Addressing Medical Mistrust in In-Patient Psychiatric African American (AA) Patients

Eselle Molua

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Addressing Medical Mistrust in In-Patient Psychiatric African American (AA) Patients

Eselle Mathias Molua

University of New Hampshire

Faculty Mentor: Cathleen Colleran, DNP, RN

Practice Mentor: Nelly Kangethe, DNP, CRNP-PMH

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MEDICAL MISTRUST
Abstract

Background: Medical Mistrust (MM) is associated with patient dissatisfaction, treatment nonadherence, and poor health outcomes. In the United States, MM is prevalent in African American patients in In-Patient Psychiatric settings. Caregiver training and education on MM and cultural sensitivity can help identify mistrust and provide strategies to increase trust and reduce mistrust.

Purpose: This aim of this project was to implement an educational tool to improve caregiver awareness about knowledge of MM. By doing so, it was the goal to enhance cultural sensitivity skills and patient-centeredness in the African American population at the adult psychiatric unit in Northwest hospital, Maryland. Ultimately, the goal was to minimize mistrust and enhance trust between caregivers and their patients.

Methods: Literature review was conducted which provided evidence-based information. An educational material was designed from the available literature and was presented to psychiatric caregivers. A pretest-posttest questionnaire design was used to evaluate the impact of the evidence-based educational intervention on caregivers in this setting. Most importantly, the questionnaires were for informative purposes - about the positive effect of the educational intervention.

Intervention: An educational intervention about MM and strategies to decrease it in African American patients with mental disorders was delivered via zoom and a cloud link. A pre and post-test questionnaire (Medical mistrust caregiver survey) comprising three sections was used to detect changes in the caregivers’ awareness and knowledge about MM and strategies to improve caregiver-patient trust before and after the educational intervention.

Results: The project participants were 34 psychiatric caregivers. An analysis of the data results showed a slight improvement in the awareness and knowledge of MM among the participants. There was an overall increase in the post questionnaire correct responses. The percentage of correct answers in part of the pre questionnaire was 82.0%; it increased to 86.6% in the post questionnaire. The importance of this
educational session as shown in the results is that it created an awareness about MM and minimization strategies on AA patients in the in-patient psychiatric unit.

**Conclusion:** There was a slight increase in caregiver awareness and knowledge about MM and practices that help improve caregiver-patient trust. Therefore, implementing an educational session about MM on AA patients to psychiatric caregivers raises an awareness of MM and reduces distrust with caregivers and their patients. However, more sensitization and strategies will help to reduce distrust with caregivers and their patients.

**Keywords:** Medical mistrust, psychiatry, education, knowledge, awareness, cultural sensitivity
Addressing Medical Mistrust in In-Patient Psychiatric African American (AA) Patients

Introduction

Medical trust is one of the leading indicators of patient satisfaction in psychiatric care settings. Psychiatric patients develop mistrust in the healthcare system when they perceive that their rights to informed consent are infringed on, experience bias, discrimination in the access to treatment, structural barriers to quality care, and inadequate involvement in the care decisions (Jaiswal & Halkitis, 2019). The implication of medical mistrust on the quality of care is evident from poor self-reported health status among patients, lapses in health screening programs, and underutilization of resources. Moreover, patients who mistrust medical processes are less likely to adhere to the treatment regimen, which leads to low quality of life (Jaiswal & Halkitis, 2019). Conversely, high patient-centered communication in psychiatric care processes leads to increased trust in the efficacy and outcomes of the treatments.

Healthcare systems worldwide have recorded an alarming increase in the levels of MM, leading to unfavorable health outcomes and racial/ethnic disparities, especially in psychiatric care, where emotional attachment between patients and providers speeds up the recovery rate. The presence of MM leads to diminished quality of care interventions due to low levels of patient-centeredness and efficiency of treatment processes. Moreover, medical doubt in inpatient psychiatric populations leads to extended hospital stays, reduced timeliness and increased cost of care (Jaiswal & Halkitis, 2019). The Institute of Medicine (IOM) report entitled Unequal Treatment: What Healthcare Providers need to know about Racial and Ethnic Disparities in Healthcare recommended all healthcare professionals receive cultural competence training to address these issues. This recommendation emerged from evidence showing that the failure of healthcare providers to understand, acknowledge and manage sociocultural variations in healthcare behavior and beliefs of patients may hinder effective communication, negatively affect trust, and lead to patient dissatisfaction, nonadherence, and poorer health outcomes, especially among patients from minority populations (Bau et al., 2019).
Additionally, in the third of the six aims of the IOM report of 2001, entitled *Crossing the Quality Chasm: A New Health System for the 21st Century*, the provision of patient-centered care was cited as a critical aspect of quality care which increases medical trust between patients and providers (Bau et al., 2019). In essence, this factor is focused on “Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions”. This entails that the individual patient’s culture, social context, specific needs deserve respect, and the patient should have an integral role in decisions about their care (Institute of Medicine, 2001).

Before implementing this project, the unit just like other facilities lacked educational modules and sensitizing projects about MM in AA patients. In this facility, just like in other neighboring facilities, the focus on in-house modules has been cultural competency; this is limited compared to the scope and goal of the teachable material developed in this project. Therefore, the goal of this Doctorate of Nursing Practice (DNP) quality improvement project was to create an educational material for psychiatric caregivers aimed at improving an understanding of MM and provision of culturally sensitive and patient-centered care of the AA minority patient population in the inpatient psychiatric unit at North West Hospital. Ultimately, with the education of caregivers about MM and the strategies for its mitigation, it was expected that it would potentially pave a way to reduce mistrust.

**Problem Description**

MM is a significant issue of concern in that it impacts adherence, timely, quality, equitable, and affordable psychiatric care in the United States (Knaak, Mantler, & Szeto, 2017). The leading causes of MM in psychiatric facilities are inadequate patient involvement in decision-making, lack of cultural awareness of caregivers, denied opportunity for informed consent, and discriminative tendencies by caregivers (Hostetter & Klein, 2021). The former article espouses that MM poses significant barriers to efficacious treatment due to stigma, high cost of care, and low self-reported mental health status cases among at-risk populations. Such issues have far-reaching implications on the quality of psychiatric care.
interventions. Patients who develop mistrust experienced considerable difficulties adhering to follow-up appointments, taking prescribed medical advice, or filling up drug prescriptions. This leads to deterioration in access to quality health care and outcomes, especially in the disproportionately marginalized populations (Knaak, Mantler & Szeto, 2017).

Improving the patient-caregiver relationship is crucial in reducing the impact of MM on outcomes (Cuevas et al., 2019). As a growing standard in health care, patient-centeredness and cultural competence incorporate patients’ needs and preferences into care, allowing caregivers and patients to work as partners and reach the best possible clinical decisions (Xanthos, 2020). Providing healthcare caregivers with training to enhance trust to include not just cultural competence, but also sensitivity has improved medical confidence with patients. Tang et al. (2019) found that promoting cultural competence among healthcare providers can help address distrust of the medical community and cultural stereotyping of minority populations. However, even though many healthcare providers are aware of the need to develop these skills to address mistrust, they lack the training to apply them (Trinh et al., 2019). This calls for the need for educational material that can help improve psychiatric caregivers’ skills to help address the issue of medical mistrust.

Available Knowledge

The primary predictors of patient satisfaction in psychiatric populations include the perceived access to equitable care that is also linguistically and culturally appropriate. Evidence shows that individual patient characteristics such as demographic markers, culture, cultural attitudes, religious beliefs, and predisposing values significantly impact the patient’s perception of care and overall health status. According to Henderson et al. (2015), AA report higher cases of MM partly as a result of involuntary commitments due to mental health disorders. Certain racial stereotypes that associated African American groups with psychiatric conditions to violence lead to under-recognition and misdiagnosis of mental health illnesses, hence fewer referrals to specialist care. Furthermore, involuntary admissions to inpatient psychiatric care
centers in ethnic minorities increase mental health stigma and dissatisfaction with the services delivered (Henderson et al., 2015). Patients are denied the rights to consent and informed decisions when placed under involuntary admission. Medical mistrust in inpatient psychiatric populations can be mitigated by developing integrated networks within traditional contexts and family models for seamless communication among patients and providers.

According to Heath (2021), from NORC at the University of Chicago on behalf of the ABIM Foundation, 59 percent of adult patients agree that implicit bias in medicine and discrimination is a problem in the United States healthcare industry, and another 49 percent of the physicians agree. The researchers of this survey espouse that this perception could effectively erode patient trust, a key ingredient to an excellent patient-provider relationship and meaningful patient engagement. The data surveyed 2,000 patients and 600 physicians; it showed that implicit bias in medicine is a striking trend. Patients perceive discrimination from the medical industry, and at least half of providers agree it is a problem that gets in the way of a quality medical encounter. 12 percent of the patients reported they had experienced discrimination in the medical setting; black patients were twice likely as white patients to report discrimination. This has led to lower patient trust in medical providers and the healthcare system.

Additionally, Heath (2021) states that racial discrimination and implicit bias in medicine affect blacks two to three times more than Caucasians. The Urban Institute and the Robert Wood Johnson Foundation concluded in their report of August 2021, entitled Most Adults Who Feel Treated or Judged Unfairly by Health Care Providers Report Adverse Consequences that implicit bias and racial discrimination towards blacks serves as a severe access barrier. Based on this report, 3.2 percent of patients of all races experienced some sort of unfair treatment in the medical setting. It is highest with 7.7 percent of Black respondents and 5.2 percent of Hispanic respondents, signaling a racial bias permeating the healthcare industry. Furthermore, the result found that implicit bias has tangible consequences on health outcomes, with 39 percent who experienced discrimination reporting they handled it by delaying medical
Postponing care leads to adverse effects such as deteriorating chronic illnesses, delayed diagnosis of new diseases, and ultimately limited care management, causing preventable conditions to be more acute and life-threatening. Furthermore, 30.7 percent of respondents reported they did not access care, and 11.4 percent reported patient-provider mistrust led patients to dismiss providers' advice (Heath, 2021).

The implementation of patient-centered approaches to care delivery in psychiatric populations is influenced by the individual characteristics that predict the mode of interactions between the mental healthcare system, patients, and providers (Clement et al., 2015). Therefore, developing Patient-Centered Medical Home (PCMH) programs for psychiatric care centers should prioritize the individual characteristics for enhanced medical trust between patients and providers. Spirituality and religious activities have been found to have a close positive correlation with higher levels of patient satisfaction and health outcomes in inpatient psychiatric populations (Clement et al., 2015).

Mistrust among psychiatric patients who live in marginalized communities, especially those inhabited by blacks, is at a higher risk of poor health outcomes due to biased health delivery systems (Opel et al., 2021). Recent research shows African Americans with mental health issues have a higher likelihood of getting terminally ill and even dying from COVID-19 than whites due to MM and consequently unwillingness to take the vaccine. MM among blacks in the United States is said to have been cemented by the infamous Tuskegee experiment in which doctors withheld syphilis treatment from black men to monitor the disease progression. This is evident from a recent study, which showed that only 42% of African Americans were willing to take the COVID-19 vaccine by November 2020 (Opel et al., 2021). This calls for patient-centered programs to create a conducive psychiatric care environment through increased transparency and communication. In addition, the well-being of mental health patients who are underserved in the psychiatric care systems can be improved through active engagements in the decision-making process (Opel et al., 2021).
Behavioral scientists propose that trust issues in psychiatric care can be fixed by strengthening patient-provider relationships (Benkert et al., 2019). This is attained by maintaining close contact and communication with patients; paying close attention to patient symptoms, complaints, and concerns about the treatment regimen. On another note, mentally ill patients, especially from ethnic minorities, undergo significant physiological changes during postpartum. Coupling this with MM is said to contribute significantly to suicide (Benkert et al., 2019).

Various studies have investigated interventions aimed at reducing MM among patients. For example, a systematic review by Fredericks et al. (2015) that included 40 studies and sought to examine the effect of patient-centered care on patient outcomes found that the patient-centered approach was associated with greater trust and satisfaction during clinical encounters and improved patient adherence on treatment compliance. In another study by Cuevas et al. (2019), the researchers concluded that physicians could buffer the impact of mistrust by utilizing patient-centered communication skills, including soliciting the concerns and priorities of the patient and being responsive to their healthcare needs.

**Rationale**

This DNP quality improvement project was based on the Patient-Centered Culturally Sensitive Health Care (PC-CSHC) model as the guiding theoretical framework. The model provides the needed conceptual framework for understanding and improving healthcare services to minority and low-income patients at risk of health problems (Tucker et al., 2017). The model's basic premise is that educating healthcare professionals can promote patient-centered, culturally sensitive care. According to the model, healthcare settings and providers that are culturally sensitive would positively influence patients' views of the providers in a culturally sensitive manner (Tucker et al., 2017). As a result, this leads to patients having feelings of comfort and trust in their caregivers, which enhances their satisfaction with care and their sense of interpersonal control in healthcare processes. Improved patient satisfaction and perceived interpersonal control positively influences the patients' stress levels when interacting with providers, leading to an
increased likelihood of adhering to provider recommendations. This ultimately leads to improved health outcomes (Tucker et al., 2017).

This evidence-based model applies to the population in question—the minority population (African Americans with mental health disorders) in an inpatient psychiatric unit and mental health caregivers. First, African Americans represent a minority population who are at the risk of reporting MM due to issues related to racism and discrimination (Hostetter & Klein, 2021; Henderson et al., 2015). Second, the model focuses on improving health outcomes by educating healthcare providers on behaviors that promote trusting relationships between patients and caregivers thus fostering the provision of patient-centered, culturally sensitive care. Education of healthcare providers on behaviors that promote trusting relationships will help to increase their knowledge on these behaviors, reduce medical mistrust with patients, and ultimately gain patient trust and adherence to treatment.

**Specific Aims**

MM is a significant barrier to access to quality healthcare and is associated with less care satisfaction, utilization of healthcare services, and treatment adherence (Knaak et al., 2017). Evidence shows higher reports of MM among African Americans (Hostetter & Klein, 2021; Henderson et al., 2015). Interventions that improve caregiver behaviors, patient-provider relationships have been shown to reduce MM, including training all healthcare professionals on cultural competency skills, recognizing implicit bias, and practicing patient-centeredness (Gaebel et al., 2014). Before implementing this project, the psychiatric unit at Northwest Hospital lacked educational modules and a sensitization project to address MM with AA patients. The primary goal of this DNP project was to provide education aimed at improving caregiver awareness on MM specific within the AA patient population. The training also intended to enhance skills of cultural sensitivity and the practice of patient-centeredness. It provided knowledge on MM and African American care provision. By educating caregivers with the material developed, it was expected that a gap
would be bridged on MM. The long-term goal or aim is that caregivers would utilize the knowledge gained in their interaction with their patients, which is expected to lead to better patient outcomes.

**Methods**

**Context**

Identifying and addressing MM in inpatient psychiatric centers required the implementation of an issue-based intervention to address the varied needs across different care settings. However, the adoption of intervention programs in inpatient psychiatric settings considered factors such as the patients' cultural beliefs and educational levels (Hostetter & Klein, 2021). For example, in the rural communities predominantly inhabited by ethnic minorities, certain cultural beliefs that mental illness is a curse may significantly undermine the implementation of the interventions. Moreover, black communities that have experienced structural racism and discrimination in access to healthcare may impose resistance to the adoption of measures to address MM (Hostetter & Klein, 2021). This creates the need to assess such population characteristics and address the socio-cultural beliefs about mental health before introducing the interventions. Empathetic care providers and counselors are invaluable in designing and implementing interventions against MM to identify and address contextual issues in a given patient population (Trinh et al., 2019).

**Cost Benefit Analysis/ Budget**

The implementation budget for this project was an important issue to consider as it influenced the availability of project resources needed to achieve the desired outcomes. From the recently published literature review, it was evident that MM was a key predictor of patient satisfaction and efficacy of treatment interventions, hence the need for relevant, actionable interventions (Bau et al., 2019). The findings of this study were expected to provide valuable insight on the creation of positive patient-caregiver relationships to enhance treatment adherence, remission of symptoms, and reduction of the cost of psychiatric care through lower readmission rates and length of hospital stay. The cost of conducting this
project was approximately $1,000 for transportation, accommodation, and all implementation expenses. Considering the cost-benefit analysis of this project to develop evidence-based, patient-centered strategies presented to caregivers about medical mistrust in inpatient psychiatric African American populations, there was a need to pursue this topic as a quality improvement project.

In general, perceived barriers to healthcare utilization predisposes patients to use acute facilities such as inpatient psychiatric units. More specifically, studies have established that high levels of MM predict lower utilization of preventive care services, which typically occurs in primary care settings. This costs more to patients financially, time wise as well as the healthcare system which pays for medical care for some of these patients (Arnett et al, 2016).

Interventions

The intervention included implementing a psychiatric caregiver training material designed to teach skills that build and maintain patient-caregiver trust. After the appropriate approvals, the DNP student sent out email messages inviting caregivers to participate in the project (Appendix A). The letter stated the date, time, and location where the intervention took place. The letter also informed participants of a zoom session and the option of viewing the training session via cloud if they would be unavailable at the time of the zoom session. Before implementing the educational intervention, approval was sought from the University of New Hampshire Nursing Department and Lifebridge, Northwest Hospital.

One week before implementing the project, all the eligible participants received an email reminder associated with the program location and time. The educational intervention included a one-hour online session developed from prior literature as detailed in the literature review section. It focused on teaching the providers about the historical foundations of MM, effects of MM on healthcare behaviors and health outcomes, signs of medical doubt, how MM could be addressed, and cultural sensitivity (Gaebel et al., 2014; Trinh et al., 2019; Fredericks et al., 2015). Before starting the program, the participants completed the socio-demographic questionnaire (Appendix B) and the pretest Medical mistrust caregiver questionnaire.
Two weeks after implementing the educational program, the participants completed the Post-Questionnaire (Appendix D). The project leader was directly involved with the development of the pre- and post-test surveys. Other team members involved in the work included the unit manager, faculty mentor, practice mentor, and the statistician. The intervention was designed to minimize costs and safeguard participants' integrity, confidentiality, and privacy.

**Study Interventions**

The DNP project assessed participants' knowledge of MM and provided educational material to educate caregivers about MM in inpatient African American populations. In this regard, pre and post-questionnaires were administered to gauge the caregiver's comprehension of MM and determine if it enhanced and created awareness after the educational material was presented. The scholar developed these questionnaires based on the available literature and interventions presented in the educational outline. After the pre-questionnaire, an annotated bibliography was presented to providers outlining the most recent literature on MM in this population. It came from the information covered in the literature review section. The annotated bibliography was followed by an educational presentation (Appendix E) on MM and the strategies from evidence-based practice to enhance trust between psychiatric caregivers and African American patients. It included lessons on cultural sensitivity, respect for patients' rights and wishes, involving the patient in care plans and strategies to build and enhance therapeutic alliances.

**Measures**

The aim of this quality improvement project was to educate providers on strategies to enhance trust with their patients. The pre- and post-questionnaires were intended to provide information about the participants’ knowledge of MM with this patient population. The questionnaires also served as a guide to better understand the improvement of participants’ knowledge after the intervention had been conducted. Descriptive statistics, including percentages, mean, and frequencies, were used to analyze and present the
results of the demographic data. Data analysis of the participants' responses on the MM questionnaires included calculating the percentage of questions answered and group means.

**Analysis**

The questionnaires comprised of three sections. The first section consisted of 9 multiple choice questions that assessed the participants' knowledge and awareness of MM among African American patients and evidence-based strategies to improve trust between psychiatric providers and African American patients. For this section, data analysis included calculation of the number of questions answered correctly. For the second and third sections, which tested the knowledge and practices of the providers regarding MM, data analysis included reporting the means of the participants for each item and the overall group means for each section. The data analysis procedure included the participant's demographic input and the pretest/posttest medical mistrust caregiver questionnaire. This was followed by ensuring the validity of the data by checking that there was no missing data. Each response was checked to ensure that participants answered all the questions. This was followed by data entry and checking and rechecking the data to ensure that the format was correct and values were within the expected range. Notably, all the data analysis included de-identified raw data and was performed using Microsoft Excel. Graphs and charts were used to display the most significant findings.

**Ethical Considerations**

Project processes, especially those that involve persons, are bound by ethical principles that seek to protect their dignity and rights to privacy. In addition, the ethical principles of the project aimed to balance the participants' costs and benefits. The implementation and study of interventions to alleviate MM in an inpatient psychiatric facility were guided by the ethical guidelines. There was a formal ethics review; the nursing department at the University of New Hampshire approved the project proposal to formally verify the suitability of data collection methods and unethical exposure or leakage of confidential information. The project leader eliminated conflict of interest by refraining from or engaging with closely related individuals.
personally or professionally to eliminate bias. Informed consent refers to the voluntary or explicit acceptance to participate in the quality improvement implementation. Informed consent was obtained by administering forms to participants to voluntarily, knowingly, and intelligently agree to participate in the implementation process by completing the attached Appendix F. Thus, the participants’ rights to privacy were integrated into the project processes. Moreover, participants were provided with valuable information on the expected benefits of participating in the project. The project environment and questionnaires were designed to minimize physical or emotional discomfort to the participants as much as possible; no sensitive questions that evoked painful memories were asked. In addition, the participants were not subjected to processes that exposed them to health risks. The ethical section was consistent with the elaborations of Peter (2015).

Results

The primary purpose of this DNP project was to provide education to improve provider awareness on MM with African American patients in an inpatient psychiatric unit. The project consisted of four phases: design, pre-intervention, intervention, and post-intervention phases. All the phases occurred within a period of five months, from August to November 2021. The design of the project phase entailed literature review, preparation of evidence-based teaching material, design of the questionnaires, and initiation of contact with participants. During the pre-intervention phase, the primary scholar collected the baseline data. The participants completed a pre-test questionnaire that included their demographics and the pre-test survey. During the intervention phase the project lead provided an online educational session. The intervention included a live Zoom presentation session about MM and strategies to minimize it between caregivers and African American patients with mental disorders. Participants who could not attend the scheduled zoom session were provided a cloud link for the educational component. The post-intervention phase took place two weeks after the implementation of the intervention. During this phase, a post-questionnaire was administered to participants. Participants had the opportunity to answer the same
questions they answered in the pre-questionnaire. Two weeks were allotted to complete the post questionnaire. Interestingly, all participants completed both the pre and post questionnaires.

The participants of the DNP project included a convenience sample of 34 caregivers working at an inpatient psychiatric unit. Participation in the project including the intervention and completion of the pre- and post-test questionnaires was voluntary. Of the 34 participants, 23 (67.6%) were female and 11 (32.4%) were male (Figure 1). 28 (82.4%) of the participants were African Americans, 5 (14.7%) were caucasians and only one (2.9%) identified to belong to other races (Figure 2). The majority of the participants (n=13, 38.2%) were nurse practitioners and registered nurses (n= 9, 26.5%) (Figure 3). All the participants were English speakers though the majority (n=25, 73.5%) reported that they are bilingual speakers who were also fluent in either European or African languages (Figure 4). The majority of the bilingual speakers reported to be also French speakers (n=5, 22.7%) or african dielects (Figure 5). The majority of the participants who were fluent in African languages were either Igbo speakers (n=3, 13.6%) or Yoruba speakers (n=2, 9.1%) (Figure 5). In regards to the years of clinical practice the majority reported 1-4 years of clinical experience (n=11, 33.3%) or 5-10 (n=11, 33.3%) (Figure 6). 33.3% (n=11) reported that they had 5-10 years of experience caring for african american patients. Only 5 (15.2%) of the participants reported less than one year of experience caring for African American patients (Figure 7). More than half ( n=18, 52.9%) of the participants reported that they were very involved in working with healthcare professionals from culturally diverse backgrounds (Figure 8).
Figure 1

*Gender*

Figure 2

*Race/Ethnicity*
Figure 3

Current Role

<table>
<thead>
<tr>
<th>Role</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Practitioner</td>
<td>13</td>
<td>38.2%</td>
</tr>
<tr>
<td>Physician Assistant</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>6</td>
<td>17.1%</td>
</tr>
<tr>
<td>Licensed Practical Nurse</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Social Worker</td>
<td>2</td>
<td>5.9%</td>
</tr>
<tr>
<td>Therapist</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td>Nurse Tech</td>
<td>2</td>
<td>5.9%</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>14.7%</td>
</tr>
</tbody>
</table>

Figure 4

*Other Languages other than English*
Figure 5

*Other Languages Spoken*

![Bar chart showing the number of languages spoken by doctors. French is the most spoken language with 5 doctors (22.7%). Other languages include: Ghanaian language (4), Igbo (1), Jive (1), Mankan (1), Some Spanish (2), Tigrigna, Amharic (2).]

Figure 6

*Years of Clinical Practice*

![Pie chart showing the distribution of years of clinical practice. 33.3% of doctors have >10 years of experience, 21.2% have 5-10 years, 12.1% have 1-4 years, and 33.3% have <1 year of experience.]
Data analysis for the study variables was performed using Excel. After implementing the education intervention, data was extracted from the participant’s demographic input and the pretest/posttest medical mistrust caregiver questionnaires. The validity of the data was ensured by making sure that there were no missing data. Essentially, every questionnaire response was checked to ensure that participants answered all
the questions. This was followed by data entry and checking and rechecking the data to ensure that the format was correct and values were within the expected range. All the data analysis included the use of de-identified raw data. In addition, the analysis process entailed a conventional analysis of percentages and group means.

The pre-and post-test medical mistrust caregiver questionnaires collected data on caregiver awareness about MM among African American patients. The questionnaires comprised of three sections. The first section consisted of 9 multiple choice questions that assessed the participant’s knowledge and awareness of MM with African American patients and evidence-based strategies to improve trust between psychiatric caregivers and African American patients. On average, the participants answered 82.0% of the questions in this section correctly before the training. After implementing the educational intervention, the participants answered 86.6% of the questions correctly, which improved their knowledge and awareness about MM. Figure 9 is a bar graph that provides a visual summary of these results.
The participants’ responses to the MM caregiver questionnaires in the pre-and post-test were examined item by item to assess knowledge and awareness in detail. Table 1 presents the results of section 1 of the medical mistrust caregiver questionnaire, pre-post intervention item by item comparison of the percentage of the correctly answered questions. As displayed in the table, there was an increase in the rate of participants who provided the correct responses during the post-test compared to the pre-test for question 1 (70.6% vs 91.2%), question 2 (82.4% vs 94.1%), question 7 (82.4% vs 94.1%), question 9 (73.5% vs 82.4%). However, the percentage of participants who provided the correct answers did not change from pre-test to post-test for question 5 (91.2% vs 91.2%) and question 8 (73.5% vs 73.5%). Additionally, there was a decline in the percentage of participants who provided the correct answers after the implementation of the project for question 3 (79.4% vs 73.5%), question 4 (94.1% vs 91.2%), and question 6 (91.2% vs 88.2%).
Table 1

Medical Mistrust Caregiver Questionnaire, section 1, Pre-Post-Intervention Item by Item Comparison of Percentage of Correct Responses

<table>
<thead>
<tr>
<th>Item Description</th>
<th>Pre</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Which of the following is a factor that fuels medical mistrust among African Americans with mental illness?</td>
<td>24</td>
<td>31</td>
</tr>
<tr>
<td>2. Which of the following are signs of medical mistrust in African American patients? Select all that applies.</td>
<td>28</td>
<td>32</td>
</tr>
<tr>
<td>3. Which one of the following does not help reduce medical mistrust during interactions with patients?</td>
<td>27</td>
<td>25</td>
</tr>
<tr>
<td>4. Which is likely to cause medical mistrust in the African American population?</td>
<td>32</td>
<td>31</td>
</tr>
<tr>
<td>5. True or False? African Americans are more likely than Caucasians to have medical mistrust.</td>
<td>31</td>
<td>31</td>
</tr>
<tr>
<td>6. True or False? Among African Americans, high levels of medical mistrust are a response to historical injustices and ongoing discrimination, including systemic racism.</td>
<td>31</td>
<td>30</td>
</tr>
<tr>
<td>7. True or False? Medical mistrust does not play a significant role in determining the health-seeking behaviors of individuals.</td>
<td>28</td>
<td>32</td>
</tr>
<tr>
<td>8. True or False? All African Americans believe that a mental health condition is a sign of personal weakness.</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>9. True or False? Many African Americans turn to healthcare providers and rarely rely on faith, family and social communities for emotional support.</td>
<td>25</td>
<td>28</td>
</tr>
</tbody>
</table>

The second section of the MM caregiver questionnaire comprised 14 items that assessed the participants' awareness regarding MM among African American patients using a five-point Likert scale. Table 2 presents the pre and post-test mean scores of the participants in each of the 14 items. As shown in the table, the participants' mean score was higher after the implementation of the education intervention compared to baseline. During the pre-test, the individual item means scores ranged from 2.9 to 4.1 on a
scale of 5. The overall mean score of the participants in this section was 3.6, representing a relatively high level of awareness of MM. After implementing the intervention, the overall mean score of the participants increased to 3.9, with individual item mean scores ranging from 3.3 to 4.5. This shows an increase in change in the trend of the level of awareness after the educational presentation.

Table 2

*Medical Mistrust Caregiver Survey, section 2, Pre-Post-Intervention Comparison of individual item mean scores*

<table>
<thead>
<tr>
<th>Practice Skill</th>
<th>Pre Mean Score</th>
<th>Post Mean Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>I recognize the signs of medical mistrust in patients</td>
<td>3.7</td>
<td>4.1</td>
</tr>
<tr>
<td>I acknowledge and affirm experiences of discrimination and expressions of mistrust in African American patients</td>
<td>3.5</td>
<td>3.7</td>
</tr>
<tr>
<td>I acknowledge the historical and current context of discrimination/systemic racism as the root cause of medical mistrust among African Americans.</td>
<td>3.5</td>
<td>3.7</td>
</tr>
<tr>
<td>Many aspects of culture influence health and health care</td>
<td>3.8</td>
<td>4.3</td>
</tr>
<tr>
<td>Spiritual and religious beliefs are important aspects of African American culture.</td>
<td>3.7</td>
<td>4.1</td>
</tr>
<tr>
<td>I believe that everyone should be treated with respect no matter their race or cultural heritage.</td>
<td>4.1</td>
<td>4.5</td>
</tr>
<tr>
<td>I understand that people from different cultures may define the concept of “health care” in different ways.</td>
<td>3.9</td>
<td>4.2</td>
</tr>
<tr>
<td>I recognize potential barriers to service that might be encountered by African Americans</td>
<td>3.6</td>
<td>3.7</td>
</tr>
<tr>
<td>I Understanding different cultures facilitates care and trust of patients and their families.</td>
<td>3.8</td>
<td>4.4</td>
</tr>
<tr>
<td>I feel most caregivers are culturally sensitive to African American patients</td>
<td>3.1</td>
<td>3.3</td>
</tr>
<tr>
<td>I feel caregivers are stereotypical and bias of African American Patients</td>
<td>2.9</td>
<td>3.3</td>
</tr>
<tr>
<td>I understand that the patients’ view of me may be influenced by stereotypes</td>
<td>3.5</td>
<td>3.8</td>
</tr>
<tr>
<td>I am aware of my own biases and preconceptions</td>
<td>3.2</td>
<td>3.4</td>
</tr>
<tr>
<td>I feel much needs to be done by caregivers to gain African American patients' trust</td>
<td>3.6</td>
<td>3.8</td>
</tr>
</tbody>
</table>

The third section of the MM caregiver questionnaire comprised six items that assessed the skills and practices that determine how often the providers practice behaviors that help enhance trust between
psychiatric providers and African American patients. The items use a four-point Likert scale. Table 3 presents the pre and post-test mean scores of the participants in each of the six items. As portrayed, there was a slight improvement in the individual item mean scores of the providers in four of the questions after implementing the education intervention. During the pretest, the average individual item means scores for the six questions ranged from 2.7 to 3.2, with an overall mean score of 3.1. After the educational presentation, the overall mean score of the providers in the six items was 3.1, indicating that there was no change.

Table 3

Medical Mistrust Caregiver Questionnaire, section 3, Pre- Post-Intervention Comparison of individual item mean scores

<table>
<thead>
<tr>
<th>Question</th>
<th>Pre-test Mean Score</th>
<th>Post-test Mean Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>I involve patients in the development of their plan of care</td>
<td>3.0</td>
<td>3.1</td>
</tr>
<tr>
<td>I use open-ended questions when assessing patients</td>
<td>3.1</td>
<td>3.2</td>
</tr>
<tr>
<td>I always use a non-judgmental and non-confrontational approach when interacting with African American patients</td>
<td>3.1</td>
<td>3.1</td>
</tr>
<tr>
<td>I always seek to understand patients’ rationale for their behaviors or illness.</td>
<td>3.2</td>
<td>3.3</td>
</tr>
<tr>
<td>I always validate medical mistrust by affirming and acknowledging experiences of discrimination and expressions of mistrust</td>
<td>2.7</td>
<td>2.7</td>
</tr>
<tr>
<td>I use bilingual/bicultural or multilingual/multicultural staff, and/or personnel who are skilled in providing medical interpretation and families who need or prefer this level of assistance.</td>
<td>3.0</td>
<td>3.1</td>
</tr>
</tbody>
</table>

Content Delivery and Feedback

The post-test questionnaire also included questions evaluating the participant’s satisfaction with the content delivery. The first question in this section asked the providers to rate the effectiveness of the educational session about MM (Did you find this educational session about medical mistrust helpful?). Potential responses included “Yes,” “No,” “Maybe,” and “unsure.” 85% (n=29) of the participants chose
“yes,” and only 14.7 (n=5) chose “No” in response to this question. This indicates that the majority of the participants found the education session helpful in their practice. The second question in this section required the providers to rate how likely they are to utilize the strategies learned to curb medical mistrust in the African American population (How likely are you to utilize the strategies identified to curb medical mistrust in the African American population). The majority of the participants (44.1%, n=15) reported that they were very likely to use the strategies. Only four (11.8%) participants reported that they are very unlikely to use the strategies. Overall, the course evaluations were positive.

Discussion

Summary

Medical trust is among the leading indicators of patient satisfaction in psychiatric healthcare settings. However, medical distrust is a significant barrier to access to mental healthcare, particularly among minority patient groups. This quality improvement project improved provider awareness of MM and strategies to alleviate distrust among African American patients in an inpatient psychiatric unit. The project used a pre-and post-questionnaire to assess the impact of the intervention on the caregiver’s awareness. In addition, the intervention included an educational program that consisted of an online provider PowerPoint session on MM. The educational intervention was based on recent literature on strategies that can be utilized to enhance trust between psychiatric healthcare caregivers and African American patients.

The participants of the project included a sample of 34 providers working at an inpatient psychiatric unit. All the 34 participants completed the pre-and post-test medical mistrust caregiver questionnaires and were included in the education session about MM. A demographic survey was used to collect the demographic data of the participants (See Charts and graphs above for demographic information).

The most prominent finding was a positive increase in awareness of the participating caregivers about MM. This was demonstrated by an increase in the number of questions that the participants answered correctly, the overall mean for the first section of the survey, and the overall mean for items in sections two
and three of the survey, from the pre-intervention to the post-intervention period. For the first section, which included nine multiple-choice questions that assessed the participant’s knowledge and awareness of MM, the number of questions answered correctly increased from 82% during the pre-intervention period to 86% during the post-intervention period. This represents an improvement in their knowledge and awareness. For the second section, which included 14 items using a five-point-Likert scale, the overall mean score of the participants increased from 3.6 to 3.9, with responses moving from “strongly disagree” to “strongly agree.” This shows an increase in the level of awareness after the educational presentation. For the third section, which included six items using a four-point Likert scale, there was no change in the overall mean score of the participants, which remained as 3.1. However, the pre and post overall mean scores for this section indicated that caregivers had skills and were often practicing behaviors that help enhance trust between psychiatric caregivers and African American patients. These behaviors and practices included involving patients in the development of plan of care, using open ended questions when assessing patients, using a non-judgmental and non-confrontational communication approach, seeking to understand the rationale of patients for their illness or behavior, validating MM and seeking language translation services for patients who may need assistance. Through the content delivery feedback, it was evident that the majority of the participants (n=29, 85%) found this educational session helpful to their practice, and the majority (44.1%, n=15) were very likely to use the strategies in their practice.

The PC-CSHC model, along with its recognition in engaging minority patients, was certainly evident in the project results. According to the model's basic premise, training healthcare providers can promote the provision of patient-centered, culturally sensitive care (Tucker et al., 2017). The model also posits that training healthcare providers on behaviors that promote trusting relationships help increase their knowledge on these behaviors, reduce MM with patients, and ultimately improve caregiver-patient trust and treatment outcomes (Tucker et al., 2017). Based on the study results, it is evident that the educational intervention improved caregivers' knowledge and awareness of these concepts and the practice of the
learned concept. Thus, the model was a key strength of the project, notably because it guided the development of an evidence-based intervention. Another strength of the project is that it provided evidence on the efficacy of an educational program about MM in improving providers' awareness and knowledge and strategies to improve trust between psychiatric caregivers and patients.

**Interpretation**

This quality project improved caregiver awareness of MM and strategies to alleviate distrust with African American patients in an inpatient psychiatric unit. According to the study results, the implementation of an educational intervention can help improve the awareness of psychiatric mental health caregivers on MM. As evidenced by the results, there was an improvement in the caregivers’ awareness, knowledge and strategies that helped improve trust between psychiatric caregivers and patients after implementing the intervention.

A significant aspect of the educational intervention was to enhance the provider's cultural sensitivity and patient-centered care in African American patients. According to Tang et al. (2019), there were significant associations between nurses' cultural competence and patient trust. Furthermore, nurses' cultural competence, shared decision-making, and trust-building behaviors were positively associated with improved nurse-patient relationships and trust. In another study by Tekeste et al. (2019), cultural competence and sensitivity training increased knowledge and awareness among caregivers. However, it was not clear if training also improves patient outcomes.

Even though there was an improvement in the post-intervention scores of the caregivers, it is evident that the participants scored well in both the pre- and post-intervention questionnaires. This can be explained in part by the high number of African American caregiver participants. These findings are consistent with those of prior studies. According to evidence, a major factor fueling MM among African Americans is the low proportion of African American providers who can provide culturally sensitive care. Evidence shows that less than 2% of the American Psychological Association members are Black or African Americans.
(Hostetter & Klein, 2021). Given the high number of African American caregiver participants in this project, this can explain the high scores in the pre-questionnaire and not a significantly higher score in the post questionnaire.

**Limitations**

Several limitations could potentially affect the findings of the project. First, the project utilized a pre-test and post-test design that lacked a control group and randomization of participants to a test group. As a result, it may be difficult to ascertain whether the improvements resulted from the intervention or confounding variables. To minimize this limitation, the same questions were utilized for the pre and post questionnaires to enhance reliability. Second, the project included caregivers in one inpatient psychiatric setting where most of them were African Americans. As such, the study's findings may not be generalizable to settings with a higher proportion of caucasian or other racial caregivers or other psychiatric settings. While this may not be generalizeable in other facilities, the methods utilized were presented in a concise format which could be used to replicate the project in different facilities and settings. Third, the project did not include an extended follow-up to assess if the participants retained the knowledge gained. However the post questionnaire was utilized to gauge caregiver improvement after the implementation of the project, even though within a two week period. The project did not include a formal and indepth data analysis. As a result, the statistical significance of the changes in awareness and knowledge is not established. That notwithstanding, there was limited analysis by a statistician.

**Conclusion**

Medical trust is one of the leading indicators of patient satisfaction in psychiatric care settings. Trust is a critical element of the caregiver-patient relationship and is crucial in developing a strong therapeutic alliance. However, historical and the current discriminatory treatment of minority ethnic groups has fueled MM among patients from AA populations. The healthcare system in the United States has an alarming
increase in the levels of MM, which leads to unfavorable health outcomes and racial/ethnic disparities, especially in psychiatric care. This calls for the need for interventions to address the problem.

The project's goal was to improve caregivers' awareness and knowledge of MM and strategies to enhance trust with AA patients. According to the project's findings, the educational intervention was associated with improving the caregivers' awareness and knowledge about MM of AA patients in the inpatient psychiatric unit at North West Hospital. With the education of caregivers, a pathway was potentially paved to reduce MM as evidenced from the pre and post questionnaires.

The findings of this project have relevance for future interventional projects aimed at decreasing mental health disparities. Essentially, the findings add to literature focusing on evidence-based interventions that psychiatric caregivers can use to address MM among AA patients in psychiatric settings. This is crucial given the sparse material about enhancing trust between caregivers and African American patients. Much of the literature in this area of study focuses on strengthening therapeutic relationships between patients and caregivers. This project goes beyond that scope and delves into other strategies that help reinforce therapeutic relationships and other factors that fuel MM with African American patients. Essentially, the project demonstrated the potential impact of caregiver education training on cultural sensitivity and patient-centered care in improving caregiver knowledge and awareness on behaviors that foster patient trust in the medical system.

In efforts to reduce MM among African American patients, other inpatient units, healthcare settings are encouraged to implement similar educational interventions that fosters awareness and strategies that promote the provision of culturally sensitive and patient-centered care. Also, it is essential to study the impact of such interventions on patient outcomes, including patient trust in the medical system. Further evidence can help build on structural changes that can help address the root causes of MM not just for AA patients, but also other minority ethnic patient populations.
Funding

There were no sources of funding from organizations or any external entities. All costs relating to this project were borne by the project lead.
References


Xanthos, C. (2020). The Relationship Between Patient-Centeredness and Cultural Competence Among Primary Care Physicians in the Southern US. *Journal of General Internal Medicine, 1*-2
October 21, 2021

RE: Invitation to attend a presentation on Medical Mistrust for In-Patient Psychiatric caregivers and providers on African American patients.

Dear Colleagues,

I am inviting you and other colleagues to participate in a training session for caregivers on Medical Mistrust in In-patient Psychiatric African American population. This activity is part of my Doctor of Nursing Practice program project at the University of New Hampshire. The topic is "Addressing Medical Mistrust in In-Patient Psychiatric African American (AA)Patients." This one-hour session will be conducted via zoom on Sunday, October 31st, from 4 PM to 5 PM. This correspondence has a pre-survey that I kindly ask to be completed prior to the zoom session. In addition, please complete the post-survey within one week after the zoom session. Realizing that some staff may not be available at the stipulated time but may be interested in participating in this exercise, I will provide a cloud link of my presentation and print the slides for those who prefer manual copies.

This teaching session is based on evidence-based information which I conducted extensively; it is intended for clinicians to include Physicians, Nurse Practitioners, Nurse Managers, and leaders, Registered Nurses, Licensed Practical Nurses, Social Workers, Nurse Techs, and other caregivers who encounter and render care to African American psychiatric patients in the inpatient psychiatric unit. I anticipate a total of at least 30 participants.

Essentially, this educational presentation is a component of my project; it embodies evidence-based material presented for quality improvement purposes. The goal is to provide a background about medical mistrust, highlight the reasons for African American mistrust of caregivers, reinforce and provide strategies to minimize distrust with this patient population.

At the end of the presentation, participants will have the opportunity to ask questions, share concerns or experiences, and different strategies to enhance the patient-caregiver relationship.

If you intend to claim credit for participating, please contact your unit management and or educational department.

There is no compensation monetarily or otherwise. However, since this session is tailored towards clinical staff like you, I am confident that it will benefit you and your patients clinically, hence a quality improvement project. Furthermore, if you want to expand on this project either as a unit project or an educational requirement, I will be available to assist you in your pursuits.

It will be a pleasure to have you on board, and I hope you accept this invitation to attend this training session, to complete the pre- and post-questionnaires.

*At any point in time, if you want to withdraw from participating, you are free to do so. Also, keep in mind that confidentiality and privacy are assured.
Please feel free to email me at eselle.molua@unh.edu with any questions or concerns.
Thank you,

Eselle Molua
Doctor of Nursing Practice Candidate,
University of New Hampshire
Appendix B

Socio-Demographic Questionnaire

Sex: Male  Female
Race/Ethnicity (please select all that apply)
- African American/Black
- American Indian/Alaska
- Native Asian American
- Latino/Hispanic
- Native Hawaiian/Other Pacific Islander
- Caucasian
- Other

Which of the following best describes your current role?
- LPN
- RN
- NP
- Social Worker
- Therapist
- Physician
- Other

Do you speak any languages other than English?  Yes  No

If Yes, please specify ________________________________

Years of Clinical Practice______________________________(<1, 1-4, 5-10, >10)

Years of Experience Practice caring for African Americans________________________(<1, 1-4, 5-10, >10)

Experience working with health care professionals from culturally diverse background
- Not involved
- Somewhat involved
- Involved
- Very involved
Appendix C

Pre-test Medical Mistrust Caregiver Questionnaire

Section 1

1. Which of the following is a factor that fuels medical Mistrust among African Americans with mental illness?
   a) Low proportion of African American providers who can provide culturally competent care to AA patients
   b) Lack of cultural awareness among mental health providers
   c) Inadequate involvement in the care decision-making processes
   d) All of the above

2. Which one of the following is not a sign of cultural mistrust in patients?
   a) Lack of engagement in healthcare interaction
   b) Lack of healthcare engagement including non-adherence and missed visits
   c) Direct statement (e.g., Says they don’t like taking medication, or don’t like the medication)
   d) None of the above

3. Which one of the following does not help reduce medical mistrust during interactions with patients?
   a) Validating mistrust
   b) Using non-judgmental and non-confrontational communication
   c) Using close-ended questions
   d) Ensuring Make eye contact

4. Which one of the following is not important as a basic area that you as a clinician should focus on when caring for African American patients to improve your cultural sensitivity?
   a) Respecting the way African Americans understand the concept of health
   b) Assessing and acknowledging the significance of spirituality
   c) Showing respectful behavior such as not maintaining eye contact with the patient
   d) Including the patients in the decision-making process about their care

5. True or False?
   I. Black Americans are more likely than white Americans to have medical mistrust.
      True ❑   False ❑
   II. Among Black Americans, high levels of medical mistrust are a response to historical injustices and ongoing discrimination, including systemic racism.
       True ❑   False ❑
   III. Medical mistrust does not play a significant role in determining the health-seeking behaviors of individuals.
        True ❑   False ❑
   IV. All African Americans believe that a mental health condition is a sign of personal weakness.
       True ❑   False ❑
### MEDICAL MISTRUST

V. Many African Americans turn to health care professionals and rarely rely on faith, family and social communities for emotional support.

### Section 2
For each of the following statements, put an ‘X’ in the box that best describes how you feel about the statement.

<table>
<thead>
<tr>
<th>Statement</th>
<th>1 –Strongly disagree</th>
<th>2 – Disagree</th>
<th>3 – Agree</th>
<th>4- Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I recognize the signs of medical mistrust in patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I acknowledge and affirm experiences of discrimination and expressions of mistrust in African American patients.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I acknowledge the historical and current context of discrimination/systemic racism as the root cause of medical mistrust among African Americans</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Many aspects of culture influence health and health care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spiritually and religious beliefs are important aspects of African American cultural groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I believe that everyone should be treated with respect no matter what their race or cultural heritage.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I understand that people from different cultures may define the concept of “health care” in different ways</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I recognize potential barriers to service that might be encountered by African Americans</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I think that knowing about different cultural groups helps direct my work with individuals, families, groups, and organizations.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I understand that the patient's view of me may be influenced by stereotypes.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am aware of my own biases and preconceptions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Section 3
For each of the following statements, put an ‘X’ in the box that best describes how you feel about the statement.

<table>
<thead>
<tr>
<th>Statement</th>
<th>1 – Never</th>
<th>2 – sometimes</th>
<th>3- Very often</th>
<th>4- Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>I involve patients in the development of their plan of care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
MEDICAL MISTRUST

I use open-ended questions when assessing patients

I always use non-judgmental and non-confrontational approach when interacting with African American patients

I always seek to understand patients’ rationale for their behaviors or illness.

I always validate medical mistrust by affirming and acknowledging experiences of discrimination and expressions of mistrust

I use bilingual/bicultural or multilingual/multicultural staff, and/or personnel who are skilled in providing medical interpretation services during treatment and interventions for individuals and families who need or prefer this level of assistance.

Thank you for taking this survey. We appreciate your time and effort!

Again, please feel free to email me at eselle.molua@unh.edu with any questions or concerns.

Eselle Molua
Appendix D

Post-test Medical Mistrust Caregiver Questionnaire

Section 1

1. Which of the following is a factor that fuels medical Mistrust among African Americans with mental illness?
   a) Low proportion of African American providers who can provide culturally competent care to AA patients
   b) Lack of cultural awareness among mental health providers
   c) Inadequate involvement in the care decision-making processes
   d) All of the above

2. Which one of the following is not a sign of cultural mistrust in patients?
   a) Lack of engagement in healthcare interaction
   b) Lack of healthcare engagement including non-adherence and missed visits
   c) Direct statement (e.g., Says they don’t like taking medication, or don’t like the medication)
   d) None of the above

3. Which one of the following does not help reduce medical mistrust during interactions with patients?
   a) Validating mistrust
   b) Using non-judgmental and non-confrontational communication
   c) Using close-ended questions
   d) Ensuring Make eye contact

4. Which one of the following is not important as a basic area that you as a clinician should focus on when caring for African American patients to improve your cultural sensitivity?
   a) Respecting the way African Americans understand the concept of health
   b) Assessing and acknowledging the significance of spirituality
   c) Showing respectful behavior such as not maintaining eye contact with the patient
   d) Including the patients in the decision-making process about their care

5. True or False?
   VI. Black Americans are more likely than white Americans to have medical mistrust.
       True   False
       [ ]   [ ]

   VII. Among Black Americans, high levels of medical mistrust are a response to historical injustices and ongoing discrimination, including systemic racism.
       True   False
       [ ]   [ ]

   VIII. Medical mistrust does not play a significant role in determining the health-seeking behaviors of individuals.
       True   False
       [ ]   [ ]

   IX. All African Americans believe that a mental health condition is a sign of personal weakness.
       True   False
       [ ]   [ ]
MEDICAL MISTRUST

X. Many African Americans turn to health care professionals and rarely rely on faith, family and social communities for emotional support.

True False

Section 2

For each of the following statements, put an ‘X’ in the box that best describes how you feel about the statement.

<table>
<thead>
<tr>
<th>Statement</th>
<th>1 –Strongly disagree</th>
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Section 3

For each of the following statements, put an ‘X’ in the box that best describes how you feel about the statement.
## MEDICAL MISTRUST

<table>
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<tr>
<th>I involve patients in the development of their plan of care</th>
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</tr>
<tr>
<td>I use bilingual/bicultural or multilingual/multicultural staff, and/or personnel who are skilled in providing medical interpretation services during treatment and interventions for individuals and families who need or prefer this level of assistance.</td>
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### Section 4

1. Did you find this educational session about medical mistrust helpful?
   a) Yes
   b) No
   c) Maybe
   d) Unsure

2. How likely are you to utilize the strategies identified to curb medical mistrust in the African population?
   
   1 2 3 4 5

   very unlikely ❑ ❑ ❑ ❑ ❑ very Likely

Thank you for taking this survey. We appreciate your time and effort!

Again, please feel free to email me eselle.molua@unh.edu with any questions or concerns.

Eselle Molua
ADDRESSING MEDICAL MISTRUST IN IN-PATIENT PSYCHIATRIC AFRICAN AMERICAN(AA) PATIENTS

PRESENTED BY: ESELLE MATHIAS MOLUA, CRNP-BC, PMHNP, BSN, RN, DOCTOR OF NURSING PRACTICE CANDIDATE, AS A COMPONENT OF MY FINAL PROJECT, SCHOOL OF NURSING, UNIVERSITY OF NEW HAMPSHIRE
PRESENTATION ROADMAP

- Overview of Medical Mistrust
- Origins of Medical Mistrust in the A A community
- Medical Mistrust, African Americans, and Mental Health
- Signs of Medical Mistrust
- How Medical Mistrust can be addressed
- Cultural Sensitivity

OVERVIEW OF MEDICAL MISTRUST

What is Medical Mistrust?
Distrust of:

- Defined as the absence of trust that providers, caregivers, and organizations genuinely care for patients’ interests, are honest, practice confidentiality, and have the competence to produce the best achievable results.
- It is also defined as the belief that the health care system is acting or will act with ill intent towards a certain individual or group.
- Minority populations experience disparities in the health care quality they receive, even when they have the same insurance, socioeconomic status, and comorbidities as their non-minority counterparts.

(Centers for Medicare and Medicaid Services, 2018; Opel et al., 2021)
ORIGINS OF MEDICAL MISTRUST

How did we get here?
Medical mistrust is deeply rooted in discrimination and racism.
- Considered “an active response to direct or vicarious (e.g., intergenerational or social network stories) marginalization.”
- Experiencing discrimination is associated with higher mistrust.
- Mistrust explains the association between discrimination and health behaviors.
  - Help-seeking behavior is affected by mistrust.
- Among Black Americans, high levels of medical mistrust are a response to historical injustices and ongoing discrimination, including systemic racism.
- Historical dehumanization, oppression, and violence against AA people have evolved into present-day racism and cultivates a uniquely mistrustful and less affluent community experience, characterized by a myriad of disparities, including inadequate access to and delivery of care in the health system.

(Medlock et al., 2018 & Blakstock, 2021).

MEDICAL MISTRUST, AFRICAN AMERICANS AND MENTAL HEALTH

- Medical mistrust is a significant barrier to AA’s receiving mental health treatment.
- Evidence suggests that the reason AA’s mistrust medicine in general, and the mental health system, in particular is linked to a unique and troubling history; a history of racism entrenched in medical research, diagnosis, and clinical management (Medlock et al., 2018).
- Black Americans are more likely than white Americans to have medical mistrust.
- In the recent decade, trust in healthcare among Americans has declined and is worse in the AA population (Hostetter & Klein, 2021).
- 13.4% of the US population identifies as black/AA
- According to Substance Abuse and Mental Health Services Administration (SAMHSA) 2018 National Survey on Drug Use and Health,
  - Of the 13.4%, 16% (Above 7 million people) reported having a mental disorder.
  - 22.4% (1.1 million people) reported a serious mental illness over the past year (American Psychiatric Association, 2019).
MEDICAL MISTRUST, AFRICAN AMERICANS, AND MENTAL HEALTH

Medical mistrust impacts mental health care.

- Medical mistrust is associated with:
  - Lower mental healthcare utilization.
  - Greater delay in preventive services.
  - Lower adherence to medical advice/prescription refill.
- Medical mistrust has been shown to be a major barrier to AA seeking mental health care. Evidence shows that AA and other ethnic minorities:
  - Have less access to mental health services.
  - Are less likely to receive needed care.
  - Are more likely to receive poorer quality care.

(Medlock et al., 2018).

SIGNS OF MISTRUST

- Lack of engagement in healthcare interaction – Does not ask questions or make eye contact, seems uncomfortable, does not verbally agree to recommended behavior.
- Lack of healthcare engagement – Evasiveness, non-adherence, missed visits.
- Direct statements – Says they do not like taking medication or do not like or trust the medicine.

(CHIPTS, 2020).
FACTORS FUELING MEDICAL MISTRUST AMONG AA WITH MENTAL ILLNESS

- Low proportion of AA caregivers to care for patients.
  - AA caregivers, known to give more appropriate and effective care to AA help-seekers, make up a tiny portion of the behavioral health provider workforce.
  - Less than 2 percent of American Psychological Association members are Black or AA.
  - In a survey conducted in 2018 by the Association of American Medical Colleges (AAMC), only 5% of AA were physicians.
  - In the Health Resources and Services Administration (HRSA) National Sample Survey in 2018 of Registered Nurses, only 7.8% of AA were Registered Nurses.
- Lack of cultural sensitivity and or awareness among mental health providers.
- Inadequate patient involvement in the decision-making processes.
- Discriminative tendencies by caregivers.
- Because of these factors, AA people are more likely to experience chronic and persistent, rather than episodic, mental health conditions.

(Hostetter & Klein, 2021)

HOW MEDICAL MISTRUST CAN BE ADDRESSED?

- There is sparse research and projects that have been conducted to enhance trust between providers, the healthcare system, and AA patients. Nonetheless, there are a few works which are referenced in different components of this presentation.
- Of course, there are strategies taught and utilized in facilities to enhance therapeutic relationship between caregivers and patients. This project goes beyond that scope; it takes cognizance of the fact that AA’s distrust caregivers and the healthcare system. It revisits available strategies to reinforce them and goes a step further to explore and break barriers for medical mistrust in the context of the AA population. By providing evidence-based information and strategies, the goal is to have caregivers utilize these strategies to improve their care of AA.
- Findings from the work of Tang et al. (2019) suggests that there should be training on cultural sensitivity, empathy, trust-building behaviors, patient-centered care, communication and shared decision making to enhance patient trust of caregivers and the medical system.
PATIENT CENTERED CARE

Sensitively respond to mistrust while conveying accurate information.

- Validate mistrust.
- Be non-judgmental and non-confrontational.
- Ask open-ended questions.
- Use reflection/reflective listening.
- Ask for permission before sharing information.
- Make eye contact, have an open figure.
- Involve patients in the planning treatment/care and the treatment process.

*Note these are visualized in the context of AA population.


VALIDATE MISTRUST

- Affirm and acknowledge experiences of discrimination and expressions of mistrust.
- Communicate that patients’/clients’ thoughts, behaviors, or emotions are well-grounded, justifiable, relevant, and meaningful.
- Acknowledge historical and current context of discrimination/systemic racism as a root cause of mistrust where indicated.
- Reflect negative feelings toward healthcare as well as concerns stemming from mistrust.
- Show empathy.

VALIDATE MISTRUST: EXAMPLES

“Considering the mistreatment African Americans have faced, at times it makes sense to believe that healthcare providers are not looking out for your best interests. There are so many past and current examples of discrimination against African Americans in the United States, especially in healthcare settings where we have heard about unethical medical experiments, like Tuskegee, and segregation in healthcare, when Black people were forced to get lower quality, separate services. So it is understandable to be cautious about healthcare providers, and wonder if the medications really work.”

“We are trying to improve our relationships with patients. If there is anything that I do or say, or that someone at the hospital does or says that makes you uncomfortable, would you mind letting me know?”

“What you tell me will not affect your treatment or healthcare. I will keep it confidential and convey your concerns anonymously to my supervisors, if you prefer.” (Blakstock, 2021).

*These examples take into consideration the experiences of AA with caregivers and the healthcare system. AAs tend to be disregarded based on the socio-economic status. Also, there is the tendency that confidentiality is not adhered to despite HIPAA laws.

BE NON-JUDGMENTAL AND NON-CONFRONTATIONAL

- Communicate using words that do not suggest a negative interpretation of what the patient is sharing.
  - Rather than using words such as “good,” “bad,” “right,” or “wrong,” use more neutral and non-judgmental words to express that you empathize with the patient, rather than judging what they say.
- Be open and focus on what the patient is saying to you.
- Listen with empathy and understanding to the patient’s perception of their problem.
  - Example: “I’m so sorry about your situation, you probably feel devastated.
- Respond with observations, acceptance, and encouragement.
  - Let the patient know what you observe when they are talking (“You were upset by what your friend said,” or “You get tearful when you talk about that situation.”)
- Use words that convey acceptance (“It’s okay,” “That makes sense,” “I hear you”); this will make the patient feel heard and valued, and they are likely to share more.

(Everts, 2019; CHIPTS, 2020).
BE NON-JUDGMENTAL AND NON-CONFRONTATIONAL

• Substitute curiosity – The antidote to falling into judgment (about ourselves or others!) is to be curious instead.

• When you feel it is hard to reserve judgment or get yourself out of that thinking, try to reframe the judgment into a curious question.
  – Example – “What does it feel like...” or “Why do you think you feel that way?” instead of “You must feel...” or “Don’t feel that way.”

• Asking a question instead of stating an opinion opens the conversation and allows for more understanding, which will lead to less judgment!

(Everts, 2019; CHIPTS, 2020).
USE OPEN-ENDED QUESTIONS AND REFLECTIVE LISTENING

• Use open-ended questions and reflective listening,
  – Show you care about them holistically.
  – Fully hear their concerns.
• Reflect/roll with resistance: Leave room for patients to say concerns in their own words (why they do not want to do something) and reflect their concerns to them.
  – Hold back your “righting reflex”: Allow patients to make their own decision (Do not tell them what to do).

(CHIPTS, 2020; Jaiswal & Halkitis, 2019).

EXAMPLE: ASKING FOR PERMISSION (AFTER VALIDATING)

• “So it sounds like you don’t trust mental health treatment. Would it be alright if I shared some information with you about the treatment, and you can tell me what you think? … I understand there are many common beliefs around mental health disorders. A lot of them are understandable responses to discrimination and mistreatment experienced by Black Americans in healthcare and society in general. At the same time, these beliefs can impede people from getting effective treatment and staying healthy. And I have personally seen many patients dramatically improve from the medications and psychotherapy—in fact, I had a patient recently who did not initially trust the medications but decided to give them a try—and is now feeling better”.

(Blakstock, 2021).
EXAMPLE: OPEN-ENDED QUESTIONS

“What might it take for you to take this treatment?”

- Encourage patients to discuss why they may be motivated to engage in the behavior (e.g., it is consistent with their goal to remain healthy).
- Reflect their reasons to them.
- Hypothetical language can be less threatening than asking directly, e.g.
  “There is strong evidence that taking antidepressants in conjunction with psychotherapy sessions has significant remission rates in Major Depressive Disorder patients. Do you think these patients should utilize both treatment types for best outcomes?”
- Direct questions such as “Why don’t you take your medications and attend group sessions?” can be confrontational and lead to resistance from patients.

(Everts, 2019; CHIPTS, 2020).

COMMON EXAMPLES OF STIGMAS AMONG AA

There is difficulty acknowledging psychological difficulties; AAs tend to deny psychiatric illnesses primarily because of certain stigmas:

- People with mental illnesses are crazy.
- People with schizophrenia are always dangerous and violent.
- Psychosis is associated with violence and dangerousness.
- Schizophrenia is the same thing as multiple personality disorder.

(Ortega et al., 2021; Medlock, et al., 2018).
CONCEPTIONS ABOUT MENTAL HEALTH AND PRACTICES AMONG AA

- A lack of spiritual imbalance may be seen as any physical, mental, acute, or chronic disease.
- Gender, age and life factors are essential considerations when caring for African immigrants (e.g., religious and ethnic or family decisions carry high importance).
- Among AA, family, community, and spiritual beliefs tend to be great sources of strength and support.
- Many African Americans rely on faith, family, and social communities for emotional support rather than turning to health care professionals.
- Religion and faith are significant determinants of how African immigrants perceive and respond to healthcare practices, diseases, and death.
- Mental illness is also viewed as something that does not apply to strong people who historically have survived racism and slavery.
- Mental illness is often seen as a sign of weakness, and therapy is considered the domain of people who do not know what “real problems” are.

(Ortega et al., 2021; Medlock et al., 2018).

ASSUMPTIONS ABOUT AA

- AAs are disproportionately regarded as poor, illiterate, perpetrators of crimes, jobless, and uncompetitive (American Psychological Association, 2017).
- As such, there is a tendency to treat them based on these general assumptions.
- Not all AA present based on these assumptions and even those who fall in any of these categories do not like to be disregarded based on these categories.
- Even though some AAs may be poor, illiterate, criminals and unmatched by their counterparts of different races, AA like to be treated with dignity and respect.
- The assumption that AAs are as characterized above is a fallacy as there are AAs who are doing well, in fact some excel in different aspects of life. An assumption and generalization of this nature will hinder patient-caregiver trust.
CULTURAL SENSITIVITY

- It is the acknowledgment that cultural differences exist, and steps are taken to incorporate cultural considerations within existing evaluation models.

Why is cultural sensitivity important?

- Cultural sensitivity is key to the provision of patient-centered care and promotes the provision of non-bias patient care.
- As a growing standard in health care, patient-centeredness and cultural sensitivity incorporates patients’ needs and preferences into care, allowing providers and patients to work as partners and reach the best possible clinical decisions.
- Practicing culturally sensitive care provision has been shown to improve medical trust between patients and caregivers.

(Foronda, 2018; Jaiswal & Halkitis, 2019).

PROVIDING CULTURALLY SENSITIVE CARE

The heart of culturally sensitive care is:

- Effective communication
- Respect
- Awareness
- Empathy
- Knowledge

(Foronda, 2018).
Providing Culturally Sensitive Care Cont

AA like to be respected; they also want their cultures and beliefs to be respected. Acknowledge and respect the patient’s meaning of illness.

- Listen carefully to the patient’s perspective.
- Spend time with the patient and ask about their health beliefs.
- Elicit patient’s explanation of an illness and its causes (Foronda, 2018).

- Acknowledging and respecting AA’s understanding of their illness will help improve communication, a cornerstone of a trusting caregiver-patient relationship.
- If there is a mismatch, many AA patients will rely on their explanations before those of medical professionals.
- Making one medically neutral suggestion that fits AA patients’ belief system builds rapport quickly.

*Refer to slide 19, which espouses that spiritual beliefs tend to be a great source of strength; therefore, it is imperative to make suggestions or treatment plans that align with the belief systems of AA if not incongruent with evidence-based practice.

Providing Cultural Sensitive Care Cont

- Assess and acknowledge the significance of spirituality
  - Avoid dominating the content of the discussion.
  - Offer choices for treatment options.
  - Be available to consult with your patient’s family if necessary.

- Include patients in the decision-making process.
  - Answer your patients’ questions and concerns about diagnoses and treatment plans.
  - Enlarge the decision-making process to include social decisions.

- Show respectful behavior.
  - Many AA tend to prefer close personal space and are comfortable with touching and hugging
  - Highly animated nonverbal communication methods are sometimes erroneously misinterpreted as being aggressive.
  - The AA regards eye contact as a sign of respect, competence, sureness and truthfulness. Poor or no eye contact is regarded as being disrespectful, incompetent, unsure and deceitful (Foronda, 2018).
PROVIDING CULTURAL SENSITIVE CARE CONT

- Establish an egalitarian relationship with AA patients.
  - Many AAs are comfortable establishing close personal connections with providers.
  - Self-disclosing and discussing some non-medical questions may be important.
  - AAs respect authenticity and genuineness.
- Avoid Making Assumptions and generalizations. Avoid the assumptions that:
  - AAs who speak English dialects or use local slangs are uneducated.
  - Speaking loudly as an indication of anger; AAs tend to speak louder than those from other cultures.
  - All AAs are poor.
- Understand that stereotypes may influence the patient's view of you.
- Be aware of your own biases and preconceptions.

  (Center for Substance Abuse Treatment, 2014; Mitchell et al., 2019).

PROVIDING CULTURALLY SENSITIVE CARE CONT

- Empathy
  - Seek out and understand the patient's rationale for their behaviors or illness.
  - Verbally acknowledge and legitimize the patient's feelings.
- Support
  - Ask about and try to understand barriers to care and adherance.
  - Help the patient overcome barriers by providing resources.
  - Involve family members if appropriate.
  - Reassure the patient that you are and will be available to help.

  (Ghosh et al., 2019).
PROVIDING CULTURALLY COMPETENT CARE CONT

Communication and Language Assistance

- Provide language assistance to individuals with limited English proficiency to facilitate timely access to all health care and services.
- Limited English proficiency is associated with several factors contributing to avoidable readmissions, lower outpatient rates of follow-up, preventive services, and medication non-adherence.
- The Centers for Medicare and Medicaid Services recommends using medical interpreters to complete assessments, discharge, and teach patients, including AA, for best outcomes and minimize readmissions.
- Inform all individuals of the availability of language assistance services.
- Provide easy-to-understand print, and multimedia materials and signage in English, French and languages better understood by a particular AA patient; make sure care is individualized.


THANK YOU!!

QUESTIONS??
REFERENCES


REFERENCES

REFERENCES


Appendix F
Informed Consent

Title: Addressing Medical Mistrust in In-Patient Psychiatric African American (AA) Patients

Project Lead: Eselle Mathias Molua, CRNP-PMH
Affiliation: University of New Hampshire School of Nursing, Lifebridge Health- Northwest Hospital

Purpose of study: To understand medical mistrust and design strategies to decrease it between behavioral health caregivers and patients.

Procedures: Pre and post questionnaires of caregivers; an educational session will be done after the pre questionnaire.

Risks: None as there will be no procedures, the project will entail anonymous questionnaires.

Benefits: There will be no financial, material, or tangible benefits. However, participation will potentially enhance medical trust and as such best patient outcomes.

Confidentiality: The questionnaire and entire project shall be strictly confidential. No personal opinions or information will be divulged. HIPPA guidelines will be strictly complied. No personal identifiers to include names, social security numbers should be written on the Questionnaires.

Contact Information: Questions or information of any kind about this study should be directed to the project lead at moluamath@yahoo.com or eselle.molua@unh.edu.

Voluntary Participation: Your participation in this survey is voluntary. If you choose to opt-out at any time, feel free to do so without giving any reason.

I have read and understood the provided information and have had the opportunity to ask questions. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and without cost. I voluntarily agree to take part in this project.

Participant’s Signature ____________________________ Date __________

Project Lead signature ____________________________ Date __________