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Angel Mbome

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Walden University
2022

Abstract

Nurses' Role in Reducing Mental Health Stigma in Health Care

by

Angel Mbome

MS, Walden University, 2019

BS, University of Maryland University College, 2016

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

December 2022

Abstract

Many patients with mental illness around the world face mental health-related stigma. Compared to other health care workers, nurses express the highest level of stigmatizing attitudes toward mentally ill patients. The purpose of this project was to change staff nurses' attitudes in a long-term care facility by educating them on mental health stigma. The practice-focused question guiding this study was whether educating staff nurses on mental health stigma changed nurses' attitudes and behavioral intentions towards people with mental illness. This project was guided by the constructivist theory of learning. Seventeen staff members voluntarily participated in a 30-minute nursing staff education that was created using the Analyze, Design, Develop, Implement, and Evaluate (ADDIE) model. The Opening Mind Scale for Health Care Providers (OMS-HC) was used in this study as the pre-and post-questionnaire to evaluate the effectiveness of education. The score for this questionnaire ranges from 20 to 100, with lesser scores suggesting the least stigmatizing attitudes and higher scores suggesting high stigmatizing attitudes. The mean pretest score for all participant samples ($N = 17$) was 64.8, showing that nursing staff had a tendency towards stigmatizing attitudes and behaviors towards people with mental health disorders; after the education the posttest mean scores dropped to 56.7, indicating an improvement in attitudes and behavioral intentions. This project has the potential to impact social change, as addressing stigma is fundamental to delivering quality health care and achieving optimal health.

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Dedication

To all my patients, family, and friends.

Acknowledgments

I am grateful to God almighty for the strength, health, and ability to have done this project. I am thankful to all the faculty members of Walden University, family members, and friends who have helped me reach this point in my academic career.

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Section 1: Nature of the Project

Introduction

One in every four persons in the world is affected by at least one type of mental disorder at some point in their life (Khushal ani et al., 2018). In the United States, mental health disorders result in approximately $193 billion in lost earnings yearly, and the annual health spending on the management of mental illness amounts to roughly $201 billion (Khushalani et al., 2018). Many patients with mental illness around the world face mental health-related stigma (Heim et al., 2019). Though mental health-related stigma may come from the public, stigma also comes from health workers worldwide, leading to many adverse effects on the patients with mental illnesses, such as discrimination with care, limited access to care, and increased mortality (Heim et al., 2019). Compared to other health care workers, nurses express the highest level of stigmatizing attitudes toward mentally ill patients (Grover et al., 2020). Therefore, educating nurses on their role in mental health-related stigma can help improve negative attitudes and behavioral intentions towards people with mental illness thereby promoting quality and better management of mental illnesses in patients (Grover et al., 2020).

A gap in practice that this Doctor of Nursing Project (DNP) addressed was the lack of knowledge related to mental health stigma among nurses in a long-term care facility in Maryland. According to the DON of the study site, the administration has expressed concerns with the stigma toward mentally ill patients and has called for education for the nursing staff to help eliminate stigmatizing attitudes towards patients with mental illness (personal communication, December 2020). This DNP project

provided education on mental health stigma to improve attitudes towards people with mental health disorders among the nursing staff. Addressing stigma is fundamental to delivering quality health care and achieving optimal health (Nyblade et al., 2019). This project has the potential to impact social change as staff members will gain knowledge on the stigma associated with mental health illnesses. The nurses will benefit from this project as they will gain the knowledge that will support a more positive attitude towards mentally ill patients. The overall goal was to improve patient care.

Problem Statement

The local nursing practice problem that was the focus of this DNP project was the lack of education among staff nurses about mental health stigma and the effects of stigmatizing attitudes on patient outcomes in a long-term care facility located in Maryland. In this facility, the nursing staffs often call patients with mental health illnesses “dangerous,” and sometimes some nurses refer to the patients as “crazy” or “coo-coo.” The nursing staff at this facility have also verbalized fear of caring for patients with mental health illnesses. Patients with mental health illnesses are often labeled by some nurses as unpredictable, dangerous, without self-control, and aggressive (Ubaka et al., 2018). The administration also has no record of prior education on mental health stigma among nursing staff (personal communication, December 2020). When the director of nursing (DON) asked why she was afraid to care for a resident with mental health illness, some nurses mentioned that she does not “know how to care for patients with mental health problems.” The administration is concerned with the stigma toward mentally ill patients and believes that the nursing staff needs the education to gain the

knowledge that can help them provide better care to mentally ill patients (personal communication, December 2020). When health care workers show stigmatizing attitudes toward mentally ill patients, it does not only cause barriers to access to care; it also affects the quality of care they provide to the mentally ill individuals (Knaak et al., 2017; Ubaka et al., 2018). Stigma lowers self-esteem, social adjustment, overall quality of life, access to care, and willingness to seek help (Ubaka et al., 2018). Health care workers also need to be advocates for the patients and be a part of helping the public reduce this stigma with the mentally ill (Ubaka et al., 2018), which requires them to be educated on how to first care for patients who are mentally ill without stigmatizing them.

This doctoral project had significance for the field of nursing because compared to other health care workers, nurses are the highest group of people who show negative behaviors toward the mentally ill (Grover et al., 2020). The attitudes of nurses toward psychiatric patients need to be appropriate and stigma-free for them to provide quality care effectively (Knaak et al., 2017). Additionally, most health education and campaigns often focus on educating the public, improving public views of mental illness, and reducing stigma. However, when it comes to educating nurses themselves, there is a gap as little attention or focus is geared toward how they view mentally ill patients and help reduce this stigma (Knaak et al., 2017). Therefore, it was expected that educating staff nurses in a long-term care facility located in Maryland on their role in mental health-related stigma can help reduce any stigmatizing attitudes and behaviors among the staff and improve the quality and management of mental illnesses in patients.

Purpose Statement

The purpose of this DNP project was to address the gap in practice in a long-term care facility in Maryland regarding the lack of education related to mental health stigma. By providing nursing staff education, the overall goal was to increase nursing staff knowledge and to improve the quality of care and management of mental illnesses in patients. This project attempted to answer the question "Will educating staff nurses on mental health stigma change nurses' attitudes and behavioral intentions towards people with mental illness?" Addressing stigma is fundamental to delivering quality health care and achieving optimal health (Nyblade et al.,2019). Educating nurses will help them equally provide quality care to everyone (Heim et al., 2019). In addition, nurses can educate others to reduce the stigma against those who are mentally ill (Heim et al., 2019).

Nature of the Doctoral Project

The nature of this project was staff education. A literature search and synthesis of evidence was completed to explain how educating nursing staff on mental health stigma have the potential to increase their knowledge, thereby resulting in better care and patient outcome. Key search terms included *Stigma, stigmas, stigmatization, Prejudice* OR *attitude* OR *discrimination* OR *mental health-related stigma*; *Nursing staff education* OR *Nursing education*; *Depression* And *Anxiety*; *bipolar disorder and Schizophrenia*; *Diagnosis of Mental illness* OR *psychiatric disorder*; *Nurses* OR *healthcare workers* OR *healthcare providers* OR *healthcare professionals*; and *Intervention* OR *Solutions* OR *reduction* OR *education* OR *educational intervention*. Databases included PsycINFO, CINAHL, PubMed, Wiley online library, and ProQuest. Search parameters included

literature in the English language from 2015 to 2022 for the best evidence.

To assess stigmatizing attitudes towards people with mental health disorders before and after the educational presentation, a questionnaire known as the Opening Mind Scale for Health Care Providers (OMS-HC) consisting of 20 items was administered. The questionnaire took about 20 minutes or less to complete each time it was issued. Descriptive statistics was used to compare and to determine the effectiveness of the education.

Significance

The stakeholders for this project included staff nurses, nursing administration, and nurse educators. Addressing this problem may impact the nursing staff positively, as their knowledge of mental health stigma will increase. Nursing staff will also feel more competent and gain better skills and ways by which they can provide stigma-free care. The nurses will also gain knowledge on stigmas associated with mental health. It was expected that this would also help reduce any stigmatizing attitudes and behaviors among staff nurses and ultimately provide quality care to everyone equally, empowering them to advocate for patients, and educate others to reduce stigma. Addressing stigma is fundamental to delivering quality healthcare and achieving optimal health (Nyblade et al., 2019). This project will positively impact the nursing administration as they will get better-quality patient reports. The facility will also be known as a place that provides quality care. If this project is successful, other facilities can use it to increase knowledge. This also gives room for the impact of positive change by transferring the knowledge to others in different facilities, which aligns with Walden university’s mission of providing

an opportunity for a diverse group of professionals to transform themselves as scholar-practitioners to effect positive social change (Walden University, 2017).

Summary

In Section 1, the problem statement for the DNP project was introduced, which is the lack of education among the nursing staff regarding mental health stigma in a long-term care setting in Maryland. The purpose was also discussed to explain that this doctoral project has the potential to address the gap by educating staff nurses on mental health stigma. This section also described the nature of the doctoral project, staff education. The significance of this project was also discussed, including the nursing staff increasing their knowledge of mental health stigma, improving any stigmatizing and attitudes and behaviors among the staff, and feeling more competent and gaining better skills and ways by which they can provide stigma-free care. Section 2 will cover the concepts, models, and theories as well as the relevance to nursing practice, local background, context, and role of the DNP student and project team.

Section 2: Background and Context

Introduction

The local nursing practice problem that was the focus of this DNP project was the lack of education among the nursing staff regarding mental health stigma in a long-term care setting in Maryland. This project attempted to answer the question: "Will educating staff nurses on mental health stigma change nurses' attitudes and behavioral intentions towards people with mental illness?" Addressing stigma is fundamental to delivering quality health care and achieving optimal health (Nyblade et al., 2019). Educating nurses will help them equally provide quality care to everyone (Heim et al., 2019). In addition, nurses can educate others to reduce the stigma against those who are mentally ill (Heim et al., 2019). This section will cover the concepts, models, and theories as well as the relevance to nursing practice, local background, context, the DNP student's role, and the project team's role. Increasing knowledge through education can improve social and clinical distance, client experiences, and care (Ungar et al., 2016).

Concepts, Models, and Theories

Stigma as a Concept

Stigma was initially described by Erving Goffman in 1963, who pointed out that tainting, discrediting, devaluing, or regarding a person as shameful is called stigma. Stigma is a negative stereotype and perception with prejudiced beliefs and discriminatory behavior (Taghva et al., 2017). It is important to note that stigma is strongly influenced by cultural and contextual value systems that differ over time and across contexts. Because of this, the concept of stigma has been explored in many contexts and cultures.

Nevertheless, most authors agree with Goffman's primary definition, which characterized labeling, stereotyping, social isolation, prejudice, rejection, ignorance, status loss, low self-esteem, low self-efficacy, marginalization, and discrimination as the main components of stigma (Subu et al., 2021).

Theory/Model

The rationale for this project was based on an educational theory, specifically the constructivist theory of learning, whose philosophical origins are frequently ascribed to Kant and whose educational origins are to Piaget (Dennick, 2016). This theory is based on the premise that the act of learning is based on a process that connects new knowledge to pre-existing knowledge (Dennick, 2016). Constructivism, as detailed by Piaget (1953), describes the construction of understanding and knowledge through experiencing phenomena and reflecting upon them. The underpinning principle is that learners compare new information and experiences with their prior beliefs and actively change behavior or disregard the learning based upon their analysis of the material (Lockey et al., 2020).

In developing effective anti-stigma interventions, it is essential to consider some factors, such as individual learner needs, to help enhance the efficacy of the intervention (Ungar et al., 2016). A core tenet of education theory is beginning with the learner by understanding their existing attitudes and behaviors about mental illness and towards persons with mental illness. All these considerations make anti-stigma intervention more effective (Ungar et al., 2016). Effective education starts by understanding the individual's current behavioral ability, followed by sorting those individuals into relevant learner

groups and educating them based on their level of awareness, knowledge, and readiness to change (Ungar et al., 2016). As such, it is essential that healthcare educators know the fundamental principles of constructivism and its influence on educational theory and clinical practice (Dennick, 2016).

Relevance to Nursing Practice

Current evidence showed that health care workers have been known to show stigmatizing behavior toward mentally ill patients (Ungar et al., 2016). Many health care workers, primarily nurses who show stigmatizing behavior, often do so because of the wrong perception of those who are mentally ill (Giandinoto & Edward, 2015). In a descriptive study on a sample of 69 nursing professionals in a hospital in Brazil, 95.3% agreed to have negative attitudes toward those who are mentally ill and believe that they are unpredictable, violent, and aggressive (de Melo et al., 2016). Similarly, Knaak et al. (2016) showed that nurses and doctors displayed the highest levels of the stigma across various health care groups. Chang et al. (2017) also showed that individuals who sought help for mental illness often report that they encountered stigmatizing attitudes from health care providers, which acted as barriers to quality care and treatment and affected their recovery due to the negative attitudes from healthcare providers. Health care provider attitudes or behaviors have been listed as a critical barrier to mental health service use and influence health care quality (Grandón et al., 2019; Lien et al., 2019). But when the nurses have the adequate education and knowledge needed to care for these patients, they can teach others, including the patients and their families (Fereidouni et al., 2019).

The lack of education needed to care for individuals with mental illness shows a positive correlation with increased stigmatization by health care givers, especially nurses in different specialties (Ungar et al., 2016). This lack of knowledge often leads to stigma, impacts the quality of care provided to these patients, and potentially leads to poor health outcomes (Knaak et al., 2017). Research has shown that educational interventions can significantly reduce this stigma by increasing knowledge, thereby improving nurses' attitudes toward mental illness and, subsequently, the quality of care or healthcare outcomes (Chang et al., 2017). Educational interventions related to mental illness could foster positive attitudes of future professionals toward people with these types of diseases (Poreddi et al., 2017). Education could dispel stigma, so nursing school curriculums are starting to incorporate mental health literacy courses (Maranzan, 2016). Research on nursing staff educational intervention focusing on mental health on mental health signs, symptoms, risk factors, and strategies for caring for a mental health patient have shown a significant increase in knowledge (Burns et al., 2017; Hawke et al., 2014), in addition to improving attitudes and decreasing stigmazing behavior (Itzhaki et al., 2017; Ng et al., 2017). Thus, core educational lectures on mental illness have been a successful intervention for improving attitudes toward mental illness among nursing students (Itzhaki et al., 2017).

Local Background and Context

This project took place in a nursing home on a 40-bed unit located in Maryland. This education was provided to staff nurses employed in this facility. A discussion with the nurse manager, staff nurse, and Director of Nursing (DON) took place at this facility

to assess knowledge about mental health stigma and the effects of stigmatizing attitudes on patient outcomes in this facility. This discussion revealed that staff nurses held negative attitudes about working with patients with mental illness. Some nursing staff in this facility label patients with mental health illnesses as “dangerous,” and sometimes, some nurses refer to patients who are mentally ill as ‘crazy” or “coo-coo.” The nursing staff at this facility have also verbalized fear of caring for patients with mental health illnesses. The administration also had no record of prior education on mental health stigma among nursing staff. The administration is concerned with the stigma toward mentally ill patients and believes that the nursing staff needs the education to gain the knowledge that can help them provide stigma free care to mentally ill patients (Personal communication, December 2020). The director of nursing and the unit manager support this project and recognize the need to educate nurses.

This facility is experiencing an increase in the number of patients admitted with chronic medical conditions and mental health conditions, including depression, anxiety, schizophrenia, bipolar disorder, and neurocognitive disorder. In this facility, it is noted that staff nurses who show stigmatizing attitudes toward their patients are often based on fear or misunderstandings of the causes and symptoms of mental illness. This is of particular concern as it may affect the care and treatment a person with mental illness receives, including treatment for physical illnesses, thereby impacting their well-being and recovery. The facility is also experiencing systemic problems, including staff shortage since the pandemic, time constraints, especially when a patient with a behavioral problem requires a 1;1 for safety reasons, and a lack of education on how to manage

patients with mental health problems. This project was in congruence with an organizational strategic plan as the organization is committed to providing person-centered care guided by strong and great workers who carry their philosophy of Serving with Pride in all they do. The organization takes pride in providing all patients with the highest quality of care. This institution sees patient-centered care as holistic care, respect and value, choice, dignity, self-determination, and purposeful living. Some of their core values are honesty, excellence, accountability, respect, and teamwork. The mission of this organization is to provide a superior customer experience that not only heals but also satisfies. This organization's strength is constantly looking for ways to improve the care experience and patient satisfaction.

Stigma

Stigma was initially described by Erving Goffman in 1963, who pointed out that tainting, discrediting, devaluing, or regarding a person as shameful is called stigma. Taghva et al. (2017) explained that Stigma is a negative stereotype and perception with prejudiced beliefs and discriminatory behavior. It is important to note that stigma is strongly influenced by cultural and contextual value systems that differ over time and across contexts. Because of this, the concept of stigma has been explored in many contexts and cultures. Nevertheless, most authors agree with Goffman's primary definition, which characterized labeling, stereotyping, social isolation, prejudice, rejection, ignorance, status loss, low self-esteem, low self-efficacy, marginalization, and discrimination as the main components of stigma (Subu et al., 2021). Stigma can be described on three conceptual levels: cognitive, emotional, and behavioral, which gives

room for the separation of mere stereotypes from prejudice and discrimination (Rössler, 2016).

Stereotypes

Stereotypes refer to prefabricated opinions and attitudes towards people who share similar characteristics, such as religious groups, whites and blacks, ethnicity, Europeans and Latin Americans, Jews and Muslims, and the mentally ill. Stereotypes are not necessarily wrong or negative because they enable one to quickly judge people sharing specific characteristics. For example, the way one can approach a police officer and an old lady will be different; stereotypes of police officers and old ladies will help adopt the appropriate behavior when approaching them (Rössler, 2016). Nevertheless, more information is always needed to make a fair and rational judgment about a person than simply calling up stereotypes (Rössler, 2016). The most prominent stereotypes surrounding people with mental illness presume dangerousness, unpredictability, and unreliability. People with mental illness experience more judgments and stigmatization than other types of illness, leaving them to struggle with coping with the devastating effects of their illness and suffer from social exclusion and prejudices (Rössler, 2016). Stereotypes can become dysfunctional when related to people with mental illness because they typically activate generalized rather than customized response patterns. To determine whether a person is dangerous, unpredictable, or unreliable, one must get to know them first (Rössler, 2016).

Prejudices

Prejudices, conversely, are consenting emotional reactions to a stereotype or a

stereotyped person (Rössler, 2016). An example of a response comprised of prejudice includes being afraid of a person with a mental illness because they are labeled as dangerous and unpredictable. Subsequently, stereotypes and prejudice can result in discrimination and exclusion. For example, excluding someone with a mental illness from a group because they are perceived as dangerous and unpredictable (Rössler, 2016).

This facility is located in the state of Maryland. Antidiscrimination legislation by the state of Maryland and the federal government, like the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, is in place to help fight against stigma (Cummings et al., 2013). Nevertheless, the law must be complemented by approaches that directly target other components of the stigma process like prejudice to improve outcomes for patients with mental illness (Cummings et al., 2013).

Although federal policies can neither legislate changes in beliefs and attitudes about mental illness nor directly prevent self-discriminatory behaviors, they can now address discriminatory behaviors by others (e.g., employers) toward those with mental illness (Moreover, these laws also hold tremendous symbolic value and the potential to indirectly improve other components of public and self-stigma (e.g., stereotypes and prejudice) by affirming that those with mental illness should not face discrimination(Cummings et al., 2013). One of the main things that the antidiscrimination law focuses on is putting policies in place to advocate for patients receiving poor health care, jobs, or education due to mental illnesses and stigma (Cummings et al., 2013).

Role of the DNP Student

As a DNP student, my role was to be a change agent by using this opportunity to

educate nurses to increase their knowledge, thereby effecting positive social change as scholar-practitioners (Walden University, 2017). As a psychiatric mental health nurse practitioner, I manage this facility's medication management. When doing rounds at this facility, I have heard nurses make unkind remarks toward mentally ill patients. I have the opportunity to educate some of the nurses during rounds when I hear them make unkind remarks toward mentally ill patients. Some of the nurses expressed that they do not have enough education to care for patients with mental health problems. I have had a conversation with the Director of Nursing (DON) at that facility, who explained that the facility had no education regarding mental health stigma and its effects on patient outcomes. She expressed the need to educate staff nurses about mental health stigma. This project provides me with an opportunity to be a part of the solution by providing education to staff nurses with the possibility of it increasing their knowledge and reducing mental health sigma. Nurses' attitudes towards psychiatric patients need to be appropriate and stigma-free for them to provide quality care effectively (Knaak et al., 2017).

My motivation for this doctoral project stemmed right from when I lost my grandmother, who suffered from what I now know to be dementia. My family attributed it to witchcraft because no one knew what dementia was. Also, no one in my family believes there is anything like mental illness and attributes it to weakness and witchcraft. I grew up hearing a lot of unkind remarks about mental health and people who are mentally ill. As I started nursing school and began to learn about different illnesses, that was when I realized my grandmother had dementia. I also started better understanding

what mental illness was and the negative effects of mental health stigma. As I learned these things, I was always passionate about teaching others and helping them understand mental health stigma. Since the days of my clinical rotations on the behavioral units as a nurse student, I found myself always advocating against mental health stigma when I would hear other students make remarks that were unkind towards those who were mentally ill. Working as a registered nurse, I always advocated against mental health stigma and taught my colleagues about mental health sigma. At home and in the community, I also advocate against mental health stigma. Today, working as a nurse practitioner specializing in mental health, I do not stop advocating against mental health stigma. I know that myths exist about mental health illnesses, and my own family tried several times to discourage me from specializing in mental health because of this myth. I also know that my family lacks knowledge about mental health sigma.

Role of the Project Team

The facility's Director of Nursing (DON) helped to inform the staff nurses when the education was to be held. Before this implementation of this project, a meeting was scheduled with the DON of the facility and nurse managers as well as the administrator. The agenda of the meeting was to formally discuss the overall project, during which I explained the project's mission, goal, and objectives, as well as the timeline for activities. During this meeting, I also explained the background of the problem, current evidence of how education intervention has helped reduce the problem, the possible positive impact the project can bring, and the impact on quality of care and outcome. The nurse educator of this facility started working in a long-term care setting as a certified nursing assistant,

a licensed practical nurse, and now a registered nurse. She has also worked in different roles from nurse manager to nurse educator and DON, accumulating 25 years of nursing experience in a long-term care setting. The nurse educator has expertise in dealing with patients with mental health illnesses in long-term settings. She shared her knowledge by providing some input on developing my educational materials and how best to present them. She also assisted in the distribution of educational materials and helped to facilitate access to resources. A timeline was discussed with all team members so that everyone knew their responsibility and promptly provided feedback (see Table 1).

Table 1

Timeline

Task	Start day
Meetings/Planning	Aug 1
Identify assumptions/ Resources	Aug 8
Data collection/ Education	Aug 22
Evaluation	Aug 29
Data Analysis	Sep 5

Summary

In this section, we covered concepts, models, and theories, relevance to nursing practice, local background and context, and the role of DNP students and the role of the project team. A gap in practice that this doctoral project will address is the lack of education among staff nurses about mental health stigma and the effects of stigmatizing attitudes on patient outcomes in a long-term care facility located in Maryland. Addressing stigma is fundamental to delivering quality healthcare and achieving optimal health (Nyblade et al., 2019). Educating nurses will help them equally provide quality care to everyone (Heim et al., 2019). In addition, nurses can educate others to reduce the stigma

against those who are mentally ill (Heim et al., 2019). Section 3 will cover the practice-focused question, the sources of evidence, the analysis, and the synthesis.

Section 3: Collection and Analysis of Evidence

Introduction

The local nursing practice problem that was the focus of this DNP project was the lack of education among staff nurses about mental health stigma and the effects of stigmatizing attitudes on patient outcomes in a long-term care facility located in Maryland. The stigma toward people with mental illness is both a longstanding and a widespread occurrence (Ubaka et al., 2018). This doctoral project aimed to address the lack of education among staff nurses, as addressing stigma is fundamental to delivering quality health care and achieving optimal health (Nyblade et al., 2019). Educating nurses will help them equally provide quality care to everyone (Heim et al., 2019). In addition, nurses can educate others to reduce the stigma against those who are mentally ill (Heim et al., 2019).

This project took place in a nursing home on a 40-bed unit located in Maryland. This education will be provided to staff nurses employed in this facility. A discussion with the nurse manager, staff nurse, and director of nursing (DON) took place at this facility to assess knowledge about mental health stigma and the effects of stigmatizing attitudes on patient outcomes in this facility. This discussion revealed that staff nurses held negative attitudes about working with patients with mental illness. The administration also has no record of prior education on mental health stigma among nursing staff. Further, this facility is experiencing an increase in the number of patients admitted with chronic medical conditions and mental health conditions, including depression, anxiety, schizophrenia, bipolar disorder, and neurocognitive disorder. In this

facility, it is noted that staff nurses who show stigmatizing attitudes toward their patients are often based on fear or misunderstandings of the causes and symptoms of mental illness. This may affect the care and treatment a person with mental illness receives, including treatment for physical illnesses, impacting their well-being and recovery.

The director of nursing and the unit manager support this project and recognize the need to educate nurses, as they are concerned with the stigma toward mentally ill patients. This project was in congruence with an organizational strategic plan, as the organization is committed to providing person-centered care guided by strong and great workers who carry their philosophy of “serving with pride” in all they do. The organization takes pride in providing all patients with the highest quality of care. This institution sees patient-centered care as holistic care, respect and value, choice, dignity, self-determination, and purposeful living. Some of their core values are honesty, excellence, accountability, respect, and teamwork. This organization’s mission is to provide a superior customer experience that not only heals but also satisfies. This organization’s strength is constantly looking for ways to improve the care experience and patient satisfaction. This section will cover the practice-focused question, the sources of evidence, the analysis, and the synthesis.

Practice-Focused Question

The local nursing practice problem that was the focus of this DNP project is the lack of education among the nursing staff regarding mental health stigma in a long-term care setting in Maryland. People with mental illness experience more judgments and stigmatization than those with other types of disease, leaving them to struggle with

coping with the devastating effects of their illness and suffer from social exclusion and prejudices (Rössler, 2016). This project will attempt to answer the question: “Will educating staff nurses on mental health stigma change nurses’ attitudes and behavioral intentions towards people with mental illness?” This doctoral project has addressed a gap in practice by educating staff nurses on mental health stigma, which is fundamental to delivering quality health care and achieving optimal health (Heim et al., 2019; Nyblade et al., 2019).

Sources of Evidence

The nature of this project was staff education. A literature search was completed to uncover evidence that explains how educating nursing staff on mental health stigma has the potential to increase their knowledge and decrease stigmatizing attitudes and behaviors, resulting in better care and patient outcomes. The evidence that was used to develop the educational program and how the effectiveness of the education is to be evaluated are also described.

Education and Mental Health Stigma

Some health care workers lack adequate knowledge and educational background to appropriately care for patients with mental health disorders (Riffel & Chen, 2019). A study showed that many health care workers, including about 50% of staff nurses, still feel that mental health disorders automatically mean the patient is dangerous and unpredictable regardless of the mental illness (Riffel & Chen, 2019). Stigma continues to influence patients’ perceptions negatively and, in some cases, creates moral injury and exacerbates mental health challenges (Coombs et al., 2021). The most recent World

Health Organization Mental Health Atlas showed that mental health stigma from health care professionals only makes it worse (Stuart, 2016). When patients refuse to seek help and decide to hide their mental problems due to the fear of stigma, it can negatively affect the financial and political support received by psychiatric services (da Silva et al., 2020). Mental health-related stigma might have a substantial financial impact on the use of health care resources, especially in terms of increased emergency services, psychiatric inpatient services, and primary health care services (Evans-Lacko et al.,2015). Knowing that health care workers are part of the perpetuation of mental illness stigma can destroy the healing process of many patients, especially those who have already been stigmatized by society (Riffel & Chen, 2019). Mental health-related stigma can also lead to a breakdown in, or exclusion from, personal relationships and reduced participation in social or recreational activities, which can affect the physical health of the patient as well as their social support, social relationships, identity, self-confidence, self-esteem, wellbeing and social capital (Osumili et al., 2016).

Educational interventions have been effective in creating a more positive attitude as well as stigma reduction toward mentally ill patients by changing the stereotype beliefs among different people, staff nurses, therapists, policymakers, media professionals, and patients and their families (Taghva et al., 2017). Education focuses on replacing inaccurate stereotypes about people living with mental disorders by educating people with facts regarding mental illness, disconfirming information, and directly addressing false ideas (Smith & Applegate, 2018). Thus, educational interventions can significantly reduce this stigma by increasing knowledge, thereby improving nurses' attitudes toward

mental illness and, subsequently, the quality of care or health care outcomes (Chang et al., 2017). Educational interventions related to mental illness could foster a positive attitude of future professionals toward people with these types of diseases in addition to increasing knowledge (Burns et al., 2017; Hawk et al., 2014; Ng et al., 2017; Poreddi et al., 2017). Attention should also be paid to nursing education and on-the-job training to prevent young nurses from developing stigmatized attitudes toward patients (Ihalainen et al., 2016). Education is an effective way to reduce nursing students' as well as nurse's stigma and negative attitudes toward people with mental illness and increases their willingness to care for people with mental illness (Gu et al., 2021; Iheanacho et al., 2014; Itzhaki et al., 2017; Knaak et al., 2016).

One way to improve mental health care is through interventions that improve the way healthcare providers "see," understand, and interact with their patients (Knaak et al., 2016). Educational interventions that focus on changing beliefs about mental disorders help aid their recognition, management, and prevention (Hadi & Samira, 2021). Education and contact efforts promise, primarily because it focuses on replacing inaccurate stereotypes about people living with mental disorders and working to change them by educating them with facts regarding mental illness, disconfirming information, and directly addressing false ideas (Smith & Applegate, 2018). Knowledge about the strategies for stigma reduction can help health care professionals develop supportive interventions and give appropriate information and advice. Therefore, considering the role of these strategies in promoting the quality of life in people with a mental health condition (Taghva et al., 2017).

Evidence Used to Develop and Evaluate the Staff Education Program

In this section, I present the current evidence that was used to develop the educational program. I discuss a background on different types of mental health disorders, their diagnosis and treatment, and scholarship on the prevalence and effects of stigma on persons with mental health disorders.

Overview of Common Mental Health Disorders

Nearly a quarter of adults in the United States have psychiatric disorders, and almost half experience at least one mental illness during their lives (Mirzaei et al., 2019). Some of the most common mental health disorders include depression, anxiety, bipolar disorder, and schizophrenia (Mirzaei et al., 2019). Most of the patients who are admitted to this nursing home facility also have some of these mental health problems like depression, anxiety, bipolar disorder, and schizophrenia.

The Epidemiology of Common Mental Illness

Depression is a mood disorder considered a common mental health disorder and potentially a chronic illness with considerable morbidity and a high rate of relapse and recurrence and affecting over 300 million people worldwide (Mirzaei et al., 2019). Some symptoms of depression include changes in sleep and appetite, low energy, sadness, irritability, loss of interest, feelings of guilt, insensibility, and difficulty concentrating Mirzaei et al., 2019). These symptoms considerably affect a patient's health-related quality of life and satisfaction with medical care (Wang et al., 2017). Depression has also been bidirectionally linked with chronic diseases and an increase in age (Ng et al., 2016). About 50% of psychiatric consultations are for depression and 12% of all hospital

admissions, making depression a significant determinant of quality of life and survival (Wang et al., 2017). The combination of chronic medical illnesses and depression can also result in a substantial economic burden and poor quality of life (Wang et al., 2017). The global prevalence of depression has increased over the years, with a lifetime range from 20% to 25% in women and 7% to 12% in men. One major thing to note is that the prevalence of depression is higher in patients than in the general public, and it is significant comorbidity of chronic medical disorders (Wang et al., 2017).

Every year, 20% of adults are affected by anxiety disorders, making them the most prevalent psychiatric diseases (Bandelow & Michaelis, 2015). Anxiety symptoms may occur without an identifiable triggering stimulus. Symptoms such as excessive worry, fear of impending doom, and a constant feeling of being overwhelmed are produced by generalized anxiety making it difficult to control. It is often accompanied by many non-specific psychological and physical (Mirzaei et al., 2019). According to epidemiological surveys, one-third of the population is affected by an anxiety disorder during their lifetime. High comorbidity is found among anxiety disorders, chronic medical conditions, and other mental disorders, respectively (Bandelow & Michaelis, 2015).

Bipolar disorder (BD) is a chronic and complex disorder of mood that is characterized by a combination of manic, hypomanic, and depressive episodes, with subsyndromal symptoms extant in between the mood episodes, involving episodes of severe mood disturbance, neuropsychological deficits, immunological and physiological changes, and disturbances in functioning (Rowland & Marwaha, 2018). Bipolar disorder

can be further subdivided into bipolar disorder I (BD I) and bipolar disorder II (BD II). The overall lifetime prevalence of bipolar spectrum disorders is 2-3%, with a prevalence of 0.6% for bipolar type I and 0.4% for bipolar type II, while the prevalence of bipolar type I in the United STates was found to be 1%, slightly higher than the other countries (Rowland & Marwaha, 2018). The incidence of death by suicide among patients with a diagnosis of bipolar affective disorder has been reported to be as high as 20 times more than the general population—most notably when bipolar disorder is untreated—making bipolar disorder the leading cause of disability worldwide and is associated with high rates of premature mortality from both suicide and medical comorbidities (Rowland & Marwaha, 2018). Shared genetic and environmental vulnerabilities, consequences of treatment, recognition bias on the part of clinicians as well as the potential for a direct causal relationship in either direction are some of the reasons why bipolar is known to be comorbid with several medical and psychiatric conditions (Rowland & Marwaha, 2018).

Schizophrenia is one of the most challenging mental disorders that often start in late adolescence or early adulthood (Charlson et a., 2018). Schizophrenia affects over 21 million people worldwide, and about seven individuals per 1000 will develop schizophrenia during their lifetime (Orrico-Sánchez et al., 2020). In addition to poor recovery outcomes, those living with schizophrenia have a significantly reduced life expectancy, with only 13.5% meeting clinical and social recovery criteria (Charlson et a., 2018). Schizophrenia has also been linked to higher rates of comorbid illnesses and most excess deaths resulting from underlying physical conditions like cancers, type 2 diabetes, coronary heart disease, respiratory diseases, and stroke (Charlson et a., 2018). High

excess mortality is found across all age groups and unnatural causes, including suicide, account for less than 15% of excess deaths (Charlson et a., 2018).

The Clinical Diagnosis of the Common Mental Disorders

To reduce morbidity and mortality in depression, it is important that depression is diagnosed on time and accurately for a prompt treatment intervention (Ng et al., 2016). According to the Diagnostic and Statistical Manual of Mental Disorders-(DSM-5), five or more symptoms must be present within two weeks before a major depression episode is diagnosed (Tolentino & Schmidt, 2018). One of the symptoms should be at least low mood or anhedonia (defined as loss of interest or pleasure) nearly every day for two or more weeks, together with other symptoms like changes in sleep (insomnia or hypersomnia) and appetite (reduced or increased), psychomotor agitation or retardation, fatigue or loss of energy, diminished ability to think or concentrate, feelings of worthlessness or excessive guilt, and suicidality (Ng et al., 2016). These symptoms are rated all or none (0 or 1) (Tolentino & Schmidt, 2018). The DSM-5 serves as a guideline just like any other diagnostic tool; therefore, it is essential to ensure that it doesn't replace clinical judgment (Ng et al., 2016).

According to the DSM-5, to diagnose generalized anxiety, the anxiety must cause significant impairment in social and occupational areas and not be linked to any physical cause (Munir & Takov, 2022). The excessiveness and worry of the anxiety must be challenging to control for at least six months. They should be associated with three symptoms: muscle tension, irritability, fatigue, difficulty concentrating, sleep disturbance and restlessness, and feeling keyed up or on edge (Munir & Takov, 2022).

Bipolar disorder types I and II are tricky to diagnose accurately in clinical practice, especially in their early stages, due to the difficulty in differentiating bipolar disorder type I or II from unipolar depression (Severus & Bauer, 2020). To diagnose bipolar I disorder, at least one past or present manic or mixed episode must be current and is mandatory; depressive episodes may occur but are not obligatory (Severus & Bauer, 2020). A manic episode which is a feature of BD I, is described as a period of abnormally and persistently elevated, expansive, or irritable mood and increased energy and activity lasting at least one week with three or more of the following symptoms (four symptoms if the mood is irritable); Low self-esteem, racing thought, decreased sleep, goal agitation, pressured speech, risk-taking behaviors, or increase in activity levels (McCormick et al., 2015). These symptoms must be severe enough to cause marked impairment (Severus & Bauer, 2020). On the other hand, to diagnose bipolar II disorder, at least one hypomanic and one depressive episode must be present during the illness (Severus & Bauer, 2020). Hypomania, a feature of BD I, BD II, or cyclothymia, is described as a period of abnormally and persistently elevated, expansive, or irritable mood and increased energy and activity lasting at least four days (McCormick et al., 2015). Also, the mood symptoms should be perceivable by others, and there should be three or more symptoms of mania present, and symptoms should not be severe enough to cause marked impairment (Severus & Bauer, 2020).

Schizophrenia is characterized by positive symptoms (delusions, hallucinations, and grossly disorganized speech and behavior), negative symptoms (apathy, social isolation, and diminished affect), and cognitive impairment (Rahman & Lauriello, 2016).

According to the DSM 5 criteria, two (or more) of the following: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, and negative symptoms (i.e., diminished emotional expression or avolition) must each be present for a significant portion of time during one month (or less if successfully treated) (Rahman & Lauriello, 2016). At least one of the symptoms must be delusion, hallucination, or disorganized speech and must have a significant impairment in functioning as well as continuous signs of the disturbance persist for at least six months (Rahman & Lauriello, 2016). This 6-month period must include at least one month of symptoms (or less if successfully treated). The disturbance must not be linked to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (Rahman & Lauriello, 2016).

The Treatment of Common Mental Disorders

The first-line treatment for mild depression is given to psychotherapy and symptom monitoring, with pharmacotherapy as the last option in cases of insufficient improvement. Regarding moderate depression, psychotherapy and pharmacotherapy or both are considered. Severe depression needs psychotherapy, pharmacological intervention, and sometimes hospitalization (Park & Zarate, 2019). Antidepressant medications (Sertraline, Fluvoxamine, Fluoxetine, Paroxetine, Citalopram, Escitalopram, Venlafaxine, Duloxetine, Bupropion, Mirtazapine, Amitriptyline, Clomipramine) have been a mainstay of treatment for depression (Park & Zarate, 2019).

For all types of anxiety disorders, psychotherapy, primarily cognitive-behavioral therapy (CBT), is the most recommended form of psychotherapy because it also has the

most robust evidence for treating anxiety (Ströhle et al., 2018). Combining pharmacotherapy with psychotherapy is usually not superior to monotherapy with either one of the two options alone (Ströhle et al., 2018). Nevertheless, the S3 guideline regarding treating anxiety disorders issued in May 2014 recommended that psychotherapy and pharmacotherapy should be offered, and the two are considered comparably effective (Ströhle et al., 2018). Treatment decisions should be made with consideration of the severity of the disorder, patient preferences, length of treatment, side effects, and the availability of treatment. If one form of the treatment proves ineffective, the other (or a combination of both) should be tried (Ströhle et al., 2018).

Treatment options for managing bipolar disorders can be broadly classified as mood stabilizers, antipsychotic medications, psychosocial interventions, electroconvulsive therapy (ECT), antidepressants, and adjunctive medications (Shah et al., 2017). Some things to consider with treatment options include side effects, treatment history, the phase of illness (mania/hypomania/depression/mixed), and patient (Shah et al., 2017). Psychosocial interventions have been linked to better treatment adherence, reduced risk of relapses, and better functioning (Shah et al., 2017).

Due to a poor understanding of the causes of schizophrenia, the treatment, engaging antipsychotic drugs, focuses mainly on reducing the symptoms of the disease and improving functioning in the cognitive and social areas. Many patients will need life-long treatment with antipsychotic medications (Stępnicki et al., 2018). The methods of treatment of schizophrenia are classified as the first (mainly dopamine D_2 receptor antagonists), second (multi-target antagonists with greater antagonism at serotonin 5-

HT_{2A} receptor than at dopamine D_2 receptor), and third-generation antipsychotics represented, e.g., by aripiprazole (Stępnicki et al., 2018). The efficacy and side effects of the current medications used in treating schizophrenia have resulted in many drawbacks. Also, despite the gradual improvements that have been achieved by the newer drugs, a deeper understanding of the path mechanism and causes of schizophrenia is still needed (Stępnicki et al., 2018). Some of the limitations of current treatments of schizophrenia include the fact that they are only half of the patient population get an efficient benefit that can enable them to have an independent life. Another limitation is that positive symptoms like hallucinations and thought disorders which are the core of the disease, are the symptoms that are easily relived, but negative symptoms like flat affect and social withdrawal, and cognitive symptoms (e.g., learning and attention disorders) remain untreated. Also, their neurological and metabolic side effects are severe and can cause sexual dysfunction or agranulocytosis (clozapine). The only partial effectiveness of current antipsychotics is the path mechanism of schizophrenia which is not adequately understood due to its complexity and involvement of many molecular targets (Stępnicki et al., 2018).

The Definition of Stigma and the Forms in Which it is Expressed

Stigma is strongly influenced by cultural and contextual value systems that change over time and across contexts (Subu et al., 2021). Stigma is defined as an undesired difference: a pejorative attribute that means intolerance, and when linked to mental health disorders, results to fear of the unknown, exclusion, and a set of false beliefs born from the lack of knowledge and understanding about mental disorders

(Santos et al., 2016). It is defined as mental health stigma when a person is disgraced, discredited, and disapproved socially because of mental illness (Subu et al., 2021). Goffman identified the main components of stigma as marginalization, low self-esteem labeling, social isolation, ignorance, prejudice, stereotyping, rejection, status loss, low self-efficacy, and discrimination (Subu et al., 2021). There are different levels of mental health-related stigma, one of which is self-stigma or internalized stigma; this happens when a person holds negative attitudes regarding their mental illness. Another dimension of stigma is public stigma; this is when the general public has negative attitudes toward a person with mental illness, often based on misconceptions, fear, and prejudice. Another dimension of stigma is professional stigma; this happens when healthcare professionals show stigmatizing attitudes toward their patients or when the professionals themselves experience stigma from the public or other healthcare professionals because of their work and connection with stigmatized individuals. Lastly, there is a dimension of stigma known as institutional stigma (an organization's policies or culture of negative attitudes and beliefs toward patients with mental health problems) (Subu et al., 2021).

In general, the public reacts negatively toward people with mental illnesses, labeling them as "dangerous, unfit, and unpredictable" because they are not familiar with mental disorders, which often leads to prejudice and stigma. Health care workers also react negatively towards people with mental health disorders due to fear and misunderstanding regarding the cause and symptoms of the disorders. Some people's reactions toward mentally ill patients can be historically linked to the culture of asylums and laws enacted by different societies (Santos et al., 2016).

The Prevalence of Stigma from Healthcare Workers

Stigma toward patients with mental health illnesses is also highly prevalent among health care professionals, not just the public (Grover et al., 2020). The manifestations of stigma from healthcare workers are widely documented in healthcare facilities, ranging from outright denial of care, provision of sub-standard care, and physical and verbal abuse, to more subtle forms, such as making certain people wait longer or passing their care off to junior colleagues (Nyblade et al., 2019). A study was done among nurses with more than six years of experience. It showed that nurses held negative attitudes toward patients with mental illnesses and often labeled them criminals, dangerous, drug-seeking, and unfit (Grover et al., 2020). A study by Knaak et al. (2017) showed that 79% of patients with mental health illnesses reported first-hand experiences of discrimination, and 53% of patients said that they observed other medical providers discriminating against a patient with mental illness.

The Effect of Health Care Workers' Stigmatizing Attitudes on Outcomes

One of the reasons why people with mental illness are reluctant to seek help have been linked to anticipated stigma from healthcare providers; the relationship between patients and healthcare provider can be compromised when the care providers show stigmatizing attitudes. Other patients may terminate their treatment early due to stigmatizing attitudes from health care providers. Stigmatization from health care providers can lead to poorer physical care for persons with mental illnesses resulting in safety concerns (Knaak et al., 2017). Nurses and other healthcare workers' stigma toward patients with mental illness can lead to delays in help-seeking, affect provider and patient

relationship, early discontinuation of treatment, patient safety concerns, and poorer quality mental and physical care (Knaak et al., 2017).

To evaluate the effectiveness of the education, the opening mind scale for health care providers (OMS-HC) tool was used in this study as the pre- and post-questionnaire. The OMS-HC is a self-report questionnaire made up of 20 items. The OMS-HC was chosen because it is specifically designed for health care providers' use, is freely available, and is time-efficient. It also has a history of wide international use and the authors of the instrument are experts on the topic of stigma (Sapag et al., 2019).

Evidence Generated for the Doctoral Project

The approach for this doctoral project included performing a literature review to ensure all information used was evidence-based and supported the project. Approval was obtained from the facility, then the Institutional Review Board (IRB) approval was obtained from Walden University. Education was created using the Analyze, Design, Develop, Implement, and Evaluate (ADDIE) model with input from experts. Participants were recruited; the education was presented and its effectiveness was evaluated using the OMS-HC. Further details on the participants and procedures follow.

Participants

This project took place in a nursing home on a 40-bed skilled unit located in Maryland. This education was offered to staff nurses employed in this facility. The nurses on this unit who voluntarily choose to participate in this project enabled me to answer the practice focused question because they get a lot of admissions consisting of patients who do not only suffer from chronic medical conditions but also have mental health problems,

including bipolar disorder, depression, anxiety, and schizophrenia. Educating the nurses may increase their knowledge regarding mental health stigma, which has the potential to improve quality of care and management of mental illnesses in patients. The participation of the nurses in the education will be voluntary. The expectation was that the staff nurses who attended the education sessions gained increase their knowledge of how to treat, care or mange patients with mental health illnesses and demonstrate changes in stigmatizing attitudes and behaviors.

Procedures

Education was created using the Analyze, Design, Develop, Implement, and Evaluate (ADDIE) model with input from experts. The content of the education was evidenced based as a literature review was performed to ensure all information used is evidence-based and supported the project. The education covered variety of topics including the epidemiology of the most common mental illnesses, overview of their clinical diagnosis, overview of their treatments; definition of stigma and forms in which it is expressed, prevalence of stigma from healthcare workers toward mentally ill patients and the effect of healthcare workers stigmatizing attitudes on outcomes among patients with mental illness. The education focused on increasing staff knowledge to ensure prevention of stigmatizing attitudes from staff nurses in the facility. At the end of the education session, it was expected that the participants would be able to:

1. Recognize the potential effects of mental health stigma on facility
2. Recognize the potential effects of mental health stigma on the patient outcome
3. Identify some factors lead to staff stigmatizing attitudes towards patients

4. Identify interventions to prevent mental health stigma including staff education

After the development of education materials, the educational sessions were announced 1-2 weeks before the educational intervention during the twice-a-day staff huddle and at the prior monthly staff meeting. Potential participants were allowed to ask questions about the participation requirements. Contact information was made available on the unit to contact the DNP student anytime with questions or concerns. To get all nurses and allow everyone to participate, education was done on four different days targeting the night nurses and day nurses to accommodate everyone's schedule and time. The educational sessions were provided to participants who showed up for the sessions. Education was 30 minutes for any eligible participant. The project was implemented over three weeks.

Before education, participants completed a pre-education questionnaire known as the Opening Minds Scale for Health Care Providers (OMS-HC) tool. This self-administered tool was specifically developed to assess outcomes of anti-stigma interventions among healthcare providers. The OMS-HC is made up of 20 items, with each of the items linking to a balance response value; strongly agree, agree, neither agree nor disagree, disagree, strongly disagree, thus assigning a score of 1 to 5 for each item. The score ranges from 20 to 100, with lesser scores suggesting least stigmatizing attitudes and higher scores suggesting high stigmatizing attitudes. The OMS-HC was chosen because it is specifically designed for health care providers' use, is freely available, and is time-efficient. Also, the OMS-HC has been psychometrically validated with an acceptable internal consistency ($\alpha = 0.79$), construct validity, has been successful in

detecting positive changes (SRM ≤ 0.50 to ≤ 0.91) in various anti-stigma interventions, and its internal consistency is also satisfactory across different health professional groups like physicians, nurses, etc. (Ng et al., 2017).

The overall internal consistency for the whole scale is ($\alpha = 0.79$), and three subscales, namely Attitudes ($\alpha = 0.68$), Disclosure ($\alpha = 0.67$), and social distance ($\alpha = 0.68$), is acceptable (Eiroa-Orosa et al., 2021). This scale has also been widely validated and used in evaluations of anti-stigma interventions in countries like Canada, further showing the OMS-HC as an accurate and reliable instrument (Beaulieu et al., 2017). Lastly, the OMS-HC was chosen for this study because, apart from its strong psychometric properties from prior validations and wide international use, research team members have been working on stigma research using this instrument since 2009 (Sapag et al., 2019).

I did not need author permission to use the tool as it is open access and free for third-party use with appropriate citation. The questionnaire took about 20 minutes to be completed.

Protection

Information regarding the purpose and intent of the project as well as its benefit was explained at the beginning of every educational session. No identifiable information was collected from participants. Participation was voluntary, and participants could withdraw at any time. Their results were not shared with other participants or employers. Participants did identify themselves when answering. Anonymity was ensured by creating a random pseudo i.d. for each participant. No identifiable information was

collected. The OMS-HC instrument collected data relevant to the healthcare provider participants' attitudes toward stigmatization. The first set of data was collected prior to education intervention and another set after the education intervention. Each questionnaire was identified by creating a random pseudo i.d. for each participant so that data could be completed and analyzed without directly identifying the subjects. The data was stored in a secured and locked cabinet only accessible by the DNP student. After all of the educational sessions were completed, the data was transferred to an electronic Excel data file and was password-protected and only accessible to the DNP student. The Institutional Review Board (IRB) was obtained from Walden University.

Analysis and Synthesis

Descriptive statistics was used to analyze the data. Descriptive methods included pre-and post-intervention results from the OMS-HC questionnaire. The number of participants from the pre and post education group was reported. The results were diagnosed with descriptive statistics of the mean and median scores with a standard deviation. The pre- and post-education responses were described and compared to assess for changes resulting from the staff education.

Summary

Section three covered the practice-focused question, the sources of evidence, and the analysis and synthesis. The local nursing practice problem that was the focus of this DNP project was the lack of education among staff nurses about mental health stigma and the effects of stigmatizing attitudes on patient outcomes in a long-term care facility located in Maryland. This project attempted to answer the question: "Will educating staff

nurses on mental health stigma change nurses' attitudes and behavioral intentions towards people with mental illness?" Thus, the nature of this project was staff education. This project took place in a nursing home on a 40-bed skilled unit located in Maryland. The educational sessions were announced, and education was provided to participants who voluntarily showed up for the sessions.To assess stigmatizing attitudes towards people with mental health disorders before and after the educational presentation, a questionnaire known as the Opening Mind Scale for Health Care Providers (OMS-HC).

Descriptive statistics was used to evaluate if the education resulted in improvements in OMS-HC scores among attendees. Section four will cover the findings and implications, recommendations, contribution of doctoral project team, and the strength and limitations of the project.

Section 4: Findings and Recommendations

Introduction

The local nursing practice problem and gap in practice that was the focus of this DNP project was the lack of education among the nursing staff regarding mental health stigma in a long-term care setting in Maryland, such as the effects of stigmatizing attitudes on patient outcomes. This project attempted to answer the practice-focused question: “Will educating staff nurses on mental health stigma change nurses’ attitudes and behavioral intentions towards people with mental illness?” The overall goal was to increase nursing staff knowledge and improve the quality of care and management of mental illnesses in patients by providing nursing staff education.

A literature search was completed to uncover evidence that explains how educating nursing staff on mental health stigma has the potential to increase their knowledge, resulting in better care and patient outcomes. The evidence used to develop the educational material was current, from 2016 to 2022. Education was created using the ADDIE model with input from experts. The education covered different topics, including the epidemiology of the most common mental illnesses, an overview of their clinical diagnosis, an overview of their treatments; the definition of stigma and the forms in which it is expressed, the prevalence of stigma among healthcare workers toward mentally ill patients and the effect of healthcare workers stigmatizing attitudes on outcomes among patients with mental illness.

To assess stigmatizing attitudes towards people with mental health disorders before and after the educational presentation, a questionnaire known as the Opening

Mind Scale for Health Care Providers (OMS-HC).

. Descriptive statistics were used to analyze the data. Descriptive methods included pre-and post-intervention results from the OMS-HC questionnaire. The number of participants from the pre- and post-education group was also reported. The results were diagnosed with descriptive statistics of the mean and median scores with a standard deviation. The pre- and post-education responses were described and compared to assess for changes resulting from the staff education.

Findings and Implications

Seventeen staff nurses employed at a long-term care facility in Maryland voluntarily participated in an education program from August 8th to August 26th, 2022. The nursing staff education was 30 minutes for eligible participants. The program included the teaching presentation and the data collection. An anonymous paper-based survey known as the OMS-HC tool was used to capture pre- and post-responses to determine the education's effectiveness. The OMS-HC comprises 20 items, linking to a balanced response value—strongly agree, agree, neither agree nor disagree, disagree and strongly disagree—with a score of 1 to 5 for each item. The score ranges from 20 to 100, with lesser scores suggesting least stigmatizing attitudes and higher scores suggesting high stigmatizing attitudes. To maintain the anonymity of the participants, no identifiable information was requested. After the pretest was completed, it was collected, the education was administered then the posttest was administered. After the posttest was completed, the tests were analyzed by calculating the mean score on the answers.

The 17 participants completed the survey comprising 20 items for the pretest and

posttest. I used SPSS statistics to analyze the data and find out if any changes in the pretest and posttest scores after the education was implemented. The total score for the 20-item OMS-HC was calculated by taking the sum of raw scores for the 20 items. The mean pretest score for all participant samples ($N = 17$) was 64.8 and a median of 59 and standard deviation of 16.056. Looking at the pretest scores, it can be said that the nursing staff had some knowledge regarding mental health stigma, but the knowledge was inadequate. After the education was implemented, the mean posttest scores dropped to 56.7 with a median of 54 and a standard deviation of 15.106, showing increased staff knowledge regarding mental health stigma (see Table 2).

Table 2

Pre- and Post-Test scores

Participants	Pretest score	Posttest score
1	58	56
2	61	60
3	57	55
4	55	49
5	72	72
6	49	40
7	54	44
8	59	57
9	89	43
10	60	52
11	100	100
12	58	54
13	54	50
14	64	60
15	100	80
16	61	48
17	51	45
Mean	64.8	56.7
Median	59	54
Standard deviation	16.056	15.106

Besides the general analysis of the effectiveness of education using the 20-item OMS-HC, further exploration was done. The 20 OMS-HC items were factored under

Attitude (6 items), *Disclosure and Help-seeking (4 items)*, Social *Distance (5 items) and general knowledge (5 items)* to make analysis clearer.

Factor 1: Attitudes of Health Care Providers Toward People with Mental Illness

Items 1, 12, 13, 14, 18 and 20 seek to evaluate the attitudes of health care providers toward people with mental illness. The result from Item 1 (I am more comfortable helping a person who has a physical illness than I am helping a person who has a mental) showed significant positive change in the responses of staff nurses after the education was implemented as the mean decreased from 3.59 pretest to 2.65 posttest. Item 12—Despite my professional beliefs, I have negative reactions towards people who have mental illness—showed that the mean difference went from 2.82 pretest to 2.18 posttest, meaning that there was a positive impact from the education for this item. For Item 3—There is little I can do to help people with mental illness—the mean went from 3.06 pretest to 2.12 posttest. Item 14—more than half of people with mental illness don't try hard enough to get better—showed that there was a slight decrease in the means (from 2.82 to 2.32). Item 18—Health care providers do not need to be advocates for people with mental illness—showed positive changes on the response of staff nurses and was also significant with a decrease in mean from pre- and post-test showing 3.53pretest to 2.53 posttest. Finally, Item 20—I struggle to feel compassion for a person with a mental illness—also showed significant positive change to the responses of staff nurses after the education intervention with the mean of 2.88 pretest and 2.00 posttest.

Factor 2: Disclosure/Help-seeking

Items 4,6,7, and 10 seek to evaluate the perception of staff nurses regarding

disclosure/help seeking. Item 4; If I were under treatment for a mental illness, I would not disclose this to any of my colleagues (Item 4 of 20) showed no significant change in the responses of the staff nurses with a pretest mean of 3.71 and posttest mean of 3.71. Item 6; I would see myself as weak if I had a mental illness and could not fix it myself (6 of 20) showed that there was a slight difference in the pre and post means showing a decrease from pretest means 3.65 and to 3.00 posttest mean. Item 7; I would be reluctant to seek help if I had a mental illness (7 of 20) had a slight change in the mean from pretest mean of 2.41 to a posttest means of 2.22. Lastly for this factor, item 10; If I had a mental illness, I would tell my friends (10 of 20) showed no positive changes in the responses of staff nurses after education with a pretest mean of 3.41 and a posttest mean of 3.47.

Factor 3: Social Distance

Items 3, 8, 9, 17 and 19 seek to evaluate the perception of staff nurses regarding social distance toward those with mental illnesses. Item 3; If a colleague with whom I work told me they had a managed mental illness, I would be as willing to work with him/her (3 of 20) showed no positive changes on the responses of the aft nurses with a pretest mean of 3.71 and posttest mean of 3.88. Item 8; Employers should hire a person with a managed mental illness if he/she is the best person for the job (8 of 20) showed a slight difference in mean from pretest mean of 3.68 to posttest mean of 3.53. Item 9; I would still go to a physician if I knew that the physician had been treated for a mental illness. (9 of 20) showed no significant changes in the responses of staff nurses after education with a pretest mean of 3.12 and a posttest mean of 3.41 .Item 17; I would not

want a person with a mental illness, even if it were appropriately managed, to work with children (17 of 20) Showed significant changes on the responses of staff nurses after the education with a pretest mean of 2.82 and posttest mean of 2.35.Lastly for this factor, item 19; I would not mind if a person with a mental illness lived next door to me (19 of 20) showed that there was a difference in the pretest 2.41 and posttest 2.06.

Factor 4: General Knowledge

Items 2, 5, 11,15, and 16 seek to evaluate some general perception staff nurses have regarding mental health illness. Item 2; If a person with a mental illness complains of physical symptoms (e.g., nausea, back pain, or headache), I would likely attribute this to their mental illness (2 of 20) Showed some changes in the pretest mean of 2.71 and posttest mean of 2.29 .Item 5; I would be more inclined to seek help for a mental illness if my treating healthcare provider was not associated with my workplace (5 of 20) did not show any significant change on the responses of the nurses with a pretest means of 3.47 and mean of 3.65 posttest. Item 11; It is the responsibility of health care providers to inspire hope in people with mental illness (11 of 20) had a pretest mean of 3.94 and mean of 4.11 posttest. Item 15; People with mental illness seldom pose a risk to the public (15 of 20) showed a pretest mean of 2.94 and a mean of 3.12 posttest. Lastly, item 16; The best treatment for mental illness is medication (16 of 20) showed significant improvement with a change in means of 3.53 pretest and a mean of 2.53 posttest.

Table 3

Pre- and Post-Test Mean for Factored OMS-HC Items

Factor 1: Attitude (6 items)

Item number	Pretest mean	Posttest mean
1 of 20	3.59	2.65
12 of 20	2.82	2.18
13 of 20	3.06	2.12
14 of 20	2.82	2.32
18 of 20	3.53	2.53
20 of 20	2.88	2.00

Factor 2: Disclosure and Help-seeking (4 items)

Item number	Pretest mean	Posttest mean
4 of 20	3.71	3.71
6 of 20	3.65	3.00
7 of 20	2.41	2.22
10 of 20	3.41	3.47

Factor 3: Social Distance (5 items)

Item Number	Pretest mean	Posttest mean
3 of 20	3.71	3.88
8 of 20	3.63	3.52
9 of 20	3.12	3.41
17 of 20	2.82	2.35
19 of 20	2.41	2.06

Factor 4: General Knowledge (5 items)

Item number	Pretest mean	Posttest mean
2 of 20	2.71	2.29
5 of 20	3.47	3.69
11 of 20	3.94	4.11
15 of 20	2.94	3.12
16 of 20	3.53	2.53

Going by the above factors or categories it is evident that the education intervention had the most significant impact on factor 1 (Attitudes of health care providers towards people with mental illness) showing that after the education there was a positive impact on the responses of staff nurses and showing that attitudes were improved the most in this area. Factor 3 (perception of staff nurses regarding social distance toward those with mental illnesses) and factor 4 (general perception staff nurses have regarding mental health illness) showed some improvement. Lastly factor 2 (the perception of staff nurses regarding disclosure/help seeking) showed that there was no impact in this area even after the education was implemented meaning that staff nurses are reluctant to seek help or disclose, they have mental illnesses.

Implications for Practice

Addressing stigma is fundamental to delivering quality healthcare and achieving optimal health (Nyblade et al., 2019). Educating nurses will help them equally provide quality care to everyone (Heim et al., 2019). In addition, nurses can educate others to reduce the stigma against those who are mentally ill (Heim et al., 2019).

The findings of this project showed that prior to the educational intervention, staff nurses in the local LTC facility expressed some stigmatizing attitudes towards patients with mental health disorders. After the education was implemented, it was evident that attitudes had become more positive, and that the education was effective.

Educational material was developed using evidence-based guidelines to ensure all information used is evidence-based and supports the project. Adopting this education

project into the nursing practice may increase staff knowledge on the stigmatization of people with mental health disorders, promote the elimination of stigmatizing attitudes from staff nurses, and improve equal and quality care. The effectiveness of this project can encourage the facility's management and other health care providers to welcome more evidence-based projects in the future.

Implications for Social Change

This project has the potential to impact social change positively. The educational program resulted in improvements in nurses' attitudes and behavioral intentions towards people with mental health disorders. The program can be used to educate other patients, families, or professionals who show stigmatizing attitudes. The knowledge gained from the education can also strengthen patient and staff relationships as they will better understand the stigma associated with mental health illnesses, their effects, and how to reduce the stigma toward mentally ill patients. In addition, it can also improve patient care as it is hoped that the nurses will treat mentally ill patients better. Also, equal and improved quality care can enhance the facility's reputation to the public, thereby leading to the potential of many people from the community seeking health services.

Recommendations

The educational intervention was effective as its findings demonstrated improved staff nurses' attitudes and behavioral intentions towards people with mental health disorders in a long-term care facility. I recommend that the education be implemented as part of the annual competency training programs. I will also recommend that the education be modified if need be and used to train other workers in the facility. This

project can also be used to develop a treatment plan for patients with mental health problems and be incorporated into their treatment plan.

Contribution of the Doctoral Project Team

The contribution of the doctoral project team (Director of Nursing and staff educator) was essential and helpful in the development and implementation of this staff education project. As the project leader, I developed the educational material with input from the nurse educator. The nurse educator started working in a long-term care setting as a certified nursing assistant, a licensed practical nurse, and now a registered nurse. She has also worked in different roles from nurse manager to nurse educator and DON, accumulating 25 years of nursing experience in a long-term care setting. The nurse educator also has expertise in dealing with patients with mental health illnesses in long-term settings. The Nurse educator provided input on how best to present the education and helped facilitate access to resources. The nurse educator and DON ensured that the education material was accurate and relevant to the facility. Staff members were also more willing to participate when they saw the involvement of leadership and their support for the project. I was also responsible for creating the educational materials and guiding the staff education while working in collaboration with the rest of the team members to ensure that the project was running smoothly. I was also responsible for evaluating the evidence and analyzing the data. I also set up meetings twice each week with the project team to share project milestones and find out if there were any concerns.

Strengths and Limitations of the Project

Strengths

One of this project's strengths is that the content of the education intervention was evidenced-based. According to research, educational interventions that are evidenced based can significantly reduce this stigma by increasing knowledge, thereby improving nurses' attitudes towards mental illness and, subsequently, the quality of care or healthcare outcomes (Chang et al., 2017). Secondly, the facility's administration was entirely in support of the project. The project involved team members with significant clinical experience and knowledge willing to share their expert opinion during the education development. Furthermore, the interest of the nurse educator and management in this project made the process smooth and access to resources easy, as well as the likelihood of incorporating the education into future annual competency and new hire training.

Limitations

One of the limitations of this DNP project was the fact that the project took place in only one long-term care facility, which can limit the possibility of generalizing the findings within the same communities or even in other countries. Another limitation was the relatively small sample size, making the generalization of the findings in a larger population difficult. This project is recommended to be conducted using a larger sample of staff nurses in long-term care facilities.

Section 5: Dissemination Plan

Dissemination, known as the distribution of new knowledge gained through research, is essential to the ethical conduct of research (Derman & Jaeger, 2018). Dissemination is also critical to developing evidence-based medicine and adopting evidence-supported interventions and improved practice patterns within specific settings. When dissemination is lacking, a project may be considered a waste of resources and a useless pursuit unable to influence positive health outcomes.

The first step will be to present the results of this DNP project to the facility nurses, the practice administrator, and the clinical leader to allow them to see the educational program's impact on nurses' attitudes. Upon formal adoption of the project, the next step would be to extend the findings to other workers in and outside the facility. For example, other workers like Certified Nursing Assistance (CNA) also work at the facility, come in contact with patients, and can benefit from this education. Other facilities that do not have any education regarding mental health stigma can also benefit from this project, as well as facilities that may want to modify the education and use it for training. The results can be presented during annual competency training, in-services, or hiring. Additional dissemination plans include presenting project findings at local chapter meetings of organizations like the Maryland Nurses Association. The project will also be submitted to ProQuest for publication after approval from Walden University's chief academic officer. Given the nature of the project, the audience most suitable for disseminating the project outcomes on a larger scale would be health care workers at other mental health facilities in long-term, inpatient, and outpatient settings.

Analysis of Self

As a Practitioner

As a psychiatric mental health nurse practitioner who provides mental health services to patients from different populations, I have gained experience and increased knowledge on how to best help patients, and their families recover. This DNP project allowed me to utilize the knowledge attained throughout my DNP program to improve quality patient care with a focus on my specialty. I also gained increased confidence, which came with a skill set that this DNP project could provide.

As a Scholar

As a scholar, carrying out an education project guided evidenced based findings are skills that not only positively impacted my role as a nurse leader but also helped me hone my communication, organizational, and leadership skills. I also had the opportunity to contribute to quality improvement by using evidence-based research findings to enhance nursing practice and achieve improved patient care. This opportunity further allowed me to appreciate the value of communication, collaboration, educating others, and influencing them to adopt new practices.

As Project Manager

As the project manager, some of the challenges I faced included time management for the activities regarding the project. Developing a written plan and timeline was beneficial as it helped me become more effective with time management and overcoming this challenge. My determination and perseverance in completing the DNP project helped me sharpen my leadership and research skills and the opportunity to

contribute to the growing field of nursing. The findings or outcome of this project, which showed an improvement in attitudes and behavioral intentions among nursing staff, encouraged me as I was able to see the positive impact that education can have on mental health stigma. As I continue in my professional journey as a lifelong learner, I plan on using the skills I have acquired during this process to promote change and improve clinical nursing practice.

Summary

Many patients with mental illness worldwide face mental health-related stigma (Heim et al., 2019). Though mental health-related stigma may come from the public, it is known that stigma also comes from health workers worldwide, leading to many adverse effects on patients with mental illnesses, such as discrimination with care, limited access to care, and increased mortality (Heim et al., 2019). Compared to other health care workers, nurses express the highest stigmatizing attitudes toward mentally ill patients (Grover et al., 2020). One of the growing concerns from mental health stigma researchers is that some health care workers lack adequate knowledge and educational background to appropriately care for patients with mental health disorders (Riffel & Chen, 2019). Research has shown that educational interventions can significantly reduce this stigma by increasing knowledge that leads to improvements in nurses' attitudes towards mental illness and, subsequently, the quality of care or healthcare outcomes (Chang et al., 2017). This DNP project addressed the lack of education among the nursing staff regarding mental health stigma in a long-term care setting in Maryland, improving attitudes and behavioral intentions towards people with mental health disorders among staff nurses and

supporting the idea that education is an effective tool to ensure quality patient care for all.

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Appendix A: Opening Minds Scale for Health Care Providers (OMS-HC)

PLEASE READ THE INSTRUCTIONS CAREFULLY

The following questionnaire contains a series of statements about individuals with mental health disorders. Read each statement and indicate how much you agree or disagree with each statement. There are no wrong answers and responses will remain anonymous.

STATEMENT	1 Strongly Disagree	2 Disagree	3 Neither Disagree nor Agree	4 Agree	5 Strongly Agree
1. I am more comfortable helping a person who has a physical illness than I am helping a person who has a mental illness					
2. If a person with a mental illness complains of physical symptoms (e.g., nausea, back pain, or headache), I would likely attribute this to their mental illness.					
3. If a colleague with whom I worked told me they had a managed mental health illness, I would be as willing to work with him/her.					
4. If I were under treatment for a mental illness, I would not disclose this to any of my colleagues.					
5. I would be more inclined to seek help for a mental illness if my treating healthcare provider was not associated with my workplace.					
6. I would see myself as weak if I					

had a mental illness and could not fix it myself.					
7. I would be reluctant to seek help if I had a mental illness.					
8. Employers should hire a person with a managed mental health illness if he/she is the best for the job					
9. I would still go to a physician if I knew had been treated for a mental illness.					
10. If I had a mental illness, I would tell my friends.					
11. It is the responsibility of health care providers to inspire hope in people with mental illness.					
12. Despite my professional beliefs, I have negative reactions towards people who have mental illness.					
13. There is little I can do to help people with mental illness.					
14. More than half of people with mental illness don’t try hard enough to get better.					
15. People with mental illness seldom pose a risk to the public.					
16. The best treatment for mental illness is medication					
17. I would not want a person with a mental illness, even if it were appropriately managed, to work with children.					
18. Healthcare providers do not need to be advocates for people with mental illness.					
19. I would not mind if a person with a mental illness lived next door to me.					
20. I struggle to feel compassion for a person with a mental illness.					

(Open access, free third-party use with citation)

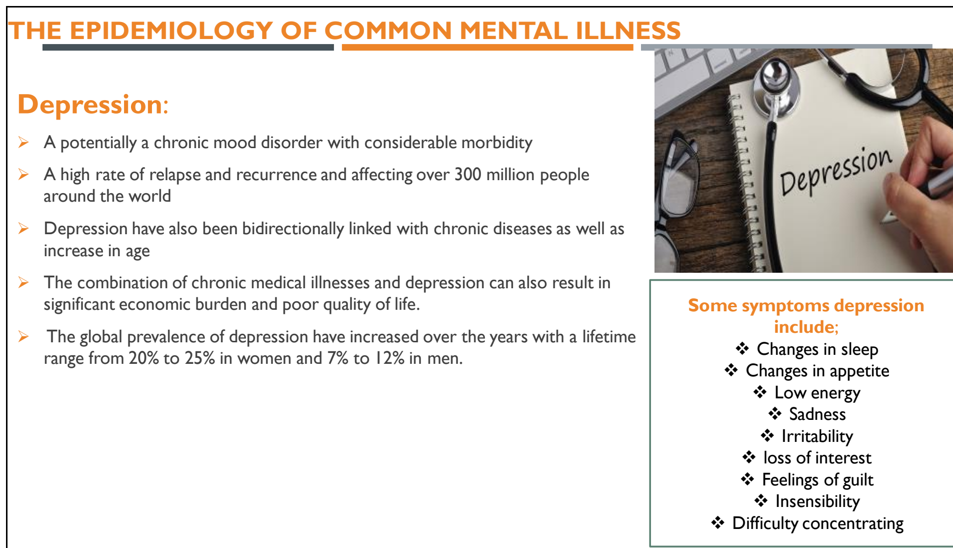
Note: “The development and psychometric properties of a new scale to measure mental illness related stigma by health care providers: The opening minds scale for Health Care Providers (OMS-HC), “by A. Kassam, A. Papish, G. Modgill, & S. Patten, 2012, BMC Psychiatry, 12(62), 9. Copyright 2012 by Springer Nature.

Appendix B: Educational Materials

Slide 1

Slide 2

Slide 3



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Anxiety

- Known as the most prevalent of psychiatric disorders
- 20% adults are affected yearly
- Symptoms may occur without an identifiable triggering stimulus
- GAD is difficult to control and often accompanied by many non-specific psychological and physical symptoms such as excessive worry, fear of impending doom, and a constant feeling of being overwhelmed.
- High comorbidity is found among the anxiety disorders and chronic medical disorders as well as between the anxiety disorders and other mental disorders, respectively

Bipolar disorder

- Bipolar disorder (BD) is a chronic and complex mood disorder
- Known as the leading causes of disability worldwide
- The incidence of death by suicide among patients with bipolar disorder is 20 times higher than those without the disorder.
- Involves episodes of severe mood disturbance, neuropsychological deficits, immunological and physiological changes, and disturbances in functioning
- Characterized by a combination of manic, hypomanic, and depressive episodes, with subsyndromal symptoms extant in between the mood episodes.

Schizophrenia

- Affects over 21 million people worldwide
- About seven individuals per 1000 will develop schizophrenia during their lifetime
- Poor recovery outcomes
- Reduced life expectancy with only 13.5% meeting clinical and social recovery criteria
- Higher rates of comorbid illnesses
- Most excess deaths

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CLINICAL DIAGNOSIS OF THE COMMON MENTAL DISORDERS

Depression

- Prompt diagnose and treatment intervention to reduce morbidity and mortality in depression
- According to the Diagnostic and Statistical Manual of Mental Disorders-(DSM-5)
- Five or more symptoms to be present within a 2-week period for a major depression episode to be diagnosed.
- One of the symptoms should, at least, be low mood or loss of interest or pleasure nearly every day for two or more weeks, together with other symptoms like changes in sleep and appetite , psychomotor agitation, fatigue difficulties to concentrate, feelings of guilt, and suicidality (Ng et al., 2016).

Anxiety

- According to the DSM-5 to diagnose generalized anxiety,
- The anxiety must cause in significant impairment in social and occupational areas
- Must not be linked to any physical cause
- The excessiveness and worry of the anxiety must be challenging to in control for at least six months and should be associated with three or more of the following symptoms; muscle tension, irritability, fatigue, difficulty concentrating, sleep disturbance and restlessness, feeling keyed up or on edge (Munir & Takov, 2022).

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Bipolar Disorder

- To diagnose bipolar, I disorder at least one past or present manic or mixed episode must be present and is mandatory
- Depressive episodes may occur, but are not obligatory bipolar, I disorder
- A manic episode is described as a period of abnormally and persistently elevated, expansive, or irritable mood and increased energy and activity lasting at least 1 week with three or more of following symptoms (four symptoms if the mood is irritable); Low self-esteem, racing thought, decreased sleep, goal agitation, pressured speech, risk taking behaviors, or increased in activity levels
- These symptoms must be severe enough to cause marked impairment
- To diagnose bipolar II disorder at least one hypomanic and one depressive episode must be present in the course of the illness
- Hypomania is a period of abnormally and persistently elevated, expansive, or irritable mood and increased energy and activity lasting at least 4 days
- The mood symptoms should be perceivable by others
- There should be three or more symptoms of mania present
- Symptoms should not be severe enough to cause marked impairment

Schizophrenia

- According to the DSM 5 criteria, two (or more) of the following; delusions, hallucinations, disorganized speech grossly disorganized or catatonic behavior, negative symptoms (i.e., diminished emotional expression or avolition) must each be present for a significant portion of time during a 1-month period (or less if successfully treated)
- At least one of the symptoms must be delusion, hallucination or disorganized speech
- Must have a significant impairment in functioning as well as continuous signs of the disturbance persist for at least 6 months
- This 6-month period must include at least 1 month of symptoms (or less if successfully treated).
- The disturbance must not be linked to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition

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THE DEFINITION OF STIGMA

- Stigma is strongly influenced by cultural and contextual value systems that changes over time and across contexts
- Stigma is defined as an undesired difference: a pejorative attribute that means intolerance, and when linked to mental health disorders results to fear of the unknown, exclusion, a set of false beliefs born from the lack of knowledge and understanding about mental disorders (Santos et al., 2016).
- When a person is disgraced, discredited and disapproved socially because they suffer from a mental illness, it is defined as mental health stigma (Subu et al., 2021).
- Goffman's identified the main components of stigma as marginalization, low self-esteem labeling, social isolation, ignorance, prejudice, stereotyping, rejection, status loss, low self-efficacy, and discrimination (Subu et al., 2021).
- Addressing stigma is fundamental to delivering quality healthcare and achieving optimal health

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THE FORMS IN WHICH STIGMA IS EXPRESSED

- There are different levels of mental health related stigma
- Self-stigma or internalized stigma; this happens when a person holds negative attitudes regarding own mental illness.
- Public stigma; this is when the general public hold negative attitudes towards a person with mental illness, and this is often based on misconceptions, fear, and prejudice.
- Professional stigma; this happens when healthcare professionals show stigmatizing attitudes toward their patients, or when the professionals themselves experience stigma from the public or other healthcare professionals because of their work and connection with stigmatized individuals
- People react negatively toward people with mental illnesses, labeling them as "dangerous, unfit and unpredictable" because they are not familiar with mental disorders which is what often leads to prejudice and stigma.
- Health care workers also react negatively towards people with mental health disorder due to fear, misunderstanding regarding the cause and symptoms of the disorders.

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THE PREVALENCE OF STIGMA FROM HEALTHCARE WORKERS

- Stigma toward patients with mental health illness is also highly prevalent among health care professionals not just the public (Grover et al., 2020).
- The manifestations of stigma from healthcare workers are widely documented in healthcare facilities, ranging from outright denial of care, provision of sub-standard care, physical and verbal abuse, to more subtle forms, such as making certain people wait longer or passing their care off to junior colleagues (Nyblade et al., 2019).
- A study was done among nurses with over 6 years' experience or more and it showed that nurses held negative attitudes towards patients with mental illnesses and often labeled them as criminals, dangerous, drug seeking and unfit (Grover et al., 2020).
- A study by Knaak et al., (2017) showed that 79% of patient with mental health illness reported first-hand experiences of discrimination and 53% of patient reported that they observed other medical providers, discriminating against a patient with mental illness.

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THE EFFECT OF STIGMATIZING ATTITUDES ON OUTCOMES

- Reluctant to seek help due to anticipated stigma from healthcare providers
- The relationship between patients and healthcare provider can be compromised when the care providers show stigmatizing attitudes.
- Patients may terminate their treatment early due to stigmatizing attitudes from health care providers
- Poorer physical care for persons with mental illnesses resulting to safety concerns

In conclusion stigma by nurses and other healthcare workers can lead to;

- Delays in help-seeking
- Provider and patient relationship problems
- Early discontinuation of treatment
- patient safety concerns, and poorer quality mental and physical care

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WHY EDUCATING NURSES IS IMPORTANT

- A study showed that many healthcare workers, including about 50% of staff nurses, still feel that mental health disorders automatically mean the patient is dangerous and unpredictable regardless of the mental illness (Riffel & Chen, 2019).
- The lack of education needed to care for individuals with mental illness shows a positive correlation with increased stigmatization by healthcare givers, especially nurses in different specialties (Ungar et al., 2016).
- Nurses spend a great amount of time with patients and have greater access to the patients compared to other members of the healthcare team. When the nurses have the adequate education and knowledge needed to care for these patients, they have the potential to confidently teach others, including the patients and their families (Fereidouni et al., 2019).
- Research has shown that educational interventions can significantly reduce this stigma by increasing knowledge, thereby improving nurses' attitudes towards mental illness and, subsequently, the quality of care or healthcare outcomes (Chang et al., 2017).
- The use of educational interventions has proven to be very effective in creating a more positive attitude as well as stigma reduction toward mentally ill patients by changing the stereotype beliefs among different folks of people, staff nurses, therapists, policymakers, media professionals, and patients and their families (Taghva et al., 2017).

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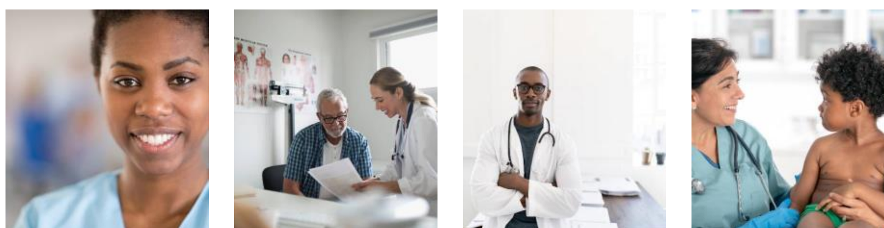

SUMMARY

- Nearly a quarter of adults in the United States have psychiatric disorders, and it has high comorbidity with chronic medical conditions.
- Stigma toward patients with mental health illness is also highly prevalent among health care professionals not just the public.
- Stigma towards patients with mental illness by nurses and other healthcare workers can lead to delays in help-seeking, affect provider and patient relationship, early discontinuation of treatment, patient safety concerns, and poorer quality mental and physical care.
- Addressing stigma is fundamental to delivering quality healthcare and achieving optimal health.

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THANK YOU

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