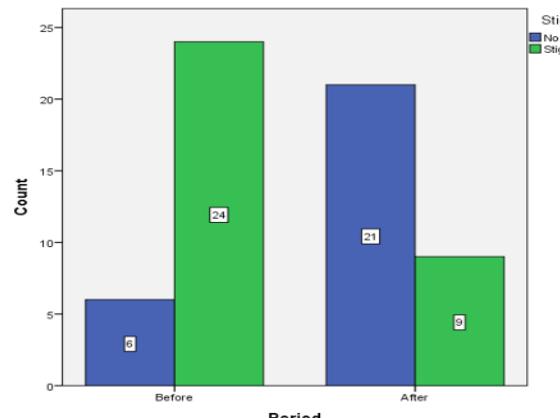


Figure 6: Cluster bar chart for stigma before and after periods for Question 7.

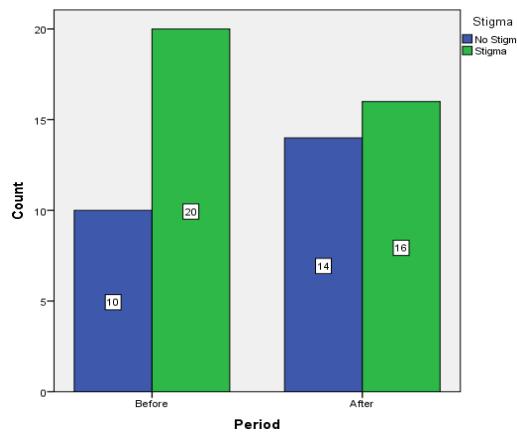


Figure 7: Cluster bar chart for stigma before and after periods for Question 8.

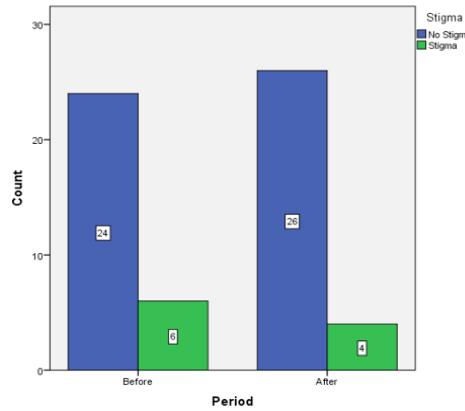


Figure 8: Cluster bar chart for stigma before and after periods for Question 9.

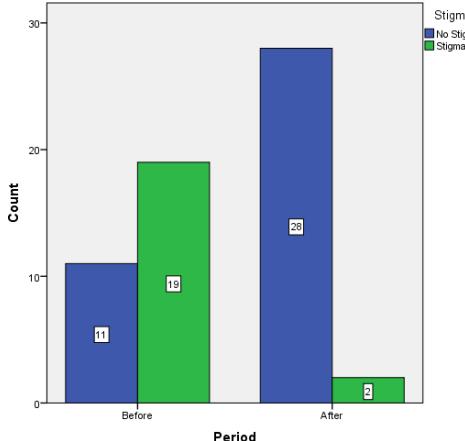


Figure 9: Cluster bar chart for stigma before and after periods for Question 10.

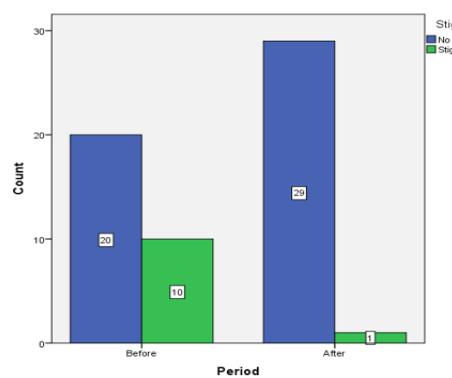


Figure 10: Cluster bar chart for stigma before and after periods for Question 11.

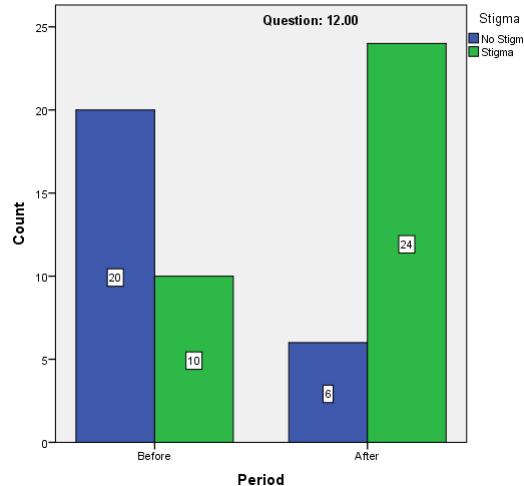


Figure 11: Cluster bar chart for stigma before and after periods for Question 12.

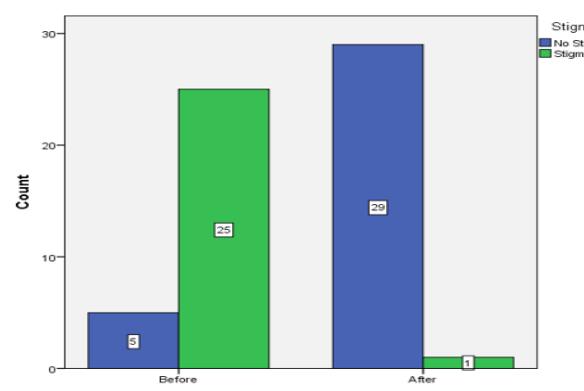


Figure 12: Cluster bar chart for stigma before and after periods for Question 13.

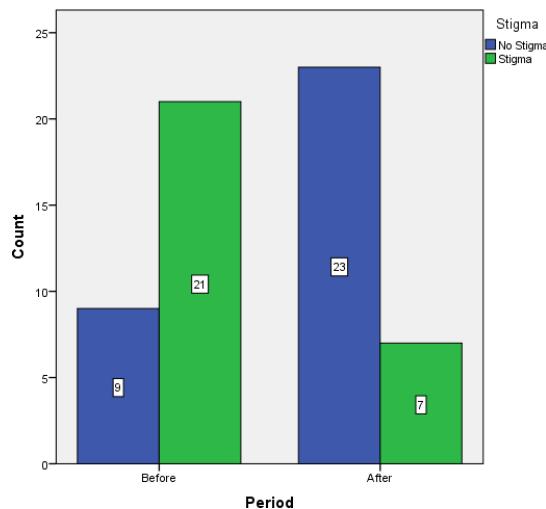


Figure 13: Cluster bar chart for stigma before and after periods for Question 14.

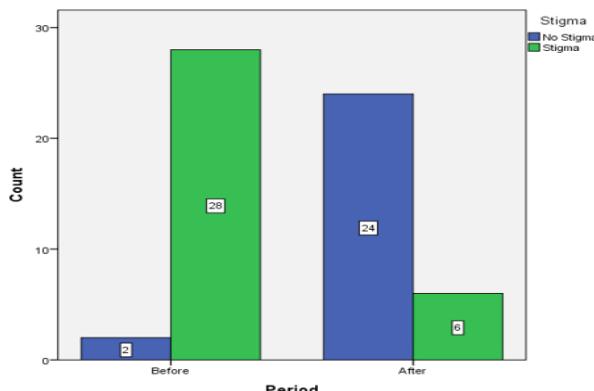


Figure 14: Cluster bar chart for stigma before and after periods for Question 15.

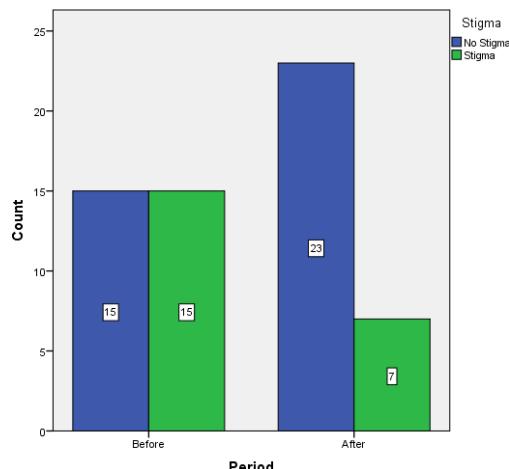


Figure 15: Cluster bar chart for stigma before and after periods for Question 16.

One thing that was not investigated was if acknowledging the stigma is enough for the practitioner to change their behavior or attitude towards the client who is diagnosed with mental illness. Although this investigator is certain that no one who participated intentionally treats those with mental illness with a level of disrespect or disbelief that they can recover, the empirical literature from Chapter 2 does indicate that negative stigmas impact patient care and outcomes [11]. By looking at each individual question the investigator can pinpoint the exact questions that reported a change in the respondents' thinking. In some cases, the respondents reported higher stigmas after the intervention on some of the questions. One of these was question number 4. Prior to the intervention, 25 of the 30 respondents reported no stigma. After the intervention, the stigma level rose from 5 to 25.

Analysis of satisfaction data. Another important component of this DPI project is to determine how or if addressing mental health stigmas amongst the health care providers will translate into improved patient satisfaction scores. This project did not seek to interview the patients, rather mental health care professionals participated in the project. This is in conjunction with the first clinical question: What is the correlation between mental health patient satisfaction scores before and after intervening to reduce bias held by the mental health care providers? Analysis of patient satisfaction data is in direct accordance with current evidence based literature [10,28]. Patients who feel they were treated without respect, for example, may have experienced stigmas from their healthcare professional and those who felt that their care was compassionate and sensitive were thought to have been provided care by those with non-identifiable mental health stigmas.

Satisfaction scores across 32 questions for December and January months are compared (Table 6). Shows descriptive statistics of overall satisfaction score for December and January. (Figure 16) gives the box plot of distribution of mean satisfaction score across 32 questions for December and January. In December, mean overall satisfaction score was $M = 3.8803$ ($SD = .237$). The mean overall satisfaction score for January is $M = 3.8031$ ($SD = .218$). This indicates that there is a small decrease in the overall satisfaction score in January compared to December. Test for the significance of difference in mean satisfaction score is compared using Paired t test. Although one could formulate a statistical hypothesis for the study by using a null hypothesis: $\mu_d \leq 0$, and an alternate hypothesis: $\mu_d > 0$, it is preferred for this DPI study to investigate the results based on the DPI project questions.

11.00	No Stigma	20	66.7	29	96.7	--	
	Stigma	10	33.3	1	3.3	30.0	.006
	Total	30	100.0	30	100.0		
12.00	No Stigma	20	66.7	6	20.0	--	
	Stigma	10	33.3	24	80.0	-46.7	.001
	Total	30	100.0	30	100.0		
13.00	No Stigma	5	16.7	29	96.7	--	
	Stigma	25	83.3	1	3.3	80.0	<.001
	Total	30	100.0	30	100.0		
14.00	No Stigma	9	30.0	23	76.7	--	
	Stigma	21	70.0	7	23.3	46.7	.001
	Total	30	100.0	30	100.0		
15.00	No Stigma	2	6.7	24	80.0	--	
	Stigma	28	93.3	6	20.0	73.3	<.001
	Total	30	100.0	30	100.0		
16.00	No Stigma	15	50.0	23	76.7	--	
	Stigma	15	50.0	7	23.3	26.7	.060
	Total	30	100.0	30	100.0		

Table 6: Stigma Rates Before and After Completing the MICA -4, Reading the Hospital Policy on Nurse/Patient Relationships and Completing the MICA -4 Again (Questions 11-16).

- What is the relationship between mental health patient satisfaction scores before and after intervening to reduce stigmas held by the mental health care providers? The intervention was re-introducing an existing hospital policy on the therapeutic nurse/patient relationship?
- What is the relationship between the amount of mental health stigmas held by a healthcare professional before and after re-introducing an existing hospital policy on the therapeutic nurse/patient relationship?

While investigating question number one, it was determined by this DPI project that no significant improvement was found between the December 2016 and January 2017 patient satisfaction scores. Results of the test indicate that null hypothesis cannot be rejected at .05 level of significance ($p = .999$). This indicates that there is no strong evidence to infer that overall mean satisfaction level has increased in January compared to December. Although other empirical evidence suggests that such a correlation be

possible [28], this DPI project did not detect the same results. It could be suggested that this was partly due to the short length of time in which the study was conducted and that patient satisfaction scores may have included patients from units where no staff participated in the DPI study and intervention. The inpatient psychiatric hospital informed this investigator, in January, that the patient satisfaction scores from all units of the hospital had been included, despite the original plan only including those from units where staff participated in the DPI project. Because the patient satisfaction surveys do not store any patient identifying information on them, it would be impossible for the hospital or anyone else to separate the results. This was not the original plan and most likely happened due to transferring of leadership and data collection policies and procedures. It would therefore be recommended that when similar work is conducted again, that the investigator ensure a more concrete method of having the patient satisfaction scores not mixed, or ensures that representation from every unit has ample opportunity to participate in a project.

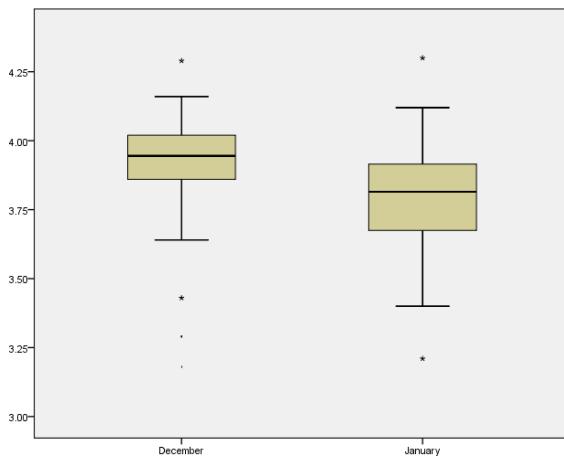


Figure 16: Box plot of distribution of satisfaction scores for December and January.

Summary

This DPI project was conducted as outlined throughout this proposal paper. It was conducted at an inpatient psychiatric hospital in the Chicago area, with only healthcare workers being part of the project. The healthcare workers comprise people from multiple age groups (all over the age of 21) and multiple ethnic backgrounds. Both men and women participated with both licensed and non-licensed healthcare staff participating. Some of the answers may be skewed by the staff as some were nursing students and others were psychiatrists who have worked in the field most of their adult life. Everyone who participated signed a consent form and completed, in full, both of the MICA -4 surveys. The mental health patients were not questioned nor interviewed for this DPI project. The patient satisfaction scores which they complete upon discharge were reviewed by this investigator in December of 2016 and again after the DPI intervention in January of 2017.

The first clinical question was as follows: What is the correlation between mental health patient satisfaction scores before and after intervening to reduce bias held by the mental health care providers? This DPI project did not find statistical significance between the patient satisfaction surveys from December 2016 and January 2017.

The second clinical question was as follows: What is the correlation between the amount of mental health bias held by a healthcare professional before and after re-introducing an existing hospital policy on the therapeutic nurse/patient relationship? The results of the MICA -4 questionnaires demonstrated that the healthcare providers who participated in this DPI project did harbor stigmas towards mental health. The data from this DPI project found that this rate was reduced after the reading of the hospitals policy on the nurse/patient relationship. Although there

was a reduction in the rate of mental health stigmas amongst the healthcare professional pre and post intervention, there was not strong evidence to infer that the mean satisfaction level of the patient satisfaction scores between December 2016 and January 2017. Despite the mixed results, there was clear evidence collected which supported the question as to if mental healthcare professionals have mental health stigmas. This was very important to detect as empirical literature from Chapter 2 demonstrates that these stigmas are detrimental to the care and outcomes for patients diagnosed with mental illness. The implications of the data and data analysis relative to the clinical questions will be discussed in Chapter 5 where the reader can be prepared to read (a) summary of the project, (b) summary of the project findings and conclusions, (c) implications, (d), recommendations for future projects, and (e), recommendations for future practice.

Findings and Conclusion

This DPI project addresses the health disparity that is often encountered by those with mental illness by addressing the attitudes and beliefs of the health care professionals who care for them. This is very important, not only to raise patient satisfaction scores, but also to help reduce stigma, increase mental health, and improve patient outcomes for those with mental illness. This DPI project is worthy of investigation as the United States has existing legislation and initiatives to reduce health care disparities for the mentally ill population [13,64]. Current empirical literature has demonstrated that stigmas towards mental health can negatively impact the quality of care that those with mental illness receive and is reflected in patient satisfaction scores [7,10,14]. This DPI project is congruent with the theoretical foundations of Peplau [31], Watson [53], and Barker [29] as it focuses on the curative factors of the nurse patient relationship and the necessity of listening to the patients' story, without judgment or pretense [29]. This DPI will provide support to the theoretical underpinnings of mental health as established by Barker [29], Peplau [31] and Watson [53]. This published information will encourage the reader to diminish disparities towards the mentally ill population by conducting a similar project in their hospital and geographical location as mental health disparities are fought and the provision of mental health care without stigma is sought [5,28,63]. The DPI project is also consistent with current, empirical literature which supports the need for reduction of stigmas towards those with mental illness in order to improve patient care delivery and outcomes, as often evidenced on patient satisfaction surveys [5,16,27,28,57]. This DPI project will complement the existing literature by adding additional support to what has already been investigated while offering insight into whether an intervention for the healthcare workers reduces stigmas and results in higher patient satisfaction scores [10,59].

Summary of the Project

Current empirical literature has identified the negative impact on patient care and outcomes, for those patients who are diagnosed with a mental illness when they are cared for by a health care professional who has negative attitudes or beliefs towards mental illness [40-42]. Investigators have shown that these negative attitudes towards mental illness are global in nature and pose a threat to public health, societal health, and individual health of people [16,17,27,77]. Health care providers should be self-assessing for negative attitudes or beliefs that they have towards those they are caring for [12,27,39]. This is consistent with the theoretical foundations of mental health nursing and current health care initiatives from the Federal Government and the intentions of this DPI project [8,13,29,72]. The identified problem for this DPI project was that the negative attitudes and beliefs of health care professionals towards mental illness negatively impacts patient care delivery and outcomes [1,45]. A lack of quality in patient care delivery and outcome planning is problematic for those diagnosed with mental illness [29,31]. The clinical questions that guided this DPI project were as follows:

- What is the correlation between mental health patient satisfaction scores before and after intervening to reduce bias held by the mental health care providers? The intervention was re-introducing an existing hospital policy on the therapeutic nurse/patient relationship? This was measured by comparing patient satisfaction scores pre and post intervention.
- What is the correlation between the amount of mental health bias held by a healthcare professional before and after re-introducing an existing hospital policy on the therapeutic nurse/patient relationship? This was measured by comparing the level of stigma pre and post intervention.

A summary of the findings and conclusions of this DPI project will be discussed. This will include theoretical, practical, and future implications as well as recommendations for future projects and practices. The DPI project was conducted by a board certified psychiatric registered nurse in an inpatient psychiatric hospital near Chicago, Illinois. The DPI project was conducted with adherence to the moral and ethical guidelines for conducting projects in conjunction with all requirements from Grand Canyon University. Sound statistical analysis was conducted in order to answer both of the clinical questions presented by this DPI project.

Summary of the Findings and Conclusions

First clinical question. The first clinical question asked what is the correlation between mental health patient satisfaction scores before and after intervening to reduce bias held by the mental health care providers? This was measured by comparing patient satisfaction scores pre and post intervention. This project did not find a statistical significance in the difference between

December 2016 and January 2017 patient satisfaction scores. Researchers Brissos et al. [71] studied the social functioning and subjective quality of life in seventy-six patients diagnosed with schizophrenia, who reside within the community and found that those patients who identify with stigmas have decreased patient outcomes and more return visits to mental health institutions. The conclusions by Brissos et al. supports the proposed need to reduce stigmas in order to improve patient outcomes. After having chosen this as the appropriate route for this paper, it was brought to the attention of the investigator that an odd occurrence had happened in the psychiatric unit. During the month of December, a large number of the population was inpatient for a minimum of 60 days, and the majority of patients were all discharged over the course of just a few days. This had the potential to impact patient satisfaction scores as the patients were inpatient longer than those who completed the scores at different points throughout the year. Also, these patients were admitted and discharged during the DPI project; therefore, there may have been a lack of time to allow the effectiveness of the questionnaire and intervention to permeate the staff and reach the patients. Despite this, the results were calculated using sound statistical analysis. Although this DPI project did not find a statistical significance in patient satisfaction score pre and post intervention, the premise of Brissos et al. is still supported.

Second Clinical Question: The second clinical question asked, what is the correlation between the amount of mental health bias held by a healthcare professional before and after re-introducing an existing hospital policy on the therapeutic nurse/patient relationship? This was measured by comparing the level of stigma pre and post intervention. This DPI project suggested the answer to this second question to be a resounding yes (Table 4). This is encouraging because the tools to combat stigma are something that most hospitals would already have policies on the nurse/patient relationships. When these policies are written with a strong theoretical mental health nursing foundation they support anti-stigma rhetoric and discourage treating patients differently based on their diagnosis. According to Gabbidon et al. [28], stigmas promote negative expectations about the person who exhibits a mental illness, as prejudiced attitudes lead people into discrimination of others. This DPI project completely supports the findings of Gabbidon et al. [28] as demonstrated in the reduction of stigma post intervention. The intervention was the reading of the hospital policy on nurse/patient relationships. A t-Test found the mean for the pre group to be 3.8 and the mean for the post group to be 2.5667. Across all 16 questions of the MICA -4, the rate of stigma before the DPI project intervention period was 56.5%. The rate of stigma after the DPI project intervention period was 28.3%. This indicates that after the intervention the stigma rate was reduced by 28.2% which is nearly a reduction of 50% compared with the rate before the intervention. Because the empirical literature suggests that reducing stigmas impacts patient care and delivery, the

findings of this study are significant to demonstrate that health care providers do have mental health stigmas [21]. The findings of this DPI project not only support the theoretical foundations of Barker [29] but also support the advancement of scientific knowledge by bringing to light stigmas as healthcare professionals are striving to reduce health disparities towards those with mental illness [8,51].

The empirical findings of international qualitative and quantitative research that highlights the negative impact on patient outcomes for those with mental illness when care is delivered by health care providers who harbor stigmas towards mental illness was supported by this DPI project [3,9,27]. Although this DPI project determined a minimal decrease rise in patient satisfaction scores between December 2016 and January 2017, the hospital had undergone a significant change during this time. The hospital had begun to provide care and treatment for those placed on the forensics unit in the hospital by the State for crimes committed. Staff assigned to the patients on the forensic units did not participate in this DPI project. Previous literature has demonstrated a connection between a decrease in stigmas amongst staff and increase in patient satisfaction scores [1,45].

This DPI project concluded that mental health stigmas do exist within the mental health professionals (Table 7). It is also concluded that the stigmas can be reduced by offering staff an intervention, such as reviewing a pre-existing hospital policy on nurse/patient relationships. This DPI project concluded that although there was a minimal decrease in patient satisfaction scores (less than 2% according to a t-Test), reducing mental health stigmas is still important and consistent with Federal guidelines [17,45]. It is proposed that future projects conducted over a longer period of time could produce a statistical significant difference on patient satisfaction scores. Repeating the MICA -4 three months later and reinforcing the anti- stigma stance of the hospital with trainings and posters may also help to improve the patient satisfaction scores. Chapter 1 introduced the reader to the history of mental health stigmas and the negative impact that current empirical literature has indicated as having negative impacts on patient care and outcomes. The literature review in Chapter 3 provided for the reader current empirical literature to support both of the clinical questions presented in this DPI project. The reader was exposed to the mixed results of this DPI project in Chapter 4.

	Mean	Std. Deviation	SE Mean	Difference in Mean	T statistic	P value
December	3.8803	.237	.0419	-0.078	-3.453	.999
January	3.8031	.218	.0387			
	Mean	Std. Deviation	SE Mean	Difference in Mean	T statistic	P value
December	3.8803	.237	.0419	-0.078	-3.453	.999
January	3.8031	.218	.0387			

Note: difference = After - Before

Table 7: Standard Deviation of Satisfaction Scores for December and January.

This DPI project found that although there were no statistical differences between the patient satisfaction scores from December 2016 and January 2017 that there were statistical and practical significance to the amount of stigmas that mental health providers demonstrated towards those with mental illness and the significant rate of reduction of those stigmas post-intervention. The DPI project parameters, as established by Grand Canyon University and this investigator, bound this DPI project to very strict time frames. As discussed earlier in Chapter 5, it is proposed by this investigator that the strict time frame may have contributed to the lack of statistical significance in the patient satisfaction survey results. In conjunction with the findings of empirical investigators discussed in Chapter 3, it is reasonable to expect a statistical significance in the results of the patient satisfaction surveys and it is proposed that the strict time frame may have contributed to the lack of statistical significance.

The first clinical question related to measuring patient satisfaction scores. What is the correlation between mental health

patient satisfaction scores before and after intervening to reduce bias held by the mental health care providers? The intervention was re-introducing an existing hospital policy on the therapeutic nurse/patient relationship? This DPI project based this question on current empirical evidence as presented in Chapter 3 and the theoretical foundations of Peplau [31], Watson [53], and Barker [29]. While investigating question number one, it was determined by this DPI project that no significant improvement was found between the December 2016 and January 2017 patient satisfaction scores. Results of the test indicate that null hypothesis cannot be rejected at .05 level of significance ($p = .999$). This indicates that there is no strong evidence to infer that overall mean satisfaction level has increased in January compared to December. Although other empirical evidence suggests that such a correlation be possible [28], this DPI project did not detect the same results. The second clinical question was as follows: What is the relationship between the amount of mental health bias held by a healthcare professional before and after re- introducing an existing hospital policy on the

therapeutic nurse/patient relationship? This DPI project found that in this project mental health bias were reduced by up to 48% after the reading of the intervention, a pre-existing hospital policy on the nurse/patient relationship.

The theoretical foundations on which this DPI project was built encourage nurses to treat patients with respect and to engage in their personal story without bias or stigma towards their mental illness [29]. As discussed in Chapter 3, despite the theoretical foundations that mental health nursing is built upon, it is appropriate to assume that there is a level of bias and stigmas towards mental illness on the part of the mental healthcare provider. It is also plausible to anticipate this rate to reduce after an intervention. This is in direct correlation to the second clinical question. What is the correlation between the amount of mental health bias held by a healthcare professional before and after reintroducing an existing hospital policy on the therapeutic nurse/patient relationship? Within this DPI project, the overall rate of bias/stigma across all 16 questions was 42.39 %. Across all 16 questions, the rate of bias/stigma before the intervention period was 56.5%. The rate of bias/stigma after the intervention period was 28.3%. This indicates that after the intervention stigma rates were reduced by 28.2% which is nearly a reduction of 50% compared with the rate before the intervention. The result of the McNemar's test indicates that null hypothesis of no significant difference in the two proportions must be rejected at .05 level of significance ($\chi^2(1) = 77.735, p = <.001$). This test was insisted upon by the statistician as it was believed it to be the most appropriate test to demonstrate the marked improvement in bias/stigma rates. More precisely, The McNemar's test result indicates that the reduction in the bias/stigma rate is statistically significant, with a 48.7% reduction in bias/stigma rates pre and post intervention of reading a hospital policy on the nurse/patient relationship.

Implications

Theoretical Implications: The implications of this DPI project are three-fold. First, the study implies on a theoretical basis that the teachings of Peplau [31], Watson [53], and Barker [29] are accurate and consistent with evidenced based care for those with mental illness. Emphasized throughout the project are theoretical pillars for psychiatric nursing. The findings of this DPI project support the foundational work of Peplau [31] as reducing stigmas provides care for the person without prejudice. The findings support the foundational teaching of Watson [53] as health care practitioners are encouraged to provide the highest quality of care to those with mental illness. Finally, the foundational teachings of Barker [29] are emphasized by the findings of the DPI project as the patient is moved to the center of care, and quality care is provided while the patient and their story are respected.

Practical Implications: Practically, the implications of this DPI project are for organizations to first realize that mental health

stigmas do exist amongst healthcare professionals in the form of bias, and the bias/stigmas negatively impact patient care and outcomes. This is supported not only by this DPI project but also by current empirical literature [12,27,39]. Second, health care organizations are reminded of negative bias/stigmas and therefore encouraged to address them amongst their staff. Addressing bias and stigma is consistent with governmental programs such as Healthy People 2020 that aim to reduce health disparities for those with mental illness. Practically, although this DPI project did not find statistically significance in the improvement of patient satisfaction scores once bias/stigmas were reduced, current empirical literature suggests that this is possible and plausible [28]. The data concluded from this DPI project is plausible given the short amount of time in between the patient satisfaction scores that were observed and the fact that many patient satisfaction surveys were included in the results that represented patients who were provided care from healthcare professionals who did not participate in this DPI project intervention [12].

Future Implications: In the future, health care organizations who treat patients with mental illness can address mental health bias/stigmas during the orientation process and throughout an employees' tenure by increasing awareness and by conducting regularly training. Future investigators can use the tools and findings of this project to conduct their own projects and thereby support the mental health community. The clinical implications mirror those of Corrigan and Rao (2012) as they reported that bias or stigmas can significantly impact overall health outcomes; techniques and interventions have been developed to help reduce bias and stigmas, but there are limited studies to validate their effectiveness.

Recommendations for Future Projects

Recommendation 1: A solid investigation often calls for further investigation and projects. This DPI project found that negative bias or stigmas amongst health care professionals towards mental illness and patients with mental illness exist. It also demonstrated that a simple intervention can help to reduce those stigmas. Therefore, the first recommendation is that future projects should include replicating this DPI project in other similar settings to measure if the outcomes are similar.

Recommendation 2: This DPI project opens the door for future studies to be conducted on how reducing stigmas impacts patient care delivery and outcomes. This could include studies that involves interviewing the patients to determine their perception of stigma reduction and quality of care provided. By including the patient in future studies and projects, one can begin to explain the phenomenon of personal stigmas impacting patient outcomes as identified in the empirical literature of Chen and Chang (2016) [16], Rusch (2014) [21], and Thoreson (2012) [10].

Recommendation 3: This investigator would welcome future projects that include identification of bias or stigmas in health care providers who treat those with mental illness in other settings beyond the psychiatric inpatient hospital; this could include emergency rooms, physician offices, and intensive care units. As mental illness reaches through every facet of healthcare, it is imperative that future projects address the issue of providing quality care to those with mental illness in all clinical settings.

Recommendation 4: Fourthly, it is the recommendation of this investigator that future projects similar to this DPI project be conducted in other geographical areas. This DPI project was unique in that it was limited to one psychiatric inpatient hospital in the Chicago area. However, the findings of this DPI project were similar to projects conducted in other countries including, Taiwan, Canada, and some European countries [16,27,52]. The publication of this DPI project will help to alleviate health care disparities towards those with mental illness by decreasing stigmas of the health care providers who care for the mentally ill, while encouraging the readers to conduct similar projects in their geographical location [4,43,56,72]. Areas that need further examination include the impact that an intervention such as reading a hospital policy on the nurse/patient relationship has not only on self-reported stigmas by the healthcare professional but also study how an intervention impacts the manner in which a healthcare professional treats a patient with mental illness. The DPI project also found that although this DPI project did not find any statistical differences in patient satisfaction scores between two months that current empirical evidence suggests that this has been the result in other studies.

Recommendation 5: Therefore, it is the fifth recommendation of this investigator that further projects be conducted to how long it takes for an intervention to result in improved patient care delivery as represented in patient satisfaction surveys. A study on the length of time between intervention and improvement in patient satisfaction surveys would be an excellent next-step. Finally, it is the opinion of this investigator that it is imperative that investigators continue to monitor the existence of mental health stigmas amongst health care professionals and how these stigmas impact patient care and delivery for those diagnosed with a mental illness. As stated in Chapter 1, such projects would positively impact public health and be in alignment with current Federal initiatives, such as Healthy People 2020 [6]. Continued study would benefit scientific knowledge and help to bridge a gap between how patients with mental illness are viewed by their providers and the level of care they receive from them [4].

Recommendations for Future Practice

This investigator determined several recommendations for future practice based off the findings of this DPI project.

Recommendation 1: This investigator would like to see anti-stigma campaigns being delivered to staff in the healthcare setting. This includes staff in the emergency departments who treat patients first, and often when they are at the height of a mental health crisis or emergency. This initial treatment can set the tone for what the patient expects throughout their care as well as determining their length of stay and level of care [63]. Therefore, it is imperative that emergency level care be provided to those with mental illness by health care professionals who do not harbor negative attitudes or beliefs towards mental illness or patients with mental illness [57]. This is also true for health care professionals who work in intensive care units and outpatient treatment centers. Mental health training should become part of the routine training of staff to ensure that this precious population receives the highest quality care, which leads to improved patient outcomes and higher patient satisfaction scores [35,59,66].

Recommendation 2: Secondly, recommendations for future practice include the early identification of negative attitudes and beliefs of health care providers towards patients with mental illness. This is consistent with the findings of this DPI project as well as current empirical literature [30,71]. The identification of negative attitudes and beliefs must be followed up with proper anti-stigma training in order to provide patients with mental illness the highest quality of patient care, patient care delivery, and patient outcomes as patients who also have to battle stigmas have lower patient outcomes [74]. Heyman [33] also supports the need for reduction in mental health stigmas once they are identified in order to provide quality care to those with mental illness [72].

Recommendation 3: The third recommendation for future practice would be to introduce mental health care workers to the theoretical foundations that have been established as the basis for evidenced based quality care, for those with mental illness [29]. It would be reasonable that nursing students be exposed to these foundations during their mental health rotations in an effort to reduce stigmas in health care workers in training, rather than waiting and addressing the concern after being hired [17]. It is important to teach future health care workers that the therapeutic relationship with a patient diagnosed with mental illness is often halted by the negative attitudes and beliefs of the health care providers [75].

Recommendation 4: Future practice should also include a solid basis of the theoretical foundations of those who greatly impact the evidence based care that is expected for those with mental illness. This includes the teachings of Barker [29], Peplau [31] and Watson [53]. All three of these theorists focus on the need for care of the mentally ill to be provided in a patient-centered approach that is free of stigmas and bias, while entering into the patients' story and understanding their projected outcomes through the development of curative, therapeutic interpersonal relationships [43,54,55]. All three theorists support stigma reduction and

provide an understanding of why those who harbor stigmas towards the mentally ill impair patient care delivery and hinder patient care outcomes [29]. These theoretical foundations are just that-foundational. Therefore, these foundations should be well taught in the workplace laying the foundation for the expectations of quality interactions and relationships with those who present with mental illness [33].

Recommendation 5: Future practice should also include allowing staff the opportunity to be introspective regarding their own stigmas and then addressing those negative thoughts and beliefs [16]. The MICA -4 is a tool that this investigator found to be well received and is used internationally for measuring the level of stigma that a person has [5]. This tool allows for one to become aware of their own stigmas in a non-threatening manner and opens the door for anti-stigma training [5]. Introspection by health care workers is also supported by the theoretical foundations of Barker [29], Peplau [31] and Watson [53]. This is also supported by Chu and Galang [27] when they reported that when health care providers are unaware of their own negative stigmas towards mental health, inadvertent discrimination, distancing of care, lack of patient-client relationship, and poor patient teaching occurs.

Recommendation 6: Future practice should include person-centered care for those with mental illness [43]. Doherty and Thompson (2014) [43] published empirical literature on the necessity of a nurse/patient therapeutic relationship in order to develop person-centered care, despite the complexity of the care that is required. Doherty and Thompson reported that this nurse patient relationship has significant implications for patient experiences and outcomes and is often reported via patient satisfaction surveys.

It is imperative that future practices strive to make the mentally ill patient the center of the care they receive. This is in agreement with Healthy People 2020 and the investigative findings of this DPI project, as well as that of current empirical literature [17,45]. The physical and mental health of those diagnosed with mental illness is negatively impacted by these patients receiving

care from providers with stigmas towards mental illness. Because the physical and mental health of citizens impacts public health, it is proposed by this investigator that individual patients, healthcare providers, and the public health of a community will benefit from the results of this DPI project. It is proposed by this investigator that healthcare facilities can begin to implement mental health stigma awareness in order to improve care given to those with mental illnesses. On an educational level, nursing students can also be made aware of mental health stigmas and be challenged to reduce their own level of stigmas prior to beginning their nursing career [67]. This is consistent with current empirical literature and the theoretical foundations on which this DPI project is based [29,67,73]. It was speculated by this author that the primary language of the person completing the MCIA-4 may impact the results of the questionnaire. This is based on the statistical results of this DPI project that found an increase in stigmas post-intervention on a couple of the questions (Chapter 4).

It is speculated that if the MICA -4 were given in the healthcare providers original language that the results may have been different. It was also speculated by this investigator, although not statistically proven, that there was not enough time between the two sets of patient satisfaction surveys to result in a statistical significance. In summary, mental health theorists call for compassion and equal treatment for those with mental illness by patient-centered care that is given without stigma [12,66]. The negative attitudes towards mental illness by health care providers are global in nature and contribute to the public health crisis of mental illness [27]. Therefore, health care providers should be searching their own selves for any negative attitudes or beliefs that they have towards those they are caring for or the illnesses they present with [12,39]. Self-examination is consistent with the theoretical foundations of mental health nursing and current health care initiatives from the Federal Government [8,13,29,72] and the findings of this DPI project. By addressing the stigmas that health care workers have towards those with mental illness, patient care delivery and outcomes will continue to improve, and health disparities towards those with mental illness will continue to reduce.

Appendix A: Mental Illness Clinicians' Attitude Scale: MICA -4.

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. Permission to use obtained in personal communication (September 4, 2016).

Question Number	Question	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 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.						
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', 'nut', '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.						

Appendix B: DHS Consumer Survey.

Mental Health Center Patient Satisfaction Survey [83].

Licker Scale: 5 =Strongly Agree; 4=Agree; 3=Neutral; 2=Disagree; 1=Strongly Disagree

1. Staff compliment me when I do something well.			5		
2. Staff believes that I can grow, change, and recover.					
3. Staff attempts to support me even after I have had a bad day.					
4. Staff respects my input.					
5. Staff sees my strengths and abilities.					
6. I am treated with dignity and respect.					
7. Staff gives me hope about my future.					
8. Staff respects my privacy.					
9. I feel comfortable asking questions about my treatment and medications.					
10. Instead of “one size fits all” treatment, my plan is designed specifically for me.					
11. I feel sure that staff is able to help me.					
12. Staff helps me plan what to do if I start to feel out of control.					
13. Staff pays attention to me when I talk to them.					
14. The hospital environment is clean and comfortable.					
15. Staff encourages individuals to help each other.					
16. Staff asks me what my goals are.					
17. I feel safe while in the hospital.					
18. Staff treats me as a person with a life rather than a patient with an illness.					
19. It is hard to get staff to listen to me.					
20. Staff helps me get better.					
21. While I am here, I am learning new skills to control my life.					
22. Staff asks if there is anyone in my life who makes me feel unsafe.					
23. Staff helps me understand how my past experiences may be affecting me now.					
24. I have a range of treatment options to choose from.					
25. I am actively involved in my treatment plan.					
26. Staff asks me to do things, instead of ordering me.					
27. The unit rules are applied fairly.					
28. Staff respects my ethnic and racial needs.					
29. Staff helps me deal with my emotions.					
30. I feel free to complain to staff.					
31. Staff tries not to do anything that brings back bad memories.					
32. Staff talks about me to others as if I wasn’t there.					

Appendix C: Interpersonal Relations Between Staff and Patients.

Manual Title: **POLICY & PROCEDURE MANUAL** Focus: **ORG. ETHICS & HUMAN RESOURCES** Vol.: **IV**

Section No. and Title: **3500 ORGANIZATIONAL ETHICS**
Policy/Procedure/Subject No. and Title: **3510 INTERPERSONAL RELATIONS BETWEEN STAFF AND PATIENTS REVISED**
11/30/2006

➤ Policy

It is the policy of this hospital that staff shall at all times relate to patients in an objective, ethical, professional, and humane manner which demonstrates an awareness of the formal helping relationship between the employee and the patient for which the employee receives monetary compensation. The human rights and dignity of patients shall be respected at all times.

The following procedures provide specific assistance to staff in carrying out this policy. The Mental Health Code, the Confidentiality Code, the DHS Employee Handbook, DHS Administrative Rule 50 (Abuse and Neglect), and oilier Elgin policies (including Ppm 180, Rights of Patients and Ppm 290, Restriction of Rights) address other aspects of employee behavior related to this subject.

➤ Definitions

See definitions in the following content.

➤ Procedures

1. Patients shall be addressed in a manner assuring their individual dignity. If first names are used, they shall be used only if the patient is agreeable to the practice.
2. Support staff; e.g., housekeeping, trades, security, clerical; shall respond to patients in a polite and civil manner, but shall not engage in discussion of patient disorders or treatment. If patients initiate conversations with support staff regarding their disorders or treatment, these staff persons shall cordially refer the patient to direct care staff.
3. Inappropriate shouting at a patient by any staff member shall not be permitted. Incidents shall be subject to disciplinary measures. Examples of appropriate instances of shouting are over high noise level in an emergency) or outside over a distance in order to be heard.
4. Staff use of threatening, violent, profane, obscene or personally/culturally disparaging language and/or gestures, shall not be permitted toward anyone, including hearing impaired non-hearing and/or blind patients, visitors, or other staff. In addition, any use of language or subject

that has been identified in the patient's Treatment Plan, Assessments, or progress notes of the clinical record as detrimental or inciting to the patient is prohibited. Such use shall be subject to disciplinary action.

5. No staff member shall interact with a patient in an intimate or essentially personal manner as described below. Such relationships shall be grounds for disciplinary action. Professional ethics may further restrict staff behavior and professional staff is required to meet the standards of their professions.
 - 5.1. Under no circumstances shall employees invite or take patients to staff lodgings (homes, hotels, motels, rooms, etc.) while patients are receiving treatment from the Department of Human Service
 - 5.2. No staff member shall engage in any interpersonal relationship with a patient which violates the patient's absolute right to freedom from intimate sexual contact while the patient is residing in this facility. The responsibility of staff to adhere to high professional standards of ethical behavior in interpersonal matters is absolute. Instances of staff initiating) responding to, discussing, or soliciting sexual intimacy with patients shall be grounds for immediate suspension pending discharge. It shall be considered inappropriate for employees to engage in intimate relations with former patients of the facility for whom the employee had provided direct treatment or care.
 - 5.3. Only staff members whose job duties include counseling, psychotherapy, or other treatments recognized by their professional discipline organization may provide treatment for problems of the patient 111 the areas of intimate interpersonal functioning and other areas of the patient's life which he or she considers private.
 - 5.4. All staff shall be respectful of the bodily privacy of patients. Direct care staff members who provide assistance in bathing, grooming, and other personal care functions shall be respectful of the bodily privacy of the patient while care is given. Staff conversation and attitude while providing such services shall be directed toward helping the patient reach a higher level of self- care skills.
 - 5.5. Staff shall not make phone calls to patients while off duty, except when requested to by the on duty shift charge person, and shall not make phone calls to patients with whom they have no on-duty facility assigned or sanctioned treatment responsibility.
 - 5.6. Staff shall not send or accept letters, cards, oilier mail or electronic communications to or from current or former patients except as follows:

5.6.1. Receiving communications: When business related, original letter or hard copy of message must be filed in the clinical record; when letter is of a thank you in nature, a copy must be given to the clinical nurse manager, but the original may be kept by the staff person to whom it is directed.

5.6.2. Sending communications: When it is necessary for a staff member to send business related communications to a current or former patient, the clinical nurse manager shall be listed on the communication as receiving a copy ("cc: Clinical nurse manager"). A copy of the communication must be filed in the clinical record. When a communication is sent in response to communications from a patient or relevant others the clinical nurse manager and program director shall be listed on the communication as receiving a copy and a copy must be filed in the clinical record.

5.6.3. Sending special occasion cards, for example, birthdays or holidays: such cards are appreciated by patients and are appropriate when they are signed by two or more staff and when they are sent on a consistent basis to all patients of the treatment unit. Sending cards from only one staff person or to only one or a few patients may be interpreted as showing favoritism or undue personal involvement.

5.7. Receiving special occasion cards: when patients or relevant others send such cards to staff they must be shown to the clinical nurse manager. Staff shall not visit patients when off duty, for personal or social purposes, except in cases where a staff member may be a relative or friend of the patient prior to EMHC hospitalization. In such an instance, the staff member shall be treated as any other patient visitor is treated. The staff member shall comply with facility policies and procedures, and program and unit procedures regarding visitors.

5.8. Staff shall not discuss their personal matters or provide personal information to patients. In no circumstances shall a staff member give a patient their home address, email address and/or phone number.

It is the responsibility of staff to avoid engaging in behaviors which give the appearance of sexual provocativeness, regardless of the motivation of the staff person. Example: frequently selecting the same patient for unassigned escorting or walks when the patient does not have pass privileges appears inappropriate. Such escorting must be provided to a range of patients who are under the same pass conditions.

➤ Other examples

Hugging - A hug can be comforting to some distressed people. However, overuse by a staff member, particularly if directed at only certain patients, may cause misunderstandings.

Repeated hugging must be questioned by supervisors and result in counseling the staff at a minimum.

Exception: if the treatment team determines for a particular patient that such contact is essential and therapeutic, the team's approval is to be documented in the patient's Individual Treatment Plan.

The clinical nurse manager shall inform the program director when this special treatment intervention has been approved.

Stroking or Patting - Stroking or patting may also be comforting. However, stroking or patting is restricted to areas of the body that are not associated with sexual significance. For example, patting a patient's shoulder in order to console, or indicate social reinforcement, is acceptable. Patting areas of the patient's body such as buttocks, lower back, upper thigh, or chest is not appropriate.

Kissing - A staff person kissing a patient is never appropriate, no matter what the reason.

6. Staff shall not engage in transactions of a business or gifting nature with patients. Such transactions are exploitative, or imply to patients that a special social (favoritism) relationship exists between the staff and the patient. Nor shall staff act as go-betweens or intermediaries in such transactions between patients. The following rules shall be followed:

- 6.1. An employee shall not accept gifts of any type from a patient.
- 6.2. An employee shall neither borrow nor loan any funds or property from or to a patient.
- 6.3. An employee shall not privately purchase property belonging to a patient or retain in his or her possession a patient's personal property or belongings. The only exception shall be as provided by DRS policy concerning the disposition of unclaimed personal property through formal procedures approved by the Hospital Administrator.
- 6.4. An employee shall not accept money or other remuneration for personal use from a patient's relatives or friends.
- 6.5. An employee shall not enter into any transaction for personal profit with a patient or any person representing the patient's interest.
- 6.6. An employee shall not present a patient with personal gifts such as clothing, radios, money or similar items without the Hospital Administrator's written prior approval. A record of such transactions and the Hospital Administrator's approval shall be made.

- 6.7. An employee shall not sell or give intoxicating beverages (i.e., containing alcohol) or the employee's cigarettes to a patient.
- 6.8. An employee shall not sell or give medicine, drugs, narcotics, or other substances with an abuse potential or that are illegal to be administered to any patient except as prescribed by the patient's primary care physician on the unit on which the patient is being treated or other facility physician treating the patient. Only registered nurses shall carry out the physician's orders for medication administration.
- 6.9. An employee shall not conduct financial transactions for patients for any purpose, except as provided for in Patient Trust Fund Deposit and Withdrawal procedures as approved by the Hospital Administrator and his/her designee.
- 6.10. Staff shall respect a patient's right to freedom of choice in religion, and shall not try to convert a patient to another religion or force the staff person's religious beliefs on the patient through the distribution of literature or through verbal coercion or persuasion. Patients with religious concerns shall be referred to the facility chaplaincy program.
7. Before entering a patient's bedroom, employees, regardless of gender, shall knock, except in emergency situations.
8. Patients language and culture shall be respected.
9. Treatment and administrative staff while on the unit shall make themselves available to patients under their care as often as reasonable while on duty. Staff shall endeavor to respond therapeutically to patient and to assure accessibility would be that each unit staff member schedule himself or herself to be in the day room areas, leave their office door open at scheduled times, or similar measures as determined by the clinical nurse manager.
10. Positive general staff interactions with patients are strongly encouraged and shall include a wide range of relationship activities which are not intrusive of individual personal privacy. Examples of positive interactions shall include, but not be limited to, those involving sports, games, music, entertainment, grooming, homemaking, budgeting, vocational skills and job problems, discussion of feelings and attitudes relating to other persons and the environment, and discussion of patient aspirations, plans, and objectives for employment, education, living skills, residence after discharge and related matters.

References

DHS Policy and Procedure Directives 01.04.03.02; 01.04.03.01; 02.01.06.02; 02.01.11.02.; DHS Employee Handbook Mental Health and Developmental Confidentiality (Mental Health Center, 2016).

Appendix D: IRB Approval and Protocol Number.



**GRAND CANYON
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DATE: December 20, 2016

TO: Ruth Cangialosi, MSN RN-BC

FROM: Grand Canyon University Institutional Review Board

STUDYTITLE: [998998-1] Improving Patient Satisfaction Scores by Reducing

Mental Health Stigmas of Health Care Professionals

IRBREFERENCE#: 998998-1

SUBMISSIONTYPE: New Project

ACTION: APPROVED

APPROVALDATE: Dec2016

EXPIRATIONDATE: December 20, 2017

REVIEWTYPE: Expedited Review

REVIEW CATEGORY: Expedited review category # [7.7]

Thank you for your submission of New Project materials for this research study. Grand Canyon University Institutional Review Board has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a study design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on the applicable federal regulation.

Please remember that informed consent is a process beginning with a description of the study and insurance of participant understanding followed by a signed consent form.

Informed consent must continue throughout the study via a dialogue between the researcher and research participant. Federal regulations require each participant receive a copy of the signed consent document.

Please note that any revision to previously approved materials must be approved by this office prior to initiation. Please use the appropriate revision forms for this procedure.

All SERIOUS and UNEXPECTED adverse events must be reported to this office. Please use the appropriate adverse event forms for this procedure. All FDA and sponsor reporting requirements should also be followed.

Please report all NON-COMPLIANCE issues or COMPLAINTS regarding this study to this office. Please note that all research records must be retained for a minimum of three years.

Based on the risks, this project requires Continuing Review by this office on an annual basis. Please use the appropriate renewal forms for this procedure.

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