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Doctor of Nursing Practice

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Mental Health Education for Nurses Caring for Adults With Severe Mental Illness

A doctoral project submitted in partial satisfaction
of the requirements for the degree of
Doctor of Nursing Practice

by

Juliet O. Onyia

September 2023

Dedication

This DNP project is dedicated to my husband, Hon. Sir Patrick Onyia; children, Gracie, Anthony, Patrick Jr., and Christa Onyia; and parents and siblings for their love, encouragement, and unwavering support and for laying the foundation for my success.

Acknowledgments

To God Almighty, the giver of life, good health, and strength, thank you. I am grateful to my husband and children for their love, encouragement, and unwavering support. I thank my parents and siblings for their inspiration and for laying the foundation for my success.

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May God bless all of you.

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Abstract

The focus of this study was on mental health education for nurses who care for adults with severe mental illness. Severe mental illness is rising, and nurses cannot adequately provide quality patient-centered care to the population due to poor knowledge. In this study, the knowledge and perceptions of mental illness and care among registered nurses in the community was assessed before and immediately after a mental illness educational session. A non-experimental quantitative descriptive study was conducted using convenience sampling in a home health setting. Dorothea Orem's self-care theory was the theoretical framework that guided the project. Instruments included the Mental Health Problems Perception Questionnaire (MHPPQ), a pretest on mental illness, education on mental illness, and a posttest on mental illness. Nurses received the MHPPQ survey and a pretest to assess their baseline knowledge and perceptions of mental illness and care. A 1 hour educational session on severe mental illness and care followed the survey and pretest. The educational session aimed to increase participants' knowledge and competency in mental health care. After the educational intervention, the original nurse participants were administered the posttest. Forty-four registered nurse participants completed the MHPPQ, pre- and posttests. Data from the survey and tests were organized using Microsoft Excel and Intellectus Statistics and analyzed using frequencies and percentages in tables/crosstabs. A dependent *t* test was used to evaluate differences or statistical significance between the pretest and posttest administered to the same nurse participants to determine whether the training impacted care or produced change. The results showed that the nurses' knowledge improved following the education session. The intervention effectively improved nurses' knowledge and perceptions of caring for the adult population with mental illness.

Keywords: Adults, comorbidity, mental illness

Table of Contents

Acknowledgments.....	iii
Abstract.....	v
List of Tables	viii
List of Figures.....	ix
Chapter 1: Introduction.....	1
Overview of Problem Statement	2
Background	3
Purpose	7
Significance	8
Nature of the Project.....	9
Practice Guided Questions	10
Research Hypothesis	10
Definitions	11
Scope and Limitations	11
Chapter Summary.....	12
Chapter 2: Literature Review	13
Theoretical Framework	14
Advantages and Disadvantages	15
Literature Review	16
SMI and Comorbid Physical Conditions	16
Nursing Education on Severe Mental Illness	18
Findings	20
EBP Search Methodology	21
Chapter Summary.....	21
Chapter 3: Research Method.....	25
Project Design	25
Interprofessional Collaboration.....	26
Practice Setting.....	26
Target Population	27
Instruments/Measurement Tools for Data Collection	27
Analysis Plan/Management.....	29
Risks/Benefits/Protection of Human Subjects	30
IRB Approval and Process	30
Feasibility	31
Summary	31
Chapter 4: Results.....	32

Purpose of the Project.....	32
Demographics.....	33
Data Analysis	34
Descriptive Statistics for MHPPQ.....	34
Descriptive Statistics for Understanding Mental Illness Pre- and Posttests.....	37
Question Guiding the Inquiry	38
Statistical Test: Dependent <i>t</i> Test.....	39
Reliability and Validity	41
Strengths and Limitations.....	42
Interpretation and Inference of the Findings	43
Summary	44
Chapter 5: Discussion, Conclusion, and Recommendations	45
Implications of Analysis for Leaders	46
Essentials of Doctoral Education for Advanced Practice Nurses.....	50
Essential I: Scientific Underpinnings for Practice.....	50
Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking.....	52
Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice.....	53
Essential IV: Information Systems/Technology and Patient Care Technology for Improving and Transforming Health Care.....	53
Essential V: Health Care Policy for Advocacy in Health Care	54
Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes	55
Essential VII: Clinical Prevention and Population Health for Improving the Nation’s Health	55
Essential VIII: Advanced Nursing Practice.....	56
Recommendations	57
Conclusion.....	59
References.....	60
Appendix A: Mental Health Problems Perception Questionnaire	73
Appendix B: Pretest Document on Mental Illness.....	76
Appendix C: Posttest Document on Mental Illness	79
Appendix D: Measurement Tools Permission	82
Appendix E: IRB Approval Letter	85

List of Tables

Table 1. Frequency Table for Years RN and Years HH.....	34
Table 2. Frequency Table for Nominal Variables	35
Table 3. Number of Correct Pretest and Posttest Responses and Percent Change	38
Table 4. Two-Tailed Paired Samples <i>t</i> Test for the Difference Between Means.....	40

List of Figures

Figure 1. Dorothea Orem's Self-Care Model	14
Figure 2. Means of Pretest and Posttest With 95.00% CI Error Bars	40

Chapter 1: Introduction

Mental illness is a brain disorder affecting mind and body functioning; it brings much frustration and burdens the affected individuals, their family or caregivers, and society. The American Psychiatric Association (2018) described a mental disorder as a health condition involving emotion, thinking, or behavior changes. Mental health disorders are associated with distress and problems functioning in family, work, or social activities (American Psychiatric Association, 2018). Mental health organizations face increasing admission rates of the adult population with mental illness. The individuals present with associated medical conditions, drug and alcohol issues, homelessness, legal commitment, or incarceration that challenge care and treatment. Nonmental health organizations and settings have increasing rates of mental disorders occurring with physical conditions that challenge nurses and other providers. Most affected individuals and families are poor, without health insurance, have poor insight into mental health conditions, and lack adequate family and societal or government support. Health organizations and providers also lack the tools to handle the challenging population.

Mental disorders are the third most common disease worldwide (Daré et al., 2019). Twenty-five percent of the population have one or more mental health conditions during their lifetime (Daré et al., 2019). Baborik et al. (2017) noted that severe mental illnesses (SMIs), such as mood disorders and schizophrenia, weaken the ability of people to function effectively and are distressing for individual patients, their families, and society. Untreated mental health disorders account for 13% of the total global burden of disease (Mahato et al., 2018) and warrant enhanced education for healthcare staff to help ameliorate the burdens that occur from mental health disorders. A mental disorder is a risk factor for developing a chronic condition (Abdin et al., 2022). Chronic physical disorders from mental illness include metabolic syndrome. The

conditions that result from metabolic syndrome are the world's leading cause of death—36 million in 2008—and have been associated with an increased risk of suicide (Ahmedani et al., 2017; Daré et al., 2019). Comorbidity of mental and physical disorders is the presence of mental and physical disorders in the same person, regardless of the chronological order in which they occur (Abdin et al., 2022).

Comorbidity is the most critical challenge affecting healthcare organizations (Abdin et al., 2022). Sixty-eight percent of adults with a mental disorder have at least one medical condition, and 29% have a mental disorder (Nowels & VanderWielen, 2018). Comorbidity management requires a well-thought-out and intensive care plan that includes addressing individuals' mental and physical health and adequate education of clinicians and providers on person-centered holistic care to ensure high-quality care delivery (Abdin et al., 2022).

Overview of Problem Statement

The increasing admission and readmission rates due to ill-treated SMIs are a problem. The increasing rate of medical issues complicates SMIs and causes debilitating conditions and death. The lack of qualified and well-educated mental health providers is an ongoing issue. Nurses verbalize poor knowledge and skills and are uncomfortable caring for the group. Nursing tends to focus on mental health needs or medical needs, depending on the care settings.

Sprah et al. (2017) noted that the SMI patient group faces an increased risk of complications and death and a greater risk of poor care outcomes due to chronic health conditions (CHCs) such as heart disease. Arms et al. (2014) assessed individuals with mental disorders during admission and concluded that metabolic syndrome often affects this group. Leung et al. (2010) found that worsening conditions can lead to complications requiring intensive care, more resources, extended hospital stays, and increased costs. The worsening

physical conditions may also lead to expensive transfers to acute care medical facilities (Sprah et al., 2017).

The trends in rising readmission rates of less than one month, complications, and more extended inpatient care are prevalent in the severe mental illness (SMI) population and contribute to high healthcare costs and increased mortality. The SMI population has not received the holistic care it deserves, and finding ways to improve care quality is vital. Healthcare organizations are challenged and struggle to find solutions to improving care for the SMI population.

Background

Arms et al. (2014) suggested educating clinicians to create awareness of co-existing conditions, enhance care, and prevent adverse outcomes. The group added that clinicians could identify persons with a body mass index greater than 25, which indicates the risk level of complications of other health problems (Arms et al., 2014). Eboreime et al. (2022) found that people with psychiatric disorders have the highest early readmission rates (within 30 days) among all hospitalized patients globally. The factors affecting frequent hospital visits are ill-treated and unsolved mental health problems and a lack of mental health staff to address the treatment gap (Eboreime et al., 2022). Admissions frequency and co-occurring medical conditions cause significant acute complications that point to inadequate quality of care that calls for attention to staff education, treatment, and prevention (Leung et al., 2010). Heslin and Weiss (2015) also found that hospital readmission within 30 days of discharge is an unfavorable clinical outcome attributed to poor access to adequate community-based aftercare and challenges in psychiatric medication adherence and self-care that prevent disease flare-ups.

The poor quality of care associated with the SMI patient group also has economic, cultural, ethical, and legal implications. Mental healthcare spending has risen in recent years with minimal impact on disease outcomes. Average hospital costs were higher for readmissions of SMI patients than any other cause—between \$7,100 and \$7,200 compared with the initial stay cost of \$5,800 for SMI patients (Heslin & Weiss, 2015). According to Soni (2022), \$106.5 billion was spent on treating adults with SMIs in 2019. Specifically, \$88.4 billion was spent on adults with SMIs between 18 and 64 years of age while \$18.1 billion was spent for those 65 years and older. Of total costs, outpatient services accounted for 41.5% of spending and prescription medications accounted for 30% of funding. Emergency room care, hospital stays, home health, and other services made up the final 28.7% of spending (Soni, 2022). Despite existing reforms, the U.S. healthcare cost continues to rise, calling for more beneficial reforms (Coombs et al., 2021).

Disparities in access to mental health care have lingered and continue to be a challenge. McGuire and Miranda (2008) noted that cultural and ethnic minorities have less access to mental health services. Minority groups are less likely to receive needed care and are more likely to receive poor-quality care when treated (McGuire & Miranda, 2008). Healthcare access impacts an individual's overall health at all stages of life; it addresses people's ability to perceive, reach, pay, seek, and engage in services (Coombs et al., 2021). Adequate healthcare utilization allows for earlier detection and diagnosis of health problems and proactive treatment and results in positive effects on chronic illness and life expectancy.

Concerns regarding mental healthcare access also focus on determining how health systems, organizations, and healthcare providers respond to the needs of individuals, households, and their social and physical environment characteristics. Most healthcare systems and

organizations worldwide emphasize the need to minimize barriers to healthcare access, but the barriers exist within healthcare systems. One-fifth of the population with a mental health condition lacks a usual source of care, and more than half face barriers related to affordability of care (Coombs et al., 2021). The effect of poor access to medical care increases the rate of illness and death for the SMI population.

Legal and ethical issues surrounding mental health care pose challenges to clinicians who struggle daily to improve care. Bipeta (2019) highlighted that the rights to make treatment decisions that are granted to the SMI patient group must be clearly defined to ensure quality care. Ethics require providers to hold protected health information in confidence, and the patient should have the right to treatment decisions (autonomy). Providers face issues that impede providing appropriate treatment if their patients feel unsafe disclosing personal information or subjecting themselves to psychoactive medications or if they refuse medically necessary treatments for co-occurring physical conditions (Saleh & Malin, 2013).

Although exceptions exist that would allow a provider not to honor a patient's wishes (e.g., threats or physical harm to self or others, worsening medical complications), the practice guidelines and process prevent prompt treatments that may cause complications (Saleh & Malin, 2013). Organizations encounter challenges (i.e., delayed treatments) that lead to worsening conditions and fatalities. For example, an SMI patient who refuses stage one wound care is likely to progress to stage four wound care (i.e., bone involvement, osteomyelitis, and sepsis). This could lead to repeated and lengthy acute medical care stays, surgery (i.e., skin and bone graft), and other involvements and costs. Similarly, non-compliance of an SMI patient with blood sugar monitoring, insulin, and recommended diet may lead to multisystem complications that require

increased monitoring (i.e., blood pressure checks, medication, and diet restrictions) and increase the risk of cardiac arrest, kidney failure, or death.

Providers and clinicians may lack adequate knowledge of the laws governing the ethics of care for SMI patients. Such laws limit the autonomy, privacy, and rights of the SMI population to refuse treatment, especially those who have committed crimes. The law mandates SMI patients to agree to treatment, and providers face tough treatment decisions; however, providers must balance competing responsibilities—putting the patient’s interests first, alerting others of possible patient harm, and keeping everyone safe. Providers must know and perform their legal and moral duties to SMI patients (Blinkhorn, 2013).

Zetterberg et al. (2022) found that individuals with mental health conditions feel disrespected and neglected by nurses whom they believe pay more attention to medical needs than their mental health issues. Mahato et al. (2018) highlighted the importance of nurses' role in caring for people with SMIs and CHCs. They are poised to tackle the challenges associated with the group but need more skills and knowledge to do so. Nurses feel ill-equipped to provide mental health care, and healthcare organizations must provide them with the needed resources and tools to perform their duties as required (Zetterberg et al., 2022). Organizations must increase staff and providers' knowledge and perceptions of the SMI group including (a) addressing co-occurring conditions; (b) cultural, ethical, and legal issues; (c) bias; and (d) SMI stigmatization. Developing new policies or updating existing policies is urgently needed to accommodate routine training and education in the SMI areas.

Nurses' mental health care education, clinical supervision, and guidance are vital in primary care, community settings, hospitals, and long-term facilities (Mahato et al., 2018). Recruiting, educating, and continued support of nurses help overcome a knowledge deficit in

clinical practice and better perceptions and skills for managing those with SMIs (Mahato et al., 2018). Changing the practice process is needed for a positive effect, including resolving the issues that prevent nurses from translating theory into practice to achieve success (Dickens et al., 2019).

Purpose

The aim of this project was to explore current nursing knowledge and skills in caring for and managing adult patients with psychiatric illnesses and chronic medical problems in the community. The Mental Health Problem Perception Questionnaire (MHPPQ), a pre-mental health knowledge test, was a crucial screening step in evaluating nursing knowledge, perception, and skills for the purposes of this study. Although issues with insufficient nursing knowledge and skills in mental health care are outstanding factors that warrant investigation, other factors also contribute to the debilitating nature of the disease (De Hert et al., 2013).

- Due to multiple associated complications, adults with SMIs need in-depth clinical attention. The SMI group has high rates of multiple unidentified and untreated medical disorders.
- Racial and ethnic beliefs about mental illness also affect quality care. Many cultures erroneously believe that people with mental illnesses do not require Western medicine, cannot recover, or cannot live an everyday healthy life.
- Ethnic disparities (i.e., poor provision, care access, and utilization) impact care. Lack of equipment and funding for the care teams narrow the scope of care. Teams may limit their focus on mental issues or physical health rather than both, per the demands of limited funding, tools, and supplies of the care setting. (De Hert et al., 2013)

Significance

A goal of this study was to determine whether nursing knowledge and perceptions of people with SMIs affected care and treatment and produced positive outcomes. The results of this study informed the nursing profession on some of the most effective ways to care for individuals with SMIs. Results highlighted the importance of mental health education for nurses at the forefront of patient care. With education, SMI care and quality of life improve, which benefits the patient population, providers, and the organization.

Education on mental illness and care can improve the knowledge and perceptions of providers in managing and caring for the SMI group. It is imperative to incorporate nursing and interdisciplinary education in the practice setting as educational programs and organizational policies can cause a change in care. Increased knowledge enhances quality patient-centered care that allows improved care and reduces complications and mortality rates. There are also financial benefits to healthcare organizations in the form of high-cost reductions in readmission rates and extended hospital stays. Further, society is safer with adequate SMI care—ensuring reduced suicide and homicide rates and cases of the SMI group. Nurses and organizations must recognize the need for widespread education on SMIs in multiple settings, embrace it, and incorporate it into their processes. Being proactive and timely with treatment is crucial.

The success of implementing safe care practices and environments requires evidence-based strategies that address the complexity of healthcare systems, individual practitioners, senior leadership, and changing healthcare (Titler, 2008). Standardizing care practices rather than following organizations' and individual practitioners' opinions is a priority and helps to improve access. Success in implementing education can affect a cultural change—the knowledge and information baggage applied for years is one of the most significant obstacles and deep-rooted

resistance to change in mental health service and needs updating. The multidisciplinary care team (not nurses alone) must learn new skills and acquire all the strategies and tools that allow similar performance levels (Vita & Barlati, 2019). Using multiple knowledge dissemination channels raises awareness of SMI care improvement outcomes and may change the negative attitudes of clinicians who have doubts (Kristensen et al., 2016).

Nature of the Project

This project was conducted at a home health agency in Texas during a monthly in-service meeting of the primary care nurses. It aimed to determine whether nursing knowledge and perceptions of SMIs affect care and treatment and produce positive care outcomes. The aim of the project was to evaluate nursing knowledge and perceptions in providing nursing care and treating adult psychiatric patients with CHCs in the community. A questionnaire (Appendix A), pretest (Appendix B), education, and posteducation test (Appendix C) were suitable for assessing nursing knowledge and perceptions. The MHPPQ (Chorwe, 2013; Lauder, 2001) was provided to the nurses after obtaining informed written consent. The pre-assessment, the education, and the posttest phase followed. The nurses received education to increase their knowledge and competency in mental health care. After educating them, a posttest was administered among the original participants. Scores were compared to assess the degree of improvement posteducation (Bennett, 2012).

Data were compiled on Excel spreadsheets and uploaded on the Intellectus Statistics application for analysis. Descriptive statistics and crosstabs tables were used to analyze the data. A paired *t* test evaluated the differences or statistical significance between the pretest and posttest to determine if education impacted care or produced some change (Bennett, 2012).

Practice Guided Questions

Utilizing the format in Melnyk and Fineout-Overholt (2015), the PICOT question was: Does mental health education affect nursing knowledge and perceptions of SMI care? The description of each component to be examined was:

- **problem and population:** Nurses working in primary care comprised the target population. (Does education affect nursing knowledge and perceptions in caring for adults with SMIs and CHCs?)
- **intervention:** This impact of education on nurses' perceptions of mental health was the intervention under study. (Among the primary care nurses, what are the effects of education on nursing knowledge and perceptions of mental health? Does education change nursing perceptions of mental health care?)
- **comparison:** Knowledge and perceptions of nurses were compared before and after the educational intervention.
- **outcome:** With adequate nursing education, there was improved nursing knowledge and perceptions of mental health. (Does nursing education improve nursing knowledge and mental health perceptions?)
- **time:** After education was the period of interest.

Research Hypothesis

H₀: Mental health education will not affect nursing knowledge and perceptions of SMI care.

H_A: Mental health education will affect nursing knowledge of treatment and perceptions of SMI care.

Definitions

Several operational definitions in the project development support the purpose and intent of the study. Below are the chosen definitions that apply to this project:

Adult. An individual who has reached the age of majority as defined by law, accompanied by the rights and responsibilities of adulthood. The age of the majority varies from state to state and country to country. Most states in the United States and other countries have set the age at 18. Nebraska (19), Alabama (21), and Mississippi (21) are notable exceptions (Legal Information Institute, 2021).

Comorbidity. The presence of two or more mental and physical disorders in the same person, regardless of the chronological order in which they occurred (Abdin et al., 2022).

Mental illness. A condition that affects a person's thinking, feeling, behavior, or mood. These conditions profoundly impact day-to-day living and relating to others. They include depression, psychosis, schizoaffective disorder (schizophrenia, mood disorders), and anxiety (National Alliance on Mental Illness, 2022).

Scope and Limitations

Primary care nurses in a home health agency participated in the study. The nurses work in the community and lack specialized education on caring for patients with SMIs. The nurses probably had SMI insight during their general studies in nursing school. They provide care to adults with CHCs who also have SMIs. Nursing students, doctors, mental health aid, or certified nurse aides were excluded from the study. Nurse participants were adults; consent was obtained from those who voluntarily agreed to participate in the study.

Nurses completed the MHPPQ and pre-mental health test before receiving the mental health education, followed by a posttest. The survey questions and pre- and postmental health

education tests were obtained from nurses and the data were analyzed. The MHPPQ has a knowledge and skills scale ideal for collecting nurses' data. Researchers used it to assess knowledge and perceptions of SMIs and found it to be easy to use and reliable. The MHPPQ had an alpha coefficient for the knowledge and skills scale of 0.85 (Chorwe-Sungani, 2013; Lauder et al., 2000).

Limitations of the study include use of the MHPPQ, since questionnaire-based studies are subject to bias and a short study period. The survey questionnaire answers were based on personal opinions and may not reflect or represent the study's outcome. The questions need to be more detailed, and the answer format does not allow for a detailed expression of feelings. Limitations of the study also include the selection of participants, which was based on convenience sampling (Rajan et al., 2014). Further, the study period was short and did not allow the nurses adequate time for personal reflection and assessment.

Chapter Summary

Adults with severe mental disorders have been widely reported to have increased risks of morbidity and mortality due to physical disorders (Sprah et al., 2017). A severe and persistent mental illness can result in patients losing up to 4 years of life (Sprah et al., 2017). Nurses meet people with various needs during their careers, including adults needing mental health care (Chorwe-Sungani, 2013). Nurses lack adequate knowledge and skills to care for people's mental and physical health problems (Chorwe-Sungani, 2013). Nursing education is essential to improve perceptions of SMIs, quality of care, and decrease disparities in care for those with mental health disorders. Education in mental health promotes knowledge and recognition of one's perceptions of mental health. It builds confidence and commitment in nurses to care for those with mental health problems in all settings (Chorwe-Sungani, 2013).

Chapter 2: Literature Review

In this chapter, the theoretical framework and pieces of literature that supported the study are presented. Dorothea Orem's self-care deficit nursing theory was selected, focusing on people as whole entities who engage with their environment to sustain health (Wazni & Gifford, 2017). The framework consists of three interrelated mid-range theories: (a) self-care, (b) self-care deficit, and (c) nursing systems (Burdette, 2010). The framework guides and organizes nursing practice, and it is a valuable framework for nurses in addressing the physical and mental health needs of adults with SMIs (Wazni & Gifford, 2017).

The reviewed literature guided the research project and answered the PICOT question: Does mental health education affect the nursing knowledge and perceptions of SMI care? Adults with SMIs have a higher risk of developing comorbid CHCs. The patient group also receives poor-quality care that exposes them to worsening complications of chronic illnesses. Increased readmission rates, acute medical facility transfers, extended inpatient admissions, increasing treatment costs, and death are some effects of disease complications (Alexander et al., 2016).

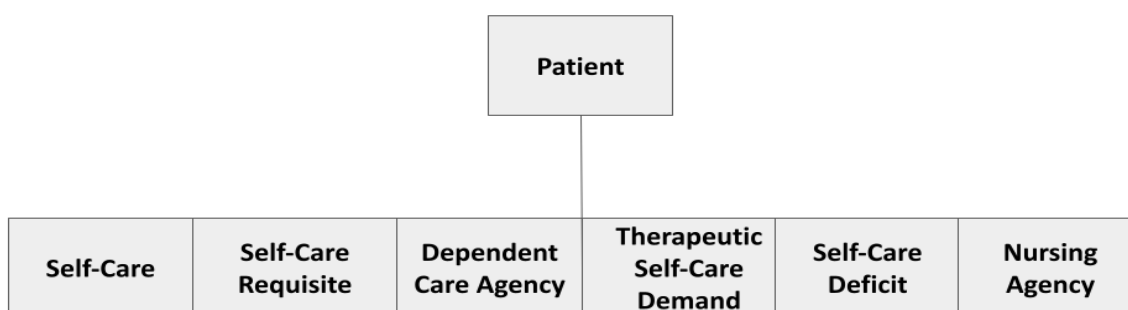
Primary care nurses in multiple settings in the community - home health, medical-surgical, and outpatient or ambulatory care often need more knowledge, skills, and attitudes to provide patient-centered holistic care to the group (Alexander et al., 2016). Poor nursing literacy concerns the nursing profession, patients, and healthcare organizations. Addressing the issues with adequate mental health education is a step in the positive direction for the patient population. Improved nurses' awareness of SMIs is a priority and raises the care standard that nursing must need to close the treatment gaps and reach favorable outcomes (Alexander et al., 2016).

Theoretical Framework

Dorothy Orem's self-care model is ideal in clinical settings to guide the best care of adults with a SMI and CHC (Irshad Ali, 2018; Seed & Torkelson, 2012). The theory aligns with recovery principles and patients' self-care abilities and explains how nurses can intervene and help patients recover and improve autonomy and independence (Irshad Ali, 2018; Seed & Torkelson, 2012). Figure 1 illustrates the six model concepts: self-care, self-care requisite, dependent-care agency, therapeutic self-care demand, self-care deficit, and nursing agency (Seed & Torkelson, 2012).

Figure 1

Dorothea Orem's Self-Care Model



The self-care model focuses on the nurses' efforts to assess patients' needs, educate and support patients, families, and caregivers to improve individuals' self-care and maintain optimal health in chronic disease management (Afrasiabifar et al., 2016).

- **self-care:** focuses on the nurse's effort to ensure patients (primary agents) develop self-care skills to improve mental and overall care (Seed & Torkelson, 2012). It involves therapeutic relationships and training on disease processes (Seed & Torkelson, 2012).

- **self-care requisite:** centers on the nursing assessment of basic needs and any barriers to successful self-management and provides training (Seed & Torkelson, 2012).
- **dependent care agency:** deals with the nursing assessment of the patients' skills that enable self-care daily routines, the degree of needed care, and the available caregivers, including family members (Seed & Torkelson, 2012).
- **therapeutic self-care demand:** highlights nurses' efforts to provide adequate knowledge of the functioning of the mind and body (Seed & Torkelson, 2012).
- **self-care deficit:** specifies nursing care related to a patient's illness and the failure of the family to perform tasks due to poor insight (Seed & Torkelson, 2012).
- **nursing system or agency** - focuses on how the nurse, the patient, or both will meet the patient's self-care needs. (Seed & Torkelson, 2012). Nurses need adequate knowledge and skills to provide a supportive education to patients, families, other nurses, and staff (Burdette, 2010).

Nurses must understand the relationship between self-care needs, adults with SMIs, and CHCs and identify strategies to improve the quality of life. Understanding the relationship is necessary for providing quality care to the people (Seed & Torkelson, 2012).

Advantages and Disadvantages

According to Afrasiabifar et al. (2016), self-care is essential in the medical and health services system. The self-care theory is ideal for improving self-care skills in individuals with chronic diseases - easy to learn, lacks complications, and is noninvasive. It can be applied in managing a wide range of CHCs and has improved self-efficacy in long-term care (Afrasiabifar et al., 2016). Researchers and providers agree that it helps mitigate disease complications and treatment costs (Afrasiabifar et al., 2016). The debilitating nature of SMIs and CHCs make

improving self-care an uphill problem. Afrasiabifar et al. (2016) stressed that nurses must continue to provide education and support to enhance self-care agency skills. Patients must be encouraged to self-care as the care receiver (Afrasiabifar et al., 2016). Nurses must improve caregivers' skills when patients cannot perform self-care activities (Afrasiabifar et al., 2016).

Literature Review

SIMs are on the rise worldwide in adults 18 years and older. The disorders carry a lot of debilitating conditions that affect society. Nursing care has failed to reach the expected standard to help with the growing disease complications. Research suggests a vital and urgent need to close the gap in care.

SMI and Comorbid Physical Conditions

Goldman et al. (2020) conducted a quantitative study to establish the prevalence of comorbid medical conditions in people with mental disorders. The authors linked Medicaid claims records and clinician data with hospital and regional data for individuals 18 to 64 years with a primary diagnosis of any mental disorder admitted to psychiatric inpatient units. The authors calculated a modified Elixhauser comorbidity index score for each unique individual ($n = 14,458$). They also calculated adjusted odds ratios of having medical comorbidity using logistic regression analyses. Goldman et al. found 74.9% of SIMs had a CHC, including 57.5% of people ages 18–24. Higher rates of CHCs are associated with older age and the female gender. SIMs had lower adjusted odds ratios (0.54) with 99% CI (0.35–0.83) of being treated in hospitals (Goldman et al., 2020). The researchers concluded that CHCs are high in the SIM population and suggested adequate detection and treatment and further research on screening protocols and follow-up methods (Goldman et al., 2020).

Park et al. (2021) identified 26 physical illnesses that presented differently in men and women and types of mental disorders in adults 19 and older with SMIs. The group conducted a qualitative study determining the prevalence of physical comorbidities and their differences in diagnoses and sex among psychiatric inpatients. Park et al. used the NHI claims data and collected data from 48,902 adult inpatients hospitalized for at least 2 days, applying the Elixhauser comorbidity measure. Park et al. identified 26 physical illnesses that presented differently in men and women and types of mental disorders. The researchers recommended systemic SMI training (Park et al., 2021).

Kusljic et al. (2020) found that adults with SMIs and CHCs have poorer quality of life and functioning. Of those diagnosed with SMIs, 64.3% had one or more CHCs, primarily cardiovascular conditions ($p < .001$), 40% experienced chronic pain ($p = .003$), and 47.6% had obesity ($p = .005$). Kusljic et al. conducted a quantitative study to determine whether the quality of life and functioning was poorer for individuals with physical comorbidity. The study design was a correlational descriptive design. Seventy participants completed the SF-36 survey, and the corresponding hospital records were audited. Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) guidelines were used in reporting this research. Using clinical guidelines, nursing involvement, and integrated SMI/CHC programs were techniques found to benefit patients (Kusljic et al., 2020).

The literature revealed that people with a SMI have higher rates of one or more physical comorbidities than the general population and require attention (Goldman et al., 2020; Kusljic et al., 2020; Park et al., 2021). Researchers agreed that interventions or programs addressing risk factors for CHC are vital (Kusljic et al., 2020). Clinicians must adopt a holistic approach to care and facilitate effective interventions to prevent and manage physical comorbidities (Kusljic et al.,

2020; Park et al., 2021). Organizational policies addressing screening, monitoring, and treating CHCs in a comprehensive, coordinated approach for the population are essential. Nursing must also coordinate the outlined care plan and activities (Kusljic et al., 2020).

Nursing Education on Severe Mental Illness

Mroueh et al. (2021) addressed the research question: Can a brief education intervention on schizophrenia and depression improve primary healthcare workers' knowledge, attitudes, and practices, using a quasi-experimental design study to evaluate brief educational effects on providers' knowledge, attitudes, and practices on caring for patients with SMIs? A total of 364 nurses and 570 primary care doctors engaged in 1-day, face-to-face, interactive education workshops, surveys, and pre- and posttests. The Wilcoxon paired test was used to compare the mean of pre- and posteducation scores of the providers.

Mroueh et al. (2021) found brief education compelling in improving knowledge, attitudes, and skills to care for patients with SMIs. Schizophrenia pre- and posteducation were 52.7% to 89.7% for nurses and 47.3% to 83.2% for PCPs. The depression mean scores were 29.3% to 74.8% for nurses and 39.7% to 78.7% for PCPs. Mean scores increased significantly ($p < .001$) for the provider groups (Mroueh et al., 2021).

Ayano et al. (2017) found that engaging in mental health education affects knowledge, attitudes, and practices (KAP). The researchers used a quasi-experimental, single-group pre- and poststudy design and quantitative data collection method. The study involved 94 primary healthcare professionals comprised of 50 nurses, and 44 health officers. A standardized WHO Mental Health Gap Action Programme (mhGAP) guide for scaling mental health care through integration into primary health care was used (Ayano et al., 2017). Researchers performed a paired sample t test with p values for differences in pre- and posttest. Providers' KAP improved

significantly from 34.04% to 87.23%; $p < .05$. (Ayano et al., 2017). Ayano et al. recommended education to enhance primary care professionals' knowledge, attitude, and practice.

A similar study by Sawadogo et al. (2019) assessed KAP in mental health among primary healthcare students' posteducation curriculum. They used random sampling, an observational, descriptive, and cross-sectional study to assess the KAP of students' posteducation curriculum. Questionnaires were given to 420 students. Data were analyzed using StatView version 5.0 software; graphical representations were developed using Microsoft Excel 2010 and STATVIEW 5.0 software, and an ANOVA test for comparing KAP in the mental health of the students' groups (Sawadogo et al., 2019). Thirty-six percent of nursing students had insufficient knowledge of mental health, and 91% and 71% of medical and pharmacy students were due to more mental health education incorporated into the different curricula (Sawadogo et al., 2019).

Mulango et al. (2018) used an observational cross-sectional study, consecutive convenience sampling, and a structured Depression Attitude Questionnaire for KAP. Of the 226 primary providers engaged in the study, 92.9% knew SMIs required intervention, and 66% were uncomfortable caring for the group (Mulango et al., 2018). The authors highlighted limited knowledge and poor attitudes regarding depression and the need for urgent education (Mulango et al., 2018).

Mulango et al. (2018) agreed that mental health education is essential for the challenging issues of treating SMIs and CHCs. Mulango et al. stressed limited understanding and poor attitudes regarding SMIs and the need for urgent education of primary care workers in mental health in general and depression diagnosis and management. Sawadogo et al. (2019) pointed out that nurses play essential roles in identifying and managing people with mental disorders yet have little knowledge about mental illnesses, which needs addressing with an adequate

education. Mroueh et al. (2021) agreed with the two groups of researchers that mental health education for providers remains lagging, globally affecting their attitude, knowledge, perceptions, and practice toward SMI care.

Research indicates that treatment disparity continues to be a big issue in mental health. Mental health education interventions for primary healthcare workers can improve mental health services and diagnose and manage mental disorders (Ayano et al., 2017; Sawadogo et al., 2019). Providing mental health education to primary care professionals to strengthen their assessment skills and improve their knowledge seems beneficial (Park et al., 2021).

Findings

Prior research has provided valuable data and implications for practice that may assist clinicians in understanding better and providing care for patients who experience physical comorbidity (Kusljic et al., 2020). Organizations must continue to assess health-related quality of life (HRQoL) alongside prevalence data in mental health populations and follow up on the impact of worsening physical health (Kusljic et al., 2020). Other studies highlighted the need for hospitals and organizations to offer systematic education for mental health professionals to provide information on physical comorbidity status and strengthen assessment skills for physical diseases in people with mental illnesses (Park et al., 2021).

Research suggests clinicians must develop assessment skills for physical health problems and refer to the appropriate specialists to prevent and manage high-risk physical problems (Park et al., 2021). Further research is needed to examine and address how clinicians recognize medical conditions during psychiatric admissions and specific protocols for screening and follow-up that clinicians can implement in these settings (Goldman et al., 2020).

EBP Search Methodology

In this literature review, I utilized studies from multiple authors. I used Google Scholar and the Abilene Christian University (ACU) library one search (academic search complete, DOAJ, EBSCO online, PubMed Science Direct) as the search engines for full text and peer-reviewed articles. ACU's search engine yielded 10,496 articles published between 2000 and 2021, which I narrowed to 154. The keywords searched were *adult, inpatients, nurses, community, psychiatric care, medical comorbidity, and admissions*. I used Google Scholar to locate scholarly articles published between 1990 and 2022. Overall, the articles used in the literature review were published between 1990 and 2022. Further, the review included studies conducted in the United States and worldwide.

Chapter Summary

Caring for adults with SMIs challenges nursing due to the complex issues and symptoms that can be acute, in remission, and sometimes flare up (Underwood & Meuser, 1990). The adults present hallucinations, delusions, isolation, poor interpersonal relations, lack of motivation, low self-esteem, and dependency (Underwood & Meuser, 1990). SMIs result in impairment, disability, and handicap (Underwood & Meuser, 1990). People with SMIs are usually handicapped in education jobs or housing, and handicaps focus on social rehabilitation (Underwood & Meuser, 1990). Adults with SMIs succumb to worsened conditions and death related to poor physical health and need a holistic and comprehensive nursing approach (Wazni & Gifford, 2017). An individual may depend on the caregiver, and the nurse plays a significant role in the care and provides essential support (Irshad Ali, 2018).

The study was designed to evaluate nurses' knowledge and perceptions of SMI care. Nursing education on mental illness was expected to improve knowledge and perceptions of

managing and caring for the group. The results may lead to improved quality of life for individuals with SMIs, and a reduction in mortality rates. There are also financial implications that could benefit healthcare organizations in the form of high-cost reductions in readmission rates and extended hospital stays. There is no doubt that Addressing the needs of adults with SMIs and CHCs is complex, and the COVID-19 pandemic did not improve the issues associated with the group. U.S. adults experienced intense mental health conditions associated with COVID-19, worsening morbidity, and mortality. Younger adults, racial and ethnic minorities, essential workers, and unpaid adult caregivers reported experiencing disproportionately worse mental health outcomes, increased substance use, and elevated suicidal ideation (Czeisler et al., 2020). The reported issues warrant effective prevention, recovery, and cures, and educating providers crucial based on a combination of findings.

Cost-effectiveness, safety, appropriateness, and effective methods impact the study. A quantitative descriptive study is the most appropriate for the study. A survey questionnaire, pretest on mental health knowledge, education, and posteducation test are easy to administer to nurse participants in the community. The methods are safe and cost nothing financially to the participants and the study organization; it is expected to provide new knowledge. The weaknesses include issues with the questionnaire - bias, and a short study period. The MHPPQ answers are based on personal opinions and may not reflect the actual study outcome. The questions need to be more detailed, and the answer format does not allow for a detailed expression of feelings. The study was based on convenience sampling, and the study period is short and will not allow the nurses adequate time for personal reflection and assessment.

The components of Orem's theory were necessary for organizing the discussion of the articles in the literature search. The patient group needs motivation, experience, and skills for

self-care activities that promote healing and maintain quality of life (Khademian et al., 2020).

The circumstances warrant reframing the current treatment approach towards a more evidence-based integrative model, which may better address the real-world challenges of psychiatric disorders and comorbid physical conditions. Nursing is tasked with providing support and education based on the assessment of the needs of patients and families (Vasquez, 1992).

Nursing focuses on continued therapeutic care to meet self-care components to sustain health and recover from illness (Seed & Torkelson, 2012).

Overall, the literature review provided essential information and knowledge on the status of physical comorbidities among psychiatric patients, supporting the project and answering the PICOT. Providing quality care to meet the needs of the patient group has been a challenge for nursing, and worsening medical conditions can lead to complications requiring intensive care, more resources, a more extended stay, and expensive transfers to medical facilities. The literature revealed a significant connection between people with SMIs, comorbidities, and poor care outcomes. It highlighted the strengths of the studies.

Two studies analyzed physical comorbidities among SMIs and provided important information on clinical problems and care (Goldman et al., 2020; Park et al., 2021). The authors revealed clinical approaches that may guide care in patients with SMIs and CHCs, including a service-wide policy that provides clinical guidelines for screening and preventive care, including referral to the appropriate specialists to prevent and manage high-risk physical comorbidities. Educating mental health professionals on physical comorbidity to strengthen their assessment skills seems beneficial (Goldman et al., 2020; Kusljic et al., 2020; Park et al., 2021). Between 76% and 85% of people with low to mid incomes and 35%–50% of individuals with high-income who have severe mental disorders worldwide receive little to no mental health treatment

(Mroueh et al., 2021; Sawadogo et al., 2019). The treatment gap in mental health affects care as fewer people receive quality care (Ayano et al., 2017). Primary care nurses are at the forefront of managing SMI care and have insufficient knowledge and perceptions. The situation calls for the urgent and proper education of primary care health professionals, mandatory for optimal performance and success of integration (Ayano et al., 2017; Mulango et al., 2018; Sawadogo et al., 2019).

Chapter 3: Research Method

In this scholarly project, nursing knowledge and perceptions in caring for adults with SMIs and CHCs were assessed. Clinicians can overlook comorbid conditions such as heart disease when co-occurring with an SMI. Exacerbating medical conditions can lead to expensive transfers to acute medical facilities, a more extended hospital stay, intensive care, more resources, increased cost, and high mortality (Goldman et al., 2020; Rodrigues-Silva & Ribeiro, 2020). Nursing education can improve knowledge and perceptions of SMI and CHC care. Study participants were primary care nurses in the community. In this project, I explored the current state of knowledge and perceptions of nursing management of the SMI population, which can guide care. Providing holistic and patient-centered care may decrease poor care outcomes. The ACU Institutional Review Board (IRB) required prior approval for the study (see Appendix E).

Project Design

In this scholarly study, nursing knowledge and perceptions in caring for adults with severe mental disorders and physical comorbidities were assessed. A non-experimental quantitative descriptive survey was appropriate for the research to answer the question: Does mental health education affect nursing knowledge and perceptions of SMI care? The ACU IRB provided approval. Home health agency nurses with primary nursing experience participated voluntarily in the study. Nonnursing staff did not participate.

The MHPPQ (Chorwe-Sungani, 2013; Lauder et al., 2000), a measurement tool for evaluating nursing knowledge, was essential in assessing and evaluating the process. The questionnaire, pretest on mental health knowledge, education, and posteducational test were suitable for determining nursing knowledge and skills. The nurses received education to increase their knowledge and competency in mental health care. After educating them, a posttest using

similar questions was administered among the original participants. Scores were compared to assess the degree of improvement using percentages crosstabs. The dependent two-tailed *t* tests analyzed the data collected from primary care nurses at a home health agency. The survey participants had no in-depth knowledge of mental health care, and the nurses participated voluntarily.

Interprofessional Collaboration

Abilene Christian University, the administrators at the project site (stakeholders), and I worked together for the project's success. The DNP project chair, committee member, the DNP program director, the IRB committee, and ACU instructors were the ACU collaboration team members. I was a registered nurse case manager at the study agency and spearheaded the project. The chief nurse executive and the administrators at the study site approved the study and affirmed their support during the process. The study participants and some administrative staff who helped with the site setup are among the stakeholders.

Practice Setting

The project setting was a home health agency office in the central Texas metropolitan area. I practiced at the site for 6 years as a registered nurse case manager and field supervisor. The agency was suitable for the study considering the participants' characteristics—nurses with predominantly primary care experience and limited knowledge of mental health care. Nurses often deal with individuals with severe mental disorders and medical conditions. I discussed the project's nature and obtained informed written consent voluntarily during a monthly in-service to those who qualified before administering the questionnaire, pretest, education, and posttest. The primary inclusion criterion was being a registered nurse with limited mental healthcare experience.

Target Population

In this study, nursing knowledge and perceptions of the target population (adults with SMIs and CHCs) were assessed. I used a convenience sampling method to recruit primary care nurses with minimal mental health care experience for the study. The nurses worked in the community and lacked specialized education on SMIs. The nurses probably had SMI insight during their general studies in nursing school. They provided care to adults with CHCs who also had SMIs. Nurse participants were adults, and their participation and consent for the study was by choice. Nursing students, doctors, mental health aid, or certified nurse aides were excluded from the study. A dependent *t* test was used to determine whether there was a statistical difference in nursing knowledge and perceptions of SMIs before and after the intervention.

Instruments/Measurement Tools for Data Collection

Assessing the nursing knowledge and skill in caring for people with mental illnesses and comorbid physical conditions was the aim of the study, which required appropriate evaluation tools to first assess nursing prior knowledge and skills in providing mental health care. The study design was quantitative, and I used a convenience sampling method. Convenience sampling is a nonrandom method of including subjects or study participants based on their availability, easy access, or willingness to participate (Etikan et al., 2016). The advantages of convenience samples are that they are inexpensive, easily accessible, and include readily available participants (Etikan et al., 2016). The disadvantages includes severe hidden biases and poor credibility due to potential outliers (Etikan et al., 2016).

In this study, I collected data using the knowledge and skills scale of the MHPPQ developed in Scotland and the Western Isles. The MHPPQ reports an alpha coefficient for the knowledge and skills scale of 0.85 as its reliability (Chorwe-Sungani, 2013; Lauder et al., 2000).

The questionnaire, a pretest, education on mental illness and care, and a posttest were suitable for this project and were provided to the nurses at a home health agency in Texas. The MHPPQ was initially developed by Professor William Lauder and his colleagues (Lauder et al., 2000) and was later adapted by Genesis Chorwe-Sungai, Ph.D. (2013). The adapted and modified version was used for the study with permission from Professor Genesis Chorwe-Sungani (see Appendix D). The tool has been validated and used in multiple studies. It can be administered without cost, and it is available in English. The pretest, educational material, and posttest were adapted resources from the online continuing education course, “Understanding Mental Illness for All Healthcare Professionals” (Swan, 2020). Permission to use the resources was obtained (see Appendix D).

The MHPPQ is a 2-point Likert scale with 12 questions developed to measure the therapeutic commitment, role support, and role competency of non-mental health specialist nurses caring for patients with mental health problems. The instrument was demonstrated to be valid and reliable in this population. The questionnaire was underpinned by an explicit theoretical model, which facilitates understanding the factors influencing effective psychosocial nursing interventions with this client group (Chorwe-Sungani, 2013; Lauder et al., 2000).

The pre- and posttests had 10 similar, multiple-choice questions with four answers. The questions relate to the information on the PPT training material. The education material was a PowerPoint slide that described mental illness, its prevalence, type, and cause of treatment and management. The PPT slides also described effective strategies to respond to patients with different conditions, challenges to care, a summary, and a reference page. The course material has been approved as a continuing education (CEU) course for nurses and accredited nationwide by the American Nurses Credentialing Center, accepted by all U.S. nursing boards. Some healthcare disciplines widely use it for continuing education (Swan, 2020).

Analysis Plan/Management

The nursing population represented the sample. The technique for collecting and managing data required no patient contact and no consent. Patient identifiers were not used. None of the participants was linked directly to patients' names, contact information, or identifiers. Permission from the data site facility was granted, and a letter of support was obtained. A dependent *t* test evaluated the differences or statistical significance between the pretest and posttest administered to the same nurse participants to determine if the training impacted care or produced some change (Bennett, 2012).

The power analysis method determined the minimum study sample size of 42. Power analysis is a statistical measurement that provides accurate information about sample size. A power analysis was done using the G-power app from <http://www.gpower.hhu.de/> (Faul et al., 2007, 2009). Brysbaert (2019) advised that two standardized numbers, $p < .05$ for the traditional, repeated analysis and $BF > 10$ for Bayesian analysis, help determine and justify the sample size of a study.

The MHPPQ was provided to nurses during a monthly in-service at the research facility after obtaining voluntary consent from the participating nurses. After the questionnaire, a pretest was provided, followed by a 1 hr education and a posttest. Data were analyzed using the MHPPQ pre- and posttest responses. The data were compiled on Excel Spreadsheets and uploaded on the Intellectus Statistics application for analysis. Intellectus Statistics for statistical data analyses was suitable for analyzing the study data using descriptive statistics, including frequencies and percentages in tables (crosstabs).

Risks/Benefits/Protection of Human Subjects

There were potential physical and psychological risks to the participant. Physical risks fell under noise, heat, or cold from the office environment or surroundings that might cause discomfort or pain to the participants. The psychological risk might be anxiety, stress due to the SMI concept being discussed, and boredom from participation (Office of the Vice President for Research and Innovation, n.d.).

There were no anticipated participation risks or benefits. There was no direct contact with the patients; nurses did not receive any monetary compensation and no anticipated risks. Nurses participated voluntarily and provided informed consent. There was no punishment for the nurses who opted to stay out and not participate in the study. The nurses were free to step aside anytime during the investigation. I maintained the participants' privacy and personal information. There were no conflicts of interest in the project implementation. Results of the study informed the nursing profession on the most effective ways to care for SIM. It highlighted the importance of mental health education for nurses at the forefront of patient care.

IRB Approval and Process

According to ACU resources, the IRB is a governing body for researchers to protect human subjects used in any research. DNP students must get approval before conducting research. Research involving human participants must abide by federal regulations protecting human subjects. ACU's Office of Research and Sponsored Programs requires two pieces of training and certificates of completion for submission of IRB applications. The two required training modules are Social-Behavioral-Educational Basic training and Responsible Conduct of Research Basic training. I completed the courses and submitted the certificates to the ACU faculty.

Feasibility

The study was conducted at a home health agency where I practiced for six years. I explained and obtained informed consent, administered the questionnaire, and analyzed the data. There was no cost for the MHPPQ, pre- and posttest materials. I covered the costs of developing the project, such as paper and printing services. Scheduling was coordinated with the research facility before the study date. The agency directors and administrators were the support personnel. Mercy, the CNO/administrator, has provided a formal letter of support.

Summary

Assessment of nursing education outcomes is essential in caring for adults with SMIs and physical comorbidities. Improved nursing knowledge and skill will affect patient care and outcomes noted by reduced readmission rates or patient days. Pre and posttest questionnaires, a *t* test, and Intellectus Statistics applications were appropriate for assessing the participants. There was no direct contact with the patients; nurse participants did not receive any monetary compensation and no anticipated risks. Findings obtained from the study provided new knowledge about the incidence and study outcomes. The IRB required prior approval from ACU. The process started, and the project chair was selected. The project timeline was from June 2021 to October 2023.

Chapter 4: Results

The study design was a non-experimental quantitative descriptive study, which was conducted at a home health agency using convenience sampling, no control group, and no randomly selected study participants. I assessed the effect of mental health education on nurses caring for adults with SMIs. The study participants were 44 registered nurses working in the community who lacked specialized education on SMIs.

I utilized the MHPPQ, a questionnaire for assessing baseline knowledge, skills, and perceptions of mental illness and care and understanding mental illness pre- and posttests (Chorwe-Sungani, 2013; Lauder et al., 2000). The intervention was an educational session designed to improve understanding of mental illness. The research hypothesis was that nursing education on mental illness and care will improve knowledge of treatment and perceptions of the patient group and promote quality care.

I administered pre- and posttests to collect data from the same participants, which were compared to help test the research hypothesis. A dependent *t* test (paired sample *t* test) was the suitable data analysis method using Intellectus Statistics software applications. A paired sample *t* test evaluated the differences or statistical significance between the pretest and posttest and determined that education produced some change.

Purpose of the Project

For this research, I explored the current knowledge and skills of nurses caring for and managing adult patients with SMIs. I assessed nurses' knowledge, skills, and perceptions before mental health education to identify gaps in knowledge and care of SMIs and associated complications and after mental health education. The results of the study informed the nursing profession on the most effective ways to care for SMIs. It highlighted the importance of mental

health education for nurses at the forefront of patient care. The findings guide the degree of support nurses in home health settings need to provide evidence-based care for adults with SMIs.

This research was crucial because nurses encounter adults with SMIs and debilitating complications in the community. Nurses feel inadequate and ill-equipped to care for the patient group (Zetterberg et al., 2022). Nursing education will improve SMI care, and improved quality of life will benefit the patient population, providers, and organizations.

The study was conducted at a home health agency's central location in Texas during a monthly in-service of the primary and community care registered nurses. I administered the MHPPQ to 44 nurse participants, which was essential in determining nurses' baseline knowledge, skills, and perceptions. The same participants received pre- and posttests in mental illness and care.

Nursing education was provided after the survey and pretest and before the posttest. The education material was a PowerPoint slide that described mental illness, its prevalence, type, and cause of treatment and management. The PowerPoint slides also described effective strategies to respond to patients with different conditions and challenges to care. The participants received education to increase their knowledge and competency in mental health care.

Demographics

Forty-four adult male and female home health registered nurses participated in the study. The nurses work in the community and lack specialized education on SMIs. The nurses probably had SMI insight during their general studies in nursing schools. They provide care to adults with SMIs who also have CHCs. I used convenience sampling to recruit those nurses with minimal mental health care experience for the study. I favored convenience sampling because of its nonrandom nature of including study participants. The technique was easy, inexpensive, cost-

effective, and accessible (Etikan et al., 2016). The disadvantages could be severe hidden biases and poor credibility due to potential outliers (Etikan et al., 2016).

Data Analysis

I collected data from survey responses and pre- and posttest results. The MHPPQ is a 2-point Likert scale questionnaire, in which participants agree and disagree with 12 statements. The pre- and posttests have 10 similar multiple-choice questions with four answers. I used a dependent t test to evaluate the differences between the pretest and posttest results administered to the same nurse participants. The t test measured the level of change. Data were compiled using Microsoft Excel and uploaded into the Intellectus Statistics software application for analysis. Descriptive statistics, including frequencies and percentages, were obtained.

Descriptive Statistics for MHPPQ

Table 1 represents the demographic section of the MHPPQ, part A. Frequencies and percentages were calculated for the number of years of experience of the participants by position (RN or HH). The most frequent response for Years RN was over 10 years ($n = 32, 72.70\%$). The most frequent response for Year HH was also over 10 years ($n = 26, 59.10\%$).

Table 1

Frequency Table for Years RN and Years HH

Variable	<i>n</i>	%
Years RN		
1–10 years	12	27.30
Over 10 years	32	72.70
Years HH		
1–10 years	18	40.90
Over 10 years	26	59.10

Note. Due to rounding errors, percentages may not equal 100%.

Table 2 represents descriptive statistics for the MHPPQ, part B. Frequencies and percentages were assessed individually. Response options were *agree* or *disagree*. Nurse participants' responses varied on the scales that measure levels of mental health knowledge and skills.

Table 2

Frequency Table for Nominal Variables

MHPPQ question #	Agree		Disagree	
	<i>n</i>	%	<i>n</i>	%
1	3	6.80	41	93.20
2	3	6.80	41	93.20
3	6	13.60	38	86.40
4	3	6.80	31	70.50
5	28	63.60	16	36.40
6	12	27.30	32	72.80
7	30	68.20	14	31.90
8	3	6.80	41	93.20
9	10	22.70	34	77.30
10	37	84.10	7	15.10
11	0	0.00	44	100.00
12	31	70.5	3	8.80

Note. Due to rounding errors, percentages may not equal 100%.

More than 90% of respondents ($n = 41$, 93.20%) reported insufficient knowledge and skills to care for SMIs and CMCs. The respondents disagreed with item 2 (I know how to care for adults with SMIs who have CHCs). Similarly, most participants ($n = 41$, 93.20%) lacked

adequate SMI and CHC care skills. They disagreed with item 8 (I have the skills to provide quality care to adults with SMIs who have CHCs).

Also, most participants ($n = 41$, 93.20%) reported poor knowledge of mental illness, care, and the factors predisposing adults to complications. The participants disagreed to question 1 (I know enough about mental illness and the factors that put adults with SMIs at risk for CHCs). All participants ($n = 44$, 100%) perceived themselves as lacking the knowledge to care for SMI and CHC flare-ups. They disagreed with item 11 (I feel I know how to care for adults with SMIs and flare-ups from their CHCs).

The results also revealed that 86.40% of the respondents ($n = 38$) felt inadequate about educating their patients and disagreed with item 3 (I can appropriately advise my patients with SMIs about the risks of CHCs). Likewise, 84.10% ($n = 37$) reported difficulty communicating adequately with adults with SMIs and CMCs. They agreed to question 10 (I often have difficulty communicating with adults with SMIs and those with CHCs).

On the other hand, the study results showed that 68.20% of the nurses ($n = 30$) felt they had the right to ask patients relevant questions about CHC risks. They agreed with question 7 (I feel I have the right to ask patients with SMIs any information relevant to their risks of CHCs). The results showed that most primary care nurses encountering adults with SMIs when caring for individuals with CHCs felt they needed more knowledge and skills.

The results of this study concur with Mulango et al. (2018) who found 66% of primary providers were uncomfortable caring for the SMI group. The results are also consistent with Chorwe-Sungani (2013) who found that 53.2% of nurses needed increased knowledge and skills to care for SMIs. Mroueh et al. (2021) agreed with the prior research suggesting that mental

health education for nurses continues to lag, which is concerning. This education gap in the profession affects nursing attitudes, knowledge, perceptions, and practice toward SMI care.

Descriptive Statistics for Understanding Mental Illness Pre- and Posttests

Table 3 represents pre- and posttest statistics. Frequencies and percentages were calculated for correct participant responses to the pre- and posttest items. The findings showed that mental illness nursing education significantly impacted nursing knowledge, evidenced by improved posttest results.

- Question 9 had the lowest pretest score ($n = 15$, 34.09%) compared to the posttest score ($n = 41$, 93.18%), which demonstrated a 59.09% change.
- Question 1 had 20 correct responses (45.45%) on the pretest compared to 44 correct responses (100.00%) on the posttest.
- Question 2 had 22 (50.00%) participants who responded correctly on the pretest compared to 44 (100%) of participants who provided correct responses on the posttest.
- Questions 5, 6, 7, 8, and 10 also recorded the maximum posttest scores, ($n = 44$, 100%).
- Questions 5, 6, 7, 8, and 10 pretest scores were 21 (47.73%), 24 (54.55%), 30 (68.8%), 18 (40.91%), and 27 (61.36%) respectively.

The results of the study showed improved posttest scores compared to pretest scores, which demonstrated increased participants' knowledge and perceptions. Frequencies and percentages, including the percent pf change from pretest to posttest are presented in Table 3.

Table 3*Number of Correct Pretest and Posttest Responses and Percent Change*

Question	Pretest		Posttest		Difference % Change
	# Correct	% Correct	# Correct	% Correct	
1	20	45.45	44	100.00	54.5
2	22	50.00	44	100.00	50.0
3	23	52.27	42	95.45	43.1
4	21	47.73	42	95.45	47.7
5	24	54.44	44	100.00	45.4
6	30	68.18	44	100.00	31.8
7	18	40.91	44	100.00	59.0
8	30	68.18	40	90.91	22.7
9	15	34.09	41	93.18	59.0
10	27	61.36	44	100.00	38.6

Note. $N = 44$. Due to rounding errors, percentages may not equal 100%.

Question Guiding the Inquiry

The PICOT question was: Does mental health education affect nursing knowledge and perceptions of SMI care? In this project, I explored the current nursing knowledge and skills in caring for and managing adult patients with psychiatric illnesses and chronic medical problems in the community. I determined if evidence-based nursing education on mental illness and care improves nursing knowledge, skills, and perceptions.

Nurses meet various patient populations daily, including adults needing mental health care in the community. These adults with SMIs also have high rates of multiple unidentified and

untreated medical disorders requiring urgent attention. Nurses lack adequate knowledge and skills to deal with people's mental and physical health problems (Chorwe-Sungani, 2013).

Nursing education is essential to improve perceptions of SMIs and quality of care and decrease disparities in care for those with mental health disorders. Education in mental illness and care promotes knowledge and perceptions of the conditions and builds confidence and commitment in nurses to deal with mental health problems in all settings (Chorwe-Sungani, 2013).

Statistical Test: Dependent *t* Test

A two-tailed paired samples *t* test was conducted to examine the mean difference between Understanding Mental Illness pretest and posttest scores. The overall average scores were pretest 49.30% and posttest 97.50%. Normality assumption was conducted to rule out gross assumption violation; none was violated. A Shapiro-Wilk test was conducted to evaluate whether the differences between the pretest and posttest results might have been generated by a normal distribution based on the methodology put forth by Razali and Wah (2011). The outcomes of the Shapiro-Wilk test were significant, given an alpha value of .05, with $W = 0.93$ and $p = .013$. These findings suggest that the differences observed between the pretest and posttest scores are unlikely to have been derived from a normal distribution, thereby violating the normality assumption.

The two-tailed paired samples *t* test was statistically significant, $t(43) = -17.94$, $p < .001$, suggesting that the null hypothesis should be rejected. This finding shows that the mean score on the posttest ($M = 9.75$) statistically differed from the mean score on the pretest ($M = 4.86$). The findings answered the PICO question: Does mental health education affect nursing knowledge

and perceptions of SMI care? The results are presented in Table 4. A bar plot of the mean scores is presented in Figure 1.

Table 4

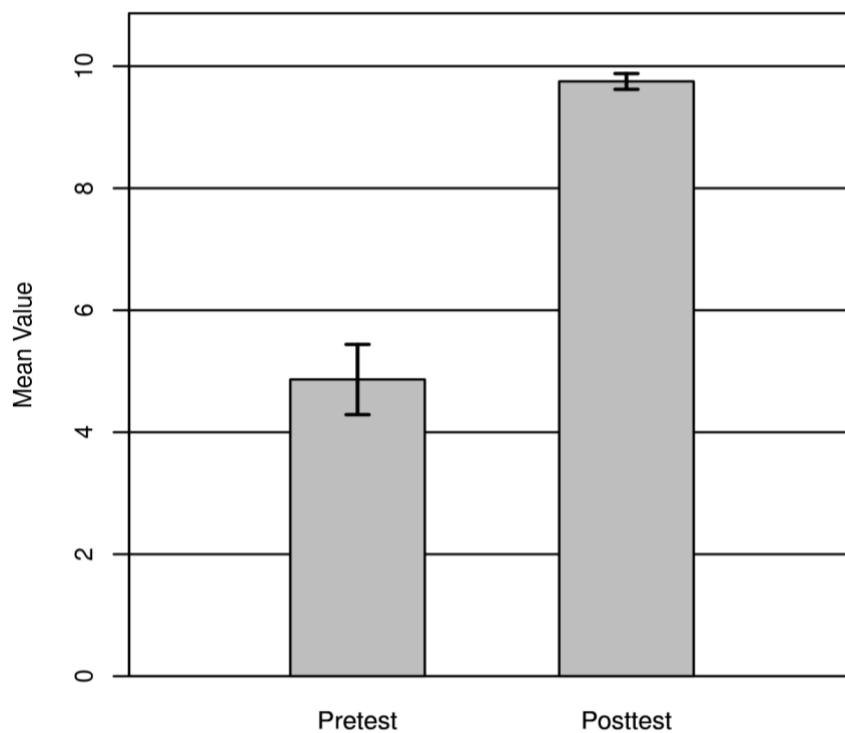
Two-Tailed Paired Samples t Test for the Difference Between Means

Pretest		Posttest		<i>t</i>	<i>p</i>	<i>d</i>
<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
4.86	1.95	9.75	0.44	-17.94	< .001	2.70

Note. *N* = 44. Degrees of Freedom for the *t*-statistic = 43. *d* represents Cohen's *d*.

Figure 2

Means of Pretest and Posttest With 95.00% CI Error Bars



Reliability and Validity

Appropriate evaluation tools assessed nursing knowledge and skills in providing mental health care to patients with SMIs and CHCs. I used the knowledge and skills scale of the MHPPQ, which has 12 Likert scale type questions. The MHPPQ was initially developed by professor William Lauder and his colleagues (Lauder et al., 2000) and was later adapted by Dr. Genesis Chorwe-Sungai (2013). The tool has been used in multiple studies. I used the adapted and modified version for the study with permission from Professor Genesis Chorwe-Sungani. Its use is free and available in English.

The MHPPQ has demonstrated validity and reliability ($\alpha = 0.85$) for the knowledge and skills scale (Chorwe-Sungani, 2013; Lauder et al., 2000). It is a reliable instrument for use with acute general and community nurses, and it measures nurses' ability and willingness to engage in psychosocial interventions with individuals with SMIs. Its reliability was demonstrated for internal reliability and test–retest reliability (Lauder et al., 2001).

Internal consistency was estimated using Cronbach's α coefficient. Values greater than 0.7 or higher indicate a strong correlation of scale items. For the MHPPQ, therapeutic commitment ($\alpha = 0.84$), role support ($\alpha = 0.89$), and role competency scales ($\alpha = 0.87$) demonstrated satisfactory internal reliability. The test–retest study produced high correlations, indicating repeated use stability (Lauder et al., 2001). Computation and comparison of correlation coefficients for each scale assessed MHPPQ's validity. Significant, low to moderate correlations were established between the three scales of the instrument (Lauder et al., 2001)

The pretest, educational material, and posttest were adapted resources from the online continuing education course "Understanding Mental Illness for All Healthcare Professionals" on the Wild Iris Medical Education website (Swan, 2020). I obtained a permission to use the

resources. The course material was approved as a continuing education course for nurses and accredited nationwide by the American Nurses Credentialing Center, accepted by all U.S. nursing boards. Some healthcare disciplines widely use it for continuing education (Swan, 2020).

I used a dependent t test (paired samples t test) to evaluate the differences and statistical significance between the pretest and posttest administered to the same nurse participants. The result of the two-tailed paired samples t test was statistically significant, ($t(43) = -17.94, p < .001$). Normality assumption assessment ruled out gross assumption violation.

Strengths and Limitations

The project shares strengths, including new knowledge, sample size, stress, risk-free, and cost-effectiveness. The results of the study may be used to inform the nursing profession on the most effective ways to care for SMIs and highlights the importance of mental health education for nurses at the forefront of patient care. The support and administrative staff helped with the study site setup and smooth operations, contributing to the success of the project.

The participants were enthusiastic and interested in the study and in learning more about mental illness and care, thus supporting a need for the study by turning out in mass. An adequate number of nurse participants whose knowledge and perceptions were assessed were excellent for the educational project outcome. Forty-four registered nurses participated in the study, ranking the study as having an average sample size.

An adequate sample size better represents the population, making the study credible. Faber and Fonseca (2014) highlighted that extreme sample sizes are unsuitable for a study; too small or too large samples have downsides that affect the study's findings and conclusions—a smaller sample size may lead to a true-false conclusion. An appropriate sample size makes for more efficient research.

Cost, safety, appropriateness, and effective methods affected the study. A quantitative descriptive study was the most appropriate for the study. Convenience sampling, a questionnaire, a pretest on mental health knowledge, mental health education, and a posteducation test were easy to administer to nurse participants and posed no risks to anyone—participants, investigator, and study location. The methods cost the participants and the study organization nothing financially. Cost-effective, appropriate, safe, and easy-to-carry-out research methods were less stressful for the participants, the study organization, and the investigator. They were vital for the success of any research.

The limitations of the study included convenience sampling, a short study period, and survey questions type. Convenience sampling has the disadvantages of severe hidden biases and poor credibility and generalizability (Etikan et al., 2016). A short study period gives participants inadequate time for personal reflection and assessment. MHPPQ issues include bias, answers based on personal opinion, and may not reflect the actual study outcome. Questions need to be more detailed. The answer format (agree/disagree) prevents detailed expression of feelings.

Interpretation and Inference of the Findings

A non-experimental quantitative descriptive survey was appropriate for the research and to answer the question: Does mental health education affect the nursing knowledge and perceptions of SMI care? A home health agency was suitable as the setting for the study considering the participants' characteristics—nurses with predominantly primary care experience and limited knowledge of mental health care.

Nurses often deal with individuals with severe mental disorders and medical conditions. The results from the MHPPQ survey pre- and post-mental health education test and a dependent *t*-test analysis revealed a robust statistical association between nursing education and increased

knowledge, skills, and perceptions of SMI care. Therefore, SMI education is a priority for primary and community care nurses for quality and improved care of adults with SMIs who live in the community. The population has a high risk for comorbid physical conditions, and nurses require adequate and proper tools to avert the increasing conditions and concerns.

Summary

I investigated the effect of mental health education on knowledge, skills, and perceptions in caring for adults with SMIs. SMI education improved nursing knowledge and perceptions, evidenced by improved posttest scores compared to pretest scores. The overall mean scores on the pretest were 49.30% and 97.50% on the posttest. A paired *t* test (dependent *t* test) compared the mean pre- and posteducation scores of the nurse participants. The mean posttest scores showed increased percentages of correct responses. These findings showed that mean posttest ($M = 9.75$) scores were statistically higher than mean pretest ($M = 4.86$) scores.

A two-tailed paired samples *t* test was statistically significant, $t(43) = -17.94, p < .001$. The findings strongly supported rejecting the null hypothesis (Nursing education will not improve knowledge of treatment and perceptions posteducational sessions) and accepting the alternative hypothesis: (Nursing education will improve knowledge of treatment and perceptions posteducational sessions). Overall improvement in nursing knowledge, skill, and perceptions of care were demonstrated, suggesting that continued mental health education is needed to deliver quality patient-centered care to the population.

Chapter 5: Discussion, Conclusion, and Recommendations

SMI are mental, behavioral, or emotional disorders that result in severe functional impairment, which substantially interferes with or limits one or more major life activities (National Institute of Mental Health [NIMH], 2023). In 2021, 14.1 million (5.5%) U.S. adults lived with a SMI. In 2020, one in five adults (52.9 million) lived with some type of mental illness. That figure increased to 57.8 million adults in 2021 (NIMH, 2023).

Providing adequate care to the mentally ill population is challenging in the United States and globally. Challenges include inadequate mental health training for primary care providers and an aging mental health workforce and dealing with low reimbursement rates, a lack of residency slots and internship sites, a diverse U.S. population, a lack of cultural and linguistic competency, a lack of license reciprocity, and providers' unwillingness to accept Medicaid patients make success unattainable (Hogg Foundation, 2016) and DNP nurses need to be aware and address the challenges and create awareness in mental health education programs and curricula. Two-thirds of people with significant behavioral health conditions receive no treatment (Hogg Foundation, 2016).

Caring for adults with SMI challenges nursing due to the complex issues and symptoms that can be acute, in remission, and sometimes flare up (Underwood & Meuser, 1990). The adults present hallucinations, delusions, isolation, poor interpersonal relations, lack of motivation, low self-esteem, and dependency (Underwood & Meuser, 1990). SMIs result in impairment, disability, and handicap (Underwood & Meuser, 1990). People with SMIs are usually handicapped in education jobs or housing, and handicaps focus on social rehabilitation (Underwood & Meuser, 1990). In other words, the burden of mental illnesses is mainly concentrated among those who experience disability due to SMIs (NIMH, 2023). Adults with

SIMs succumb to worsened conditions and death related to poor physical health and need a holistic and comprehensive nursing approach (Wazni & Gifford, 2017).

An individual may depend on the caregiver, and the nurse plays a significant role in the care and provides essential support (Irshad Ali, 2018). Nurses voice working in a psychiatric care setting is stressful, which affects their mental health. The nature and acuity of the patient population make care challenging. Nurses often feel overwhelmed caring for patients diagnosed with schizophrenia in acute psychotic mode and voice, lacking clinical experience and supervision. Nurses also feel abandoned when patients threaten them or their coworkers (Sundberg et al., 2022). Nurses need adequate human resources for support and to intervene during crises and avert injuries. Nurses need education for skills and knowledge to function effectively in this caring field. Nurse leaders are challenged to give full support, advocate for nurses' needs, and make policy changes. Apra (2023) mentioned that nurse leaders must support the team's mental health and provide physical, moral, emotional, and spiritual support. Ensuring a supportive workplace creates an environment that allows nurses to unburden their hearts safely without fear (Apra, 2023). DNP nurses must work to mitigate these problems, which must be addressed collectively.

Implications of Analysis for Leaders

Undoubtedly, addressing the needs of SIMs with CHCs is complex. The COVID-19 pandemic has not improved the issues associated with the group. U.S. adults reported intense mental health conditions related to COVID-19, worsening morbidity and mortality. Younger adults, racial/ethnic minorities, essential workers, and unpaid adult caregivers reported having experienced disproportionately worse mental health outcomes, increased substance use, and elevated suicidal ideation (Czeisler et al., 2020). Adequate health care is unavoidably linked to

the state of the nursing profession (Catton & Iro, 2021). Nurses are the most significant healthcare workforce and are at the center of care; they provide direct care services to the sick, including the marginalized population. Nurse leaders face increasing challenges due to ongoing healthcare demands compounded by stress and uncertainty. Before the COVID-19 pandemic, the issues that caused enormous nursing stress were chronic staff shortages (understaffing) and burnout (Kurtzman et al., 2022). The reported issues require effective prevention, recovery, and cure methods, and educating providers is crucial based on other findings. As the study was geared towards evaluating nursing knowledge and perceptions, the findings on nursing training and education on mental illness and care met the expectation of improving knowledge and perceptions of managing and caring for the group.

The care for the SMI population, in general, is already impacted. There are ongoing access issues, even with the Obamacare reform (Affordable Healthcare Act of 2010) meant to improve quality and safe care, and the problems need further improvement. Thus, translating the research result into practice requires considering the interventions to promote patient safety practices. Some strategies may be needed depending on the practice setting. They include determining the aspect of the findings that need to be shared, specific practice recommendations, and partnering with professional opinion leaders and other healthcare organizations (Cardoso et al., 2021).

An adequate workforce is necessary to monitor patients, deescalate aggressive situations as they arise, support coworkers, and enhance safety. Eliminating processes that cause a tense environment and engaging in advocacy and policy changes that favor retention, diversity, and inclusivity is a priority. The multidisciplinary team must be involved in ensuring the proposed measures are implemented. Providing adequate nursing staff to care for the group adequately is a

mirage and remains far-fetched. Nursing turnover and shortages have worsened after COVID-19. Employing quality contract nurses with knowledge of mental health care is difficult; research shows that only 1% of nurses work in mental health (Swan, 2020). The result is chronic burnout and poor patient outcomes for the few nurses who continue to serve. Generally, 52% of US nurses are considering leaving their current position due primarily to insufficient staffing, work negatively affecting health and well-being, and inability to deliver quality care. 60% of acute care nurses report feeling burnt out, and 75% report feeling stressed, frustrated, and exhausted (American Association College of Nursing [AACN], 2022). Five hundred thousand seasoned U.S. RNs were expected to retire in 2022, and 1.1 million new RNs were expected to expand the workforce, replace the retirees, and avoid a nursing shortage. Over half of the nursing workforce felt exhausted during the pandemic; 30% wanted to quit (Modern Healthcare, 2021); 29% of nurses across all license types considered leaving their jobs in 2021, compared with 11% in 2020 (AACN, 2022). One million registered nurses will retire from the workforce by 2030 (AACN, 2022). The issues call for competent leaders and new ways of leadership: (a) innovative models of nurse-led care; (b) reimagined nursing-sensitive performance measures; (c) new and sustained efforts for promoting continued nursing education, diversity, equity, and inclusion; (d) payment policies that reflect nurses' value; and (e) innovative organizational and institutional approaches that enable flexibility (Kurtzman et al., 2022).

The nursing leadership characteristics include integrity, accessibility, motivation of others, emotional capability, and social intelligence (Brunt & Bogdan, 2022). Other features include a commitment to excellence, passion for work, clear vision and strategic focus, trustworthiness, respectfulness, approachability, empathy, caring, and commitment to coaching and development staff. Leaders must be open and approachable, with the ability to motivate

others through support and empowerment. Developing these qualities is essential for existing and emerging leaders (Brunt & Bogdan, 2022). Nurse leaders must be skilled in communication, creating a favorable work environment, and collaborating/teamwork or partnership with others. The leader must be a good coach, mentor, and conversant with task delegation.

Servant leadership is worthy of emulation and is essential in the current stressful work environment. Putting the needs of followers first (the employees) is a must. Personal qualities, skills, and knowledge are the tools that DNP nurses need to create a healthy work environment that supports the nurturing of staff, which must be prioritized. Attending to staff's physical, social, and mental health and well-being is essential—including giving and soliciting feedback. Nurse leaders must be quick to listen, speak slowly, and react cautiously. Good working relationships with members of the other disciplines comprising the healthcare team always pay off (Brunt & Bogdan, 2022). Servant leaders' focus on supporting and developing followers and promoting connectivity and trust are vital. The leaders' acceptable behaviors include following ethical norms, helping followers grow and succeed, empowering, emotional healing, creativity, and communicating effectively (Canavesi & Minelli, 2021).

Communication is essential in all tasks as a mental health nurse leader. It is vital in all aspects of care but unavoidable in caring for the challenging mentally ill population. It is needed in mental health care due to the challenges posed by patients and the essential role of communication from diagnosis to treatment. Communication skills are important indicators of patients' quality of care regarding adherence, satisfaction with care, physical and mental health measures, and indicators of providers' including lower stress, higher quality of life, and levels of confidence (Novais et al., 2022). Sending and receiving information may be the only treatment an individual needs in the form of counseling services. The therapist or nurse must know how to

communicate in acceptable ways. Bedside nurses must communicate therapeutically with the patients in all aspects of their care, including when they exhibit unacceptable behaviors or aggression, to deescalate behaviors. Communication is vital when carrying out nursing and medical procedures, during medication management, including consenting for psychiatric medications, and medication refusal administration processes, such as court-ordered medications. Nurse leaders must do an excellent job in this area considering its importance—to ensure mental health nurses and other caregivers receive adequate training in communication. Teaching communication skills in the pre- and postgraduate periods in a generic way—all medical areas or more directed to the different specificities is an option (Novais et al., 2022). Yearly or 6-month refresher training may be advocated. Nurse leaders must advocate for policies and influence change of existing ones to incorporate communication as a course in the nursing school curriculum.

Essentials of Doctoral Education for Advanced Practice Nurses

The DNP-prepared nurse transforms decisions and practices at the bedside, classroom, and boardroom. The eight essentials focus on identifying the DNP nurses' impacts on health care delivery, advocacy, and quality improvement of issues relating to SMI care and associated CHC complications (Anderson, 2013).

Essential I: Scientific Underpinnings for Practice

This essential focuses on nursing—middle age theories that advance nursing practice (Chism, n.d). SMIs have been on the rise in the U.S. population over the last 10 years, and nurses have encountered these individuals in various healthcare settings and feel ill-equipped to provide adequate care (Zetterberg et al., 2022). The recovery for patients in this group seems slow due to the associated physical conditions, poor course, and outcome (Bahorik et al., 2017). Fifty to

eighty percent of the individuals experience medical complications that worsen their recovery from mental conditions (Bahorik et al., 2017). Healthcare organizations must provide nurses with the needed resources and tools to perform their duties as required. DNP nurses are challenged with identifying and tackling barriers to delivering quality patient-centered care to individuals with the conditions and their associated chronic debilitating medical conditions. By 2030, U.S. residents aged 65 and older are projected to be 82 million, leading to an increased need for geriatric care, CHCs, and comorbidities care (Modern Healthcare, 2021).

Dorothea Orem's self-care deficit nursing theory (SCDNT) is the theoretical framework that guides the project, and it focuses on people as whole entities who engage with their environment to sustain health (Wazni & Gifford, 2017). The framework consists of three interrelated mid-range theories: (a) the theory of self-care, (b) the theory of self-care deficit, and (c) the theory of nursing systems. The framework guides and organizes nursing practice, and it is a valuable framework for nurses in addressing the physical and mental health needs of adults with SMIs (Wazni & Gifford, 2017).

The project findings revealed that SMI nursing education improves knowledge, skills, and perceptions of care. Primary care nurses in multiple settings in the community often need more knowledge, skills, and attitudes to provide patient-centered holistic care to the group. Addressing the issues with adequate mental health education is a step in the positive direction for the patient population. Improved nurses' awareness of SMIs is a priority and raises the care standard that nursing must need to close the treatment gaps and reach favorable outcomes (Alexander et al., 2016). DNP nurses must spearhead improvement initiatives in their healthcare settings—introduce, educate, and advocate policies that promote ongoing nursing education and care for the SMI population.

Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking

The essential emphasizes using leadership for practices and systems change that benefit the population. The complexity of the SMI population, increasing number, and worsening complications drive care improvement efforts. SMIs carry a lot of debilitating conditions that affect society. Nursing care has failed to reach the expected standard to help with the growing disease complications, and researchers have proved that closing the care gap is vital. Based on the non-experimental quantitative study findings, improving nursing education and awareness of SMIs and challenges is a priority. The DNP must address leadership and system issues that derail efforts to improve care quality, such as barriers to access within an organization—how health systems, organizations, and healthcare providers respond to the needs of individuals with an SMI. DNP leaders must look at and address legal and ethical issues surrounding mental health care and challenge the clinicians who struggle daily to improve care. Changing the practice process will have a positive effect, but it requires resolving the issues that prevent nurses from translating theory to practice and achieving success (Dickens et al., 2019).

Issues affecting nursing practice include registered nurses' nursing shortage in the psychiatric setting and burnout, and finding effective mitigating measures has eluded organizations and leadership. There is a serious concern that the nursing profession needs to attract sufficient nurses to care for SMI populations in the future (Turale & Nantsupawat, 2021). Nurses disengage from the psychiatric setting for fear of patients' aggression and assault, physical restraints, injury risk, poor support during patients' -to-patients' threats, and threats to coworkers due to understaffing. Ninety-five percent of most organizations' nurses verbalized being stressed and burned out. Five to 10 nurses get assaulted or injured weekly. Six hundred and

thirty-five psychiatric nurses, 41.3%, had experienced assault in 2021 (Modernnurse, 2022). The DNP nurse must continue to find ways to address existing and emerging issues.

Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice

Providing opportunities for nurses in all settings to familiarize mental illness through refresher courses, continuing education, seminars, and workshops will significantly benefit the population. Responses from the MHHPQ revealed the areas of general and most nursing needs. All respondents did not know how to care for SMIs and flare-ups from chronic debilitating complications like heart disease. The DNP nurses must make education a priority. The project results showed that education is crucial. Nurses' mental health care education, clinical supervision, and guidance are vital in primary care, community settings, hospitals, and long-term facilities (Mahato et al., 2018). Recruiting, educating, and continued support of nurses help with a knowledge deficit in clinical practice, better perceptions, and skills for managing SMIs (Mahato et al., 2018).

Essential IV: Information Systems/Technology and Patient Care Technology for Improving and Transforming Health Care

Health IT is essential in mental health practice. Health IT made organizing and analyzing this project data more efficient. Using the Microsoft Excel tools, Intellectus Statistics software applications enabled translating research findings into evidence-based practice for the SMI population.

The MHPPQ was also beneficial in assessing nursing knowledge in caring for the group, which helps direct care. Health IT, including EHR, video consulting, e-prescribing, and e-MAR, has made care accessible and cost-effective and avoids medical and practice errors.

Telehealth (Telepsychiatry) is expanding and changing how providers render services and treat patients with SMIs. It enhances the exchange of medical information through electronic communications, encompassing two-way video and email, smartphones, and other telecommunications technology, for diagnosing and treating illnesses (Chan et al., 2015). It's convenient, inexpensive, and readily accessible service improves financial reimbursement (Chan et al., 2015). In outpatient clinics, telehealth is used for diagnosis and treatment, including medication management and individual and group psychotherapy. In primary care, it is used for consultations at home and specialist clinics. Telepsychiatry is used in hospitals and mental health facilities for consultation and emergencies and in correctional and substance use rehabilitation settings. The technology has been implemented and used for all ages, including adults with SMIs. Telepsychiatry leads to high patient and provider satisfaction and outcomes equivalent to in-person care. The DNP nurse plays a crucial role in educating novice nurses on the importance of technology and big data in the care of SMIs, encouraging the use, and making policy provisions for technology learning in systems and organizations. Using care delivery methods such as health IT helps with burnout.

Essential V: Health Care Policy for Advocacy in Health Care

Providing adequate care through SMI nursing education requires policy changes and advocacy. The DNP graduates are leaders who can influence and shape healthcare policies and policies that affect the nursing practices of the SMI population. DNP nurses can analyze health policy proposals, health policies, and other issues from a nursing perspective, other professionals and the stakeholders, demonstrate leadership in the development and of policy at all levels, influence policymakers through active participation on committees and boards at all levels to improve healthcare delivery and outcomes, educate policymakers about nursing, health policy,

and care outcomes, advocate for nursing profession within the policy and healthcare communities, develop, evaluate, and provide leadership for healthcare policy that shapes health financing, regulation, and delivery, advocate for social justice, equity, and ethical policies within the healthcare arena (Mulin, n.d.)

Essential VI: Interprofessional Collaboration for Improving Patient and Population Health

Outcomes

The SMI challenges have called for care collaboration and partnerships to ensure optimal care of the patient group. Changes in organizational leadership and processes can affect the long-existing culture that deters progress. Leaders' behaviors, teamwork, and partnership must be emphasized to improve issues within the nursing discipline, such as retention. An improved workforce and practical, innovative leadership favor quality and safe care. DNP Nurse leaders must be accessible, build trust, show integrity, communicate effectively, and teach and coach others (Sundberg et al., 2022). DNP Nurse leaders must continue to improve the work environment, ensure safe working conditions, and make other efforts that minimize fatigue and improve retention (Texas Center for Nursing Workforce Studies 2022).

Essential VII: Clinical Prevention and Population Health for Improving the Nation's Health

Disease prevention in the SMI group is a priority through evidence-based practices. The increasing admission and readmission rates due to ill-treated SMIs are a problem. The increasing rate of medical issues complicates SMIs and causes debilitating conditions and death.

Comorbidity is the most critical challenge affecting healthcare organizations in SMI care (Abdin et al., 2022). Sixty-eight percent of adults with a mental disorder have at least one medical condition, and 29% have a mental disorder (Nowels & VanderWielen, 2018). Comorbidity management requires a well-thought-out and intensive care plan that addresses individuals'

mental and physical health and adequate education of clinicians and providers on person-centered holistic care to ensure high-quality care delivery (Abdin et al., 2022).

The lack of qualified and well-educated mental health providers is an ongoing issue. Nurses verbalize poor knowledge and skills and are uncomfortable caring for the group. Nursing either focuses on mental health needs or medical needs, depending on the care settings. The SMI patient group faces an increased risk of complications and death and a greater risk of poor care outcomes due to CHCs such as heart disease and diabetes (Sprah et al., 2017). DNP nurse leaders must prioritize education in care settings. This research revealed significant gaps in knowledge, skills, and perceptions. The responses from the MHPPQ, pre, and post-mental health education, were evident and striking.

Essential VIII: Advanced Nursing Practice

The DNP nurse has the knowledge and skills to deliver care to all patient populations, including the SMI group, in varied settings. The study results provided more insight into SMI care and practice guides on the psychological needs and physical needs that seemed to be neglected. Worsening SMI conditions can lead to complications requiring intensive care, more resources, extended hospital stays, and increased costs (Leung et al., 2010). The worsening physical conditions may also lead to expensive transfers to acute care medical facilities (Sprah et al., 2017). Increasing readmission rates of less than one month, complications, and more extended inpatient care are prevalent in the SMI population and contribute to high healthcare costs and increased mortality. The population has not received the holistic care it deserves, and finding ways to improve care quality is vital. Healthcare organizations are challenged and struggle to find solutions to population problems. The factors affecting frequent hospital visits are ill-treated and unsolved mental health problems and a lack of mental health staff to address

the treatment gap (Eboreime et al., 2022). Admissions frequency and co-occurring medical conditions cause significant acute complications that point to inadequate quality care that calls for attention to staff education, treatment, and prevention (Leung et al., 2010). DNP nurses know the challenges and the research outcome of improving and making nursing education ongoing in practice settings. DNP nurses can make a difference.

Recommendations

The study provided insight and new knowledge on the importance of evidence-based mental health education for nurses at the forefront of care for quality, improved care that mitigates complications of SMIs and prevents future ones. The DNP nurses are equipped to assume multiple roles and effect change—from leaders, educators, clinicians, policymakers, politicians, and advocates. Multiple sources of SMI education dissemination include the internet, which provides a wealth of knowledge, multimedia resources, continuing education courses, and professional journals. Sadly, research suggested that translating evidence into practice for nursing has not been accessible due to several factors. Poor knowledge, attitude towards implementation, lack of resources and training methods, time mismanagement, and lack of motivation remain the barriers to implementing evidence-based practice and must be addressed. Nurses reported decreased interest in unclear tasks, assignments, and job descriptions (Dagne & Beshah, 2021).

Despite efforts to increase access to evidence-based mental health programs, stigma remains a significant barrier to care. An increasing number of adults with new SMIs and flare-ups is alarming, and despite the rising rate, only a few seek mental health treatment. Since other methods of obtaining new knowledge and reducing mental health stigma have been ineffective, storytelling seems more practical. Storytelling is crucial in disseminating outcomes and results

and influences the knowledge and attitude of patients and caregivers. Davidson et al. (2018) discussed digital storytelling and mental health access. In Our Own Voice (IOOV) is an exciting program that successfully reduces stigmatizing attitudes. It involves a 90-minute group interaction led by two facilitators successfully managing their mental illness. The group interaction consists of watching educational videos, sharing personal experiences with group facilitators, and open discussion (Davidson et al., 2018). People are most responsive to information and education from familiar people, and storytelling of mental health issues is not left out. Mental illness stigma reduction is most effective when using the targeted population to deliver the message, and when it involves contact with peers who have experienced mental health problems, those with a similar disorder and symptoms can provide accurate information and a personal connection with a similar peer that, in turn, can challenge perceptions about mental illness (Davidson et al., 2018).

DNP nurse leaders must ensure patient care assignments have clear directions, processes, and protocols. Nurses' job tasks and descriptions must be spelled out and communicated clearly. DNP nurses must think outside the box and develop newer ways of information dissemination of SMI care. Innovation and creativity are crucial. Cianelli et al. (2016) described innovation in health care as putting new ideas into practice or incorporating existing ideas into practice in a new way. It is central to improving healthcare quality. Health care is evolving due to changes requiring improving care quality, patient outcomes, increased care access, and reduced costs considering new technologies, including telemedicine, genome therapy, and online healthy lifestyle resources. Cianelli et al. (2016) outlined the characteristics of innovation that are helpful in health care, including divergent thinking, risk-taking, failure tolerance, agility/flexibility, and

autonomy/freedom. Promoting a culture of innovation involves e leaders exhibiting, fostering, encouraging, and rewarding the five essential characteristics (Cianelli et al., 2016).

Conclusion

SIMs are on the rise in the adult subgroup who are predisposed to increased morbidity and mortality due to physical disorders (Sprah et al., 2017). Nurses meet adults with SIMs in multiple settings and have inadequate knowledge and skills to deal with mental and physical health problems. Nursing education is essential to improve knowledge, skills, and perceptions of SIMs and quality of care and decrease disparities in care (Chorwe-Sungani, 2013). The study evaluated nursing knowledge, skills, and perceptions of SIMs and care and found that nursing education on mental illness and care improves knowledge and perception of managing and caring for the group. SIM quality of life can be improved, and mortality rates with continued SIM education in health care settings.

Achieving organizational and systems successes requires specific leadership attributes and qualities after the COVID-19 pandemic. Nurse leaders must be transformative—informational, motivating, and advancing organizations (Fowler & Robbins, 2022). Integrity and social intelligence are among the leadership characteristics required to lead change through building the leadership culture, mentorship, and coaching. The CNE and organizations must identify and develop traits in existing and emerging leaders (Brunt & Bogdan, 2022). Nurse executives must always pay attention to and address administrative issues that impact ineffective processes through policy updates and changes. The issues can cause unfavorable work environments, high turnover, and loss of millions of dollars.

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Appendix A: Mental Health Problems Perception Questionnaire

Instructions: This questionnaire assesses your knowledge about the care of individuals with mental illness. The participants must be registered nurses in the home health setting. Please answer the questions below to the best of your ability by checking 'agree or disagree' for each question.

PART A

How many years have you worked as a registered nurse?

One Day -10 Years Over 10 Years

How many years have you worked in a home health setting?

One Day -10 Years Over 10 Years

PART B

I know enough about mental illness and the factors that put adults with severe mental illness at risk for chronic health conditions.

Agree Disagree

I know how to care for adults with severe mental illness who have chronic health conditions.

Agree Disagree

I can appropriately advise my patients who have severe mental illness about the risks of chronic health conditions.

Agree Disagree

I have a clear idea of my responsibilities to adults with severe mental illness who have chronic health conditions.

Agree Disagree

I have the right to ask my patients who have severe mental illness about the risks of chronic health conditions.

Agree Disagree

My patients who have severe mental illness believe I have a right to ask them questions about the risks of chronic health conditions.

Agree Disagree

I feel that I have the right to ask patients who have severe mental illness any information relevant to their risks of chronic health conditions.

Agree Disagree

I have the skills to provide quality care to adults with severe mental illness who have chronic health conditions.

Agree Disagree

I have the skills to assess and identify adults with severe mental illness who have chronic health conditions.

Agree Disagree

I often have difficulty knowing how to communicate with adults with severe mental illness and those who have chronic health conditions.

Agree Disagree

I feel I know how to care for adults with severe mental illness and flareups from their chronic health conditions.

Agree Disagree

I often have difficulty knowing how to assess adults with severe mental illness and chronic health conditions.

Agree Disagree

The survey was Adapted and modified with permission by Genesis Chorwe-Sungani, Ph.D.

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Appendix B: Pretest Document on Mental Illness

A Instructions: This pre-test assesses your knowledge about mental illness and the care of individuals with mental illness. The participants must be registered nurses in a home health setting who completed the Mental Health Survey questionnaire. Please answer the questions below to the best of your ability by selecting and circling the best answers.

1. Which is a true statement about mental illness?
 - a. Very young children do not experience mental illness
 - b. All persons with mental illness are unpredictable and dangerous.
 - c. Mental illness does not include addiction.
 - d. People with mental illness can get better.
2. Which is a correct statement regarding the biological causes of mental illness?
 - a. There are blood tests to determine the biological causes of specific mental illnesses.
 - b. Epigenetics does not play a role in the cause of mental illness.
 - c. Susceptibility to certain mental illnesses tends to run in families.
 - d. Environmental stress does not play a role in causing mental illness.
3. Effectively responding to persons with depressive symptoms involves:
 - a. Reassuring them that everything will be okay.
 - b. Giving them helpful advice about how to deal with their problems.
 - c. Encouraging self-compassion within themselves.
 - d. Disagreeing when they make negative assumptions about themselves.

4. Clinicians in healthcare settings outside of mental health should suspect bipolar disorder when a patient presents with:
 - a. Multiple somatic complaints.
 - b. A strong family history of depression.
 - c. Erratic patterns at work and in relationships.
 - d. Personality traits such as low self-esteem.
5. An effective way to respond to a patient with bipolar disorder symptoms or behaviors is to:
 - a. Appeal to the patient using logic to change behavior.
 - b. Tell the patient you forbid them to behave and say inappropriate things.
 - c. Provide consistent limits on the patient's behaviors and verbal abuse.
 - d. Encourage the patient to focus on more than one topic.
6. An effective strategy when responding to a patient experiencing symptoms of an anxiety disorder is to:
 - a. Acknowledge what the patient is experiencing.
 - b. Ask the patient to calm down.
 - c. Remind the patient there is nothing to fear or be nervous about.
 - d. Tell the patient not to overreact.
7. Which is a true statement about the consequences for patients with psychotic disorders?
 - a. The prognosis in patients is favorable for a full recovery.
 - b. Patients are generally outgoing and social.
 - c. Most patients can maintain employment.
 - d. Many patients slide into poverty or incarceration.

- d. Neutropenia.

8. To respond effectively to a patient who is hallucinating voices, the clinician:

- a. Avoids asking the patient if they are hallucinating.
- b. Speaks to the voices and tells them to stop talking to the patient.
- c. Explains to the patient that none of the experience is real.
- d. Directs the patient to tell the voices to go away.

9. When responding to a patient with a delusion, the clinician:

- a. Does not challenge the delusion directly.
- b. Goes along with the patient's delusion.
- c. Touches the patient to offer reassurance.
- d. Does not attempt to distract the patient.

10. Angry reactions to relatively minor provocations, a grandiose self-image, needing admiration, and a lack of empathy are symptoms of which type of personality disorder?

- a. Paranoid
- b. Narcissistic
- c. Histrionic
- d. Antisocial



Courtesy:

Swan, J. (2020). Understanding mental illness for all healthcare professionals: Integrating physical and mental health care. *Wild Iris Medical Education*.

<https://wildirismedicaleducation.com/courses/physical-mental-illness-integration>

Appendix C: Posttest Document on Mental Illness

B Instructions: This post-test is used to assess your knowledge about mental illness and the care of individuals with mental illness after the education session. The participants must be registered nurses in a home health setting who completed the Mental Health Survey questionnaire, pre-mental health test, and 60-minute educational session. Please answer the questions below to the best of your ability by selecting and circling the best answers.

- 
- 
1. Which is a true statement about mental illness?
 - a. Very young children do not experience mental illness.
 - b. All persons with mental illness are unpredictable and dangerous.
 - c. Mental illness does not include addiction.
 - d. People with mental illness can get better.
 2. Which is a correct statement regarding the biological causes of mental illness?
 - a. There are blood tests to determine the biological causes of specific mental illnesses.
 - b. Epigenetics does not play a role in the cause of mental illness.
 - c. Susceptibility to certain mental illnesses tends to run in families.
 - d. Environmental stress does not play a role in causing mental illness.
 3. Effectively responding to persons with depressive symptoms involves:
 - a. Reassuring them that everything will be okay.
 - b. Giving them helpful advice about how to deal with their problems.
 - c. Encouraging self-compassion within themselves.

- d. Disagreeing when they make negative assumptions about themselves.
4. Clinicians in healthcare settings outside of mental health should suspect bipolar disorder when a patient presents with:
- a. Multiple somatic complaints.
 - b. A strong family history of depression.
 - c. Erratic patterns at work and in relationships.
 - d. Personality traits such as low self-esteem.
5. An effective way to respond to a patient with bipolar disorder symptoms or behaviors is
- a. Appeal to the patient using logic to change behavior.
 - b. Tell the patient you forbid them to behave and say inappropriate things.
 - c. Provide consistent limits on the patient's behaviors and verbal abuse.
 - d. Encourage the patient to focus on more than one topic.
6. An effective strategy when responding to a patient experiencing symptoms of an anxiety disorder is to:
- a. Acknowledge what the patient is experiencing.
 - b. Ask the patient to calm down.
 - c. Remind the patient there is nothing to fear or be nervous about.
 - d. Tell the patient not to overreact.
7. Which is a true statement about the consequences for patients with psychotic disorders?
- a. The prognosis in patients is favorable for a full recovery.
 - b. Patients are generally outgoing and social.
 - c. Most patients can maintain employment.

- d. Many patients slide into poverty or incarceration.
- d. Neutropenia.

8. To respond effectively to a patient who is hallucinating voices, the clinician:

- a. Avoids asking the patient if they are hallucinating.
- b. Speaks to the voices and tells them to stop talking to the patient.
- c. Explains to the patient that none of the experience is real.
- d. Directs the patient to tell the voices to go away.

9. When responding to a patient with a delusion, the clinician:

- a. Does not challenge the delusion directly.
- b. Goes along with the patient's delusion.
- c. Touches the patient to offer reassurance.
- d. Does not attempt to distract the patient.

10. Angry reactions to relatively minor provocations, a grandiose self-image, needing admiration, and a lack of empathy are symptoms of which type of personality disorder?

- a. Paranoid
- b. Narcissistic
- c. Histrionic
- d. Antisocial



Courtesy: Swan, J. (2020). Understanding mental illness for all healthcare professionals:

Integrating physical and mental health care. *Wild Iris Medical Education*.

<https://wildirismedicaleducation.com/courses/physical-mental-illness-integration>

Appendix D: Measurement Tools Permission

- Forwarded message -----

From Janis MacDonald <xxxxxx@xxxxxx>

Date: Mon, Jun 6, 2022, at 10:38 AM

Subject: Re: Permission To Use Some Mental Health Course Material

To Juliet Onyia <xxxxxxxx@acu.edu>

Hi Juliet,

Thank you for your inquiry and your interest in our course content. You may use content in your project. Please give Wild Iris Medical Education credit for the content.

Here is to your success.

Janis MacDonald

Wild Iris Medical Education

PO Box xxxx

Comptche CA xxxxxx

xxx-xxx-xxxx

On Fri, Jun 3, 2022, at 6:10 PM Juliet Onyia <xxxxxxxxx@acu.edu> wrote:

Greetings, Ms. Swan,

My name is Juliet Onyia. I am a Doctor of Nursing Practice student at the Abilene Christian University, Dallas, Texas, USA. I am doing a DNP project about nursing knowledge and skills in providing care to adult psychiatric patients with comorbid physical conditions.

I reviewed your online course material, "Understanding Mental Illness for All Healthcare Professionals: Integrating Physical and Mental Health Care," and took the post-test

and passed. I found the course material suitable for the study, and I ask for your permission to use some of the material and questions.

I appreciate your support.

Juliet Onyia MSN RN,
School of Nursing, ACU, Dallas, Texas.

----- Forwarded message -----

From: GENESIS CHORWE xxxxxxxx@xxxxxxxxxx

Date: Thu, Jun 16, 2022, at 5:43 AM

Subject: Re: Permission to Use the Mental health Problems Perception Questionnaire
(MHPPQ)

To: Juliet Onyia <xxxxxxxx@acu.edu>

Dear Onyia,

You are welcome to use the adapted tool I used in my study. However, I advise that in your report you should remember to also acknowledge that the tool was originally developed by Prof Lauder (Lauder W., Reynolds W., Reilys V., et al. (2000) The development and testing of the Mental Health Problems Perception Questionnaire. Journal of Psychiatric and Mental Health Nursing 7, 221–226.

Thank you

Genesis Chorwe-Sungani, PhD

Associate Professor in Mental Health

Acting Director Institute of Postgraduate Studies and Research

Kamuzu University of Health Sciences

Blantyre

Cell: +xxxxxxxxxxxxxx

Skype: xxxxxxxxxxxxxx

Email: xxxxxxxxx@xxxxx or xxxxxxx@gmail.com

ORCID iD: <https://orcid.org/0000-0002-4296-6394>

MyNCBI: [My Bibliography - NCBI \(nih.gov\)](#)

Virus-free. www.avg.com

On Wed, Jun 15, 2022, at 7:54 PM, Juliet Onyia <xxxxxxx@acu.edu> wrote:

Greetings, Mr. Chorwe-Sungani,

My name is Juliet Onyia. I am a Doctor of Nursing Practice student at the Abilene Christian University, Dallas, Texas, USA. I am doing a DNP project about nursing knowledge and skills in providing care to adult psychiatric patients with comorbid physical conditions.

I reviewed your online article "Nurses' knowledge and skills in providing mental health care to people living with HIV/AIDS in Malawi." I found the survey questions suitable for the study, and I ask your permission to use some of the questions.

I appreciate your support.

Onyia MSN RN,

School of Nursing Juliet, ACU, Dallas, Texas.

Appendix E: IRB Approval Letter

----- Forwarded message -----

From: <do-not-reply@cayuse.com>

Date: Mon, Jun 19, 2023, at 12:46 AM

Subject: IRB-2023-48 - Initial: Initial - Exempt – ACU

To: <xxxxxxx@acu.edu>, <xxxxxxxxx@acu.edu>

Date: June 19, 2023

PI: Juliet Onyia

Department: ONL-Online Student, 17260-Doctor of Nursing

Re: Initial - IRB-2023-48

Mental Health Education for Nurses Caring for Adults with Severe Mental Illness

The Abilene Christian University Institutional Review Board has rendered the decision below for *Mental Health Education for Nurses Caring for Adults with Severe Mental Illness*. The administrative check-in date is June 16, 2023.

Decision: Exempt

Category: Category 2.(i). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:

The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects.

Research Notes:

Additional Approvals/Instructions:

If at any time the details of this project change, please resubmit to the IRB so the committee can determine whether or not the exempt status is still applicable. All approval letters and study documents are located within the Study Details in Cayuse IRB.

The following are all responsibilities of the Primary Investigator (PI). Violation of these responsibilities may result in suspension or termination of research by the Institutional Review Board. If the Primary Investigator is a student and fails to fulfil any of these responsibilities, the Faculty Advisor then becomes responsible for completing or upholding any and all of the following:

- When the research is completed, inform the Office of Research and Sponsored Programs. If your study is Exempt, Non-Research, or Non-Human Research, email orsp@acu.edu to indicate that the research has finished.
- According to ACU policy, research data must be stored on ACU campus (or electronically) for 3 years from inactivation of the study, in a manner that is secure but accessible should the IRB request access.
- It is the Investigator's responsibility to maintain a general environment of safety for all research participants and all members of the research team. All risks to physical, mental, and emotional well-being as well as any risks to confidentiality, should be minimized.

For additional information on the policies and procedures above, please visit the IRB website <http://www.acu.edu/community/offices/academic/orsp...>

or email orsp@acu.edu with your questions.

Sincerely,

Abilene Christian University Institutional Review Board