Høgskolen i Sørøst-Norge

Fakultet for helse – og sosialvitenskap

–Mastergradsavhandling i psykisk helsearbeid

Studieprogram: Master i klinisk helsearbeid, studieretning psykisk helsearbeid

Høst 2017

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Kartlegging av sykepleieres holdninger til pasienter med psykiske lidelser i somatiske akuttmottak.

En spørreskjemaundersøkelse

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Denne avhandlingen representerer 30 studiepoeng

Sammendrag

Sammendrag: Masteroppgaven består av en artikkel og en refleksjonsoppgave. Gjennomgangstema for oppgaven er holdninger blant sykepleiere i somatiske akuttmottak.

Formål: Formålet med studiet er å belyse sykepleiernes holdninger til pasienter med psykiske lidelser. Det vurderes om det er en sammenheng mellom bakgrunnsvariabler og positive eller negative holdninger. Videre diskuteres forskjeller og likheter med andre tilsvarende studier gjort i andre land.

Teoretisk forankring: Artikler og litteratur om holdninger basert på Hummelvoll og Tornicrofts definisjoner, samt relevante offentlige dokumenter som omhandler tiltak for å forbedre holdningen til psykisk lidelse.

Metode: Studiet er gjennomført som en tverrsnittsundersøkelse ved tre akuttmottak og en intensivavdeling. 294 sykepleiere og spesialsykepleiere ble invitert til å delta. 173 svarte på et spørreskjema Community Attitude toward Mentally Ill (CAMI), samt et skjema med spørsmål om bakgrunn.

Resultater: Studien viste at holdningene til pasienter med psykiske lidelser var generelt positive blant respondentene. Det var ingen signifikant sammenheng mellom bakgrunnsvariablene og sykepleiernes holdninger. Respondentene svarte mindre positive på spørsmål som omhandlet lokalisering av psykiatriske behandlingsinstitusjoner i nærmiljøet.

Konklusjon: Studien viser at sykepleiere har gode holdninger i møte med mennesker med psykiske lidelser. Mangel på differensiering mellom de forskjellige psykiatriske diagnosene gjorde det vanskelig å svare på noen av spørsmålene. Videre forskning for å finne mulige forklaringer på hva som forårsaker positive og negative holdninger er anbefalt.

Nøkkelord: Holdninger, stigma, psykisk lidelse, sykepleiere og akuttmottak.

Abstract

Abstract: The master thesis contains an article and an essay. The recurring theme for the thesis is attitude among nurses in an acute ward

Purpose: The purpose of this study is to shed light on nurse´s attitude toward mentally ill patients. It considered it there is a correlation between the background variables and positive or negative attitudes. Further on discuss differences and similarities with other equivalent studies done in other counties.

Theoretic background: Articles and literature on the subject attitude based on Hummelvoll and Thornicroft´s definitions, in addition to relevant public documents who concerns interventions to improve attitude toward mental illness.

Methods: Cross-sectional. Data is collected from three Norwegian acute wards and one intensive care unit. 294 nurses and special trained nurses were invited to participate. 173 answers were included in the study. The CAMI (Community Attitude toward Mentally Ill) scale was used. In addition to a scale for background variables.

Results: The study reviled that attitude toward patients with mental illness were generally positive among the participants. We found no significant correlation between the background variables and the nurses attitude. The responders answered less positive on the questions concerns locating mental facilities in residential neighbourhood.

Conclusion: The study shows that nurses have a positive attitude in meeting persons with mentally ill. Lack of differentiation between the psychiatric diagnosis in the questionnaire made it difficult for the respondents to give an accurate answer. Further research to find possible explanation on what causes positive and negative attitude what is recommended.

Keywords: Attitude, stigma, mentally ill, nurses, acute ward and emergency department

Innholdsfortegnelse

Forord

Jeg ser med en skrekkblandet fryd at melken på frokostbordet har en utløpsdato som er etter fristen for innlevering. Skrekken er nok fordi man har gjort noe man kanskje ikke er helt herre over, og at muligheten for endringer snart er forbi. Fryd fordi man sitter igjen med en følelse av mestring. I dårlige øyeblikk har jeg tenkt at dette unner jeg ingen. Fortvilelsen og motløsheten har noen morgner sittet sammen med meg ved nevnte frokostbordet. Heldigvis har familien min også sittet der. Et prosjekt som dette angår ikke bare meg. Menneskene rundt meg har gjort det mulig å fullføre. En fantastisk kone, hjelpsomme barn, en dyktig veileder, en forståelsesfull sjef og noen gode venner med akademisk bakgrunn har lagt en trygg ramme rundt min tilværelse slik at jeg kom i mål. Takk til dere alle. Dere har betydd mye.

Drammen, 15. September 2017

Geir Wibe Østerdahl Nyblin

Antall ord i refleksjonsdel: 5492

1.0 INNLEDNING

1.1 Oppbygging av refleksjonsdel til masteroppgaven

Vi har gjennomført en empirisk studie og skrevet artikkel til tidsskriftet Journal of Emergency Nursing (Vedlegg 8). Refleksjonsdelen vil utdype de metodologiske sidene ved studiet og fordype seg i begrepene holdninger. Forskningsspørsmål presenteres i artikkelen. Studiet har en ontologisk og epistemologisk forankring. Vi ønskt å finne ut hvordan holdninger blant sykepleiere var, samt å vurdere en metode for å tilegne oss denne kunnskapen. Studien har også en forankring i den humanistiske tradisjonen. Begreper som verdighet, respekt, gjensidighet, medmenneskelighet og ansvarlighet står sentralt i sykepleiefaget. Helsefremmende og forbyggende aspekter danner grunnlaget for bevisstgjøring av sykepleieres holdninger i en behandlingssituasjon. Sykepleiens yrkesetiske retningslinjer danner det etiske fundamentet i møte med pasienten (Norsk Sykepleierforbund, 2011). Retningslinjene bygger på grunnleggende menneskerettigheter, samt etiske prinsipper som autonomi, ikke- skade, velgjørenhet og rettferdighet. Først presenteres refleksjonsdelen. Her vil jeg presentere teori og metodevalg som ligger til grunn for arbeidet med den vitenskapelige artikkelen. Sentrale begreper og valg av metodiske verktøy diskuteres opp mot teorien og våre resultater.

1.2 Bakgrunn for valg av tema

Som sykepleier ved et akuttmottak gjennom flere år opplevde jeg nesten daglig å møte pasienter med en eller annen form for psykisk lidelse. De fleste var nok pasienter med angst, eller depresjon knyttet til den somatiske lidelsen de ble innlagt for. Noen kom med en fysisk skade som følge av mer alvorlige psykiatriske diagnoser, noen var ruset, og noen psykotiske. De aller fleste av disse følte jeg ble tatt hånd om på en god måte. Sykepleiere har erfaring med redsel, tristhet og nedstemthet. Hvis pasienten var urolig, virket uforutsigbar, og i verste fall var truende og aggressiv, merket jeg at flere ble usikre. Mange av pasientene med psykiske lidelser ble liggende lenge i akuttmottaket fordi det ikke alltid var noe opplagt sted å plassere dem. Noen måtte ha en pleier til å

passe på seg om de skulle på en somatisk avdeling. Om pasienten ble henvist til en psykiatrisk avdeling kunne ventetiden bli lang i påvente av plass. I en travel hverdag kunne denne pasientgruppen utgjøre en utfordring. Det kunne bli en utfordring å ivareta pasientenes behov på en verdig måte. Egne og kollegers erfaringer skapte ideen til denne oppgaven.

1.3 Studiens relevans

I denne refleksjonsdelen av masteroppgaven vil jeg se på sykepleieres holdninger til pasienter med psykiske lidelser i akuttmottak. Det er gjort flere studier på dette tema, men ingen i Norge. Etter søk i utenlandske og norske medisinske databaser fant vi ikke forskning om norske sykepleiere, og deres holdninger til pasienter med psykiske lidelser i den somatiske delen av spesialhelsetjenesten. Som en del av Regjeringens opptrappingsplan for psykisk helse (St. prp. nr. 63 (1997-98), 1997) ble det fokusert på økt kompetanse om, og mer positive holdninger til, psykiske lidelser blant helsepersonell og befolkningen generelt. Om økt satsing på dette feltet har gitt en økt bevissthet om dette er usikkert i og med at det finnes lite forskning. Akuttmottaket er ofte pasientens første møte med spesialhelsetjenesten. Pasienter henvises fra fastlege, legevakt og legges direkte inn ved behov. Clarke et. al. (2007) fant at pasienter med psykiske lidelser opplever å bli nedprioritert og ikke bli tatt på alvor i et akuttmottak. De fant også at pasienter med en psykiatrisk diagnose opplevde at de ble merket som pasienter med psykiske lidelser selv om deres besøk gjaldt fysiske plager. Noe som førte til lang ventetid for å få adekvat behandling. I de tilfellene der pasienten mente at de fikk adekvat behandling i forhold til sin lidelse, følte fortsatt mange av de spurte at adferden til sykepleieren var avmålt, og at de ble behandlet på en nedverdigende måte (D. E. Clarke et al., 2007). Negative holdninger kan i verste fall utgjøre en fare for den enkelte pasienten. Hvis pasienter opplever å bli møtt av negative holdninger, hva kan årsaken til dette være?

1.4 Sentrale begreper

1.3.1 Holdninger

Holdning betyr innstilling. Det har sitt opphav i det latinske ordet ”aptitudo”, som vi kan kjenne igjen i det engelske ordet ”attitude”, og betyr egnethet. Holdninger kan komme til uttrykk gjennom oppfatninger, ytringer, eller følelsesmessige reaksjoner, samt gjennom handling. Holdninger kan basere seg på erfaringer, kunnskap, oppdragelse, sosialisering og miljø (Svartdal, 2016).

1.3.2 Personer og pasienter med psykiske lidelser

Mennesker som i følge ICD – 10 (Helsedirektoratet, 2015) har en klinisk psykiatrisk diagnose, eller mennesker som har symptomer som tilfredsstiller kriteriene til en diagnose, men enda ikke er blitt diagnostisert.

2.0 Holdninger til personer med psykiske lidelser

2.1 Tidligere forskning

Flere studier er blitt gjennomført for å belyse sykepleieres og helsepersonells holdninger til psykisk lidelse og pasienter/personer med psykiske lidelser. (Björkman, Angelman, & Jönsson, 2008; Chambers et al., 2010; D. Clarke, Usick, Sanderson, Giles-Smith, & Baker, 2014; Kluit, Goossens, & Leeuw, 2013). Resultatene er ikke ensartede, og vi fant ingen studier som konkluderte med at sykepleiere og helsepersonell hadde utelukkende positive eller negative holdninger. Det finnes studier der mottagere av helsetjenester opplever å bli godt ivaretatt til tross for sine psykiske problemer (McCann, Clark, McConnachie, & Harvey, 2007; McCarthy & Gijbels, 2010). I studie der man fant mindre positive holdninger blant helsepersonell, var det konkludert med at en gruppe respondenter som ble testet hadde noe mer eller mindre positive holdninger enn en annen gruppe (Chambers et al., 2010).

Clarke et.al. (2014) så på 42 artikler i en litteraturstudie. Disse studiene var fra flere land. Det er lite samsvar i hva som er årsak til positive eller negative holdninger. Høy alder kan korrelere positivt i en studie, rettet mot en diagnose, men negativt i et annet. Björkman et.al (2008) finner at flest negative holdninger er rettet mot pasienter med uforutsigbar og aggressiv adferd. McCarthy et.al (2010) fant at det var generelt positive holdninger rettet mot pasienter med et skadet seg selv. Sykepleiere med videreutdanning hadde mer positive holdninger enn de uten. Noe mer negative holdninger ble funnet hos eldre sykepleiere. Clarke et.al (D. Clarke et al., 2014) mente holdningene til pasienter med selvskadingsproblemer i stor grad avhenger av oppfattelsen sykepleierne hadde av fenomenet selvskading. De som mente at selvskading i stor grad var viljestyrt av pasienten definerte dette i mindre grad som et akseptabelt problem. Bjökmans et. al (2008) studie deler opp pasientgruppen i alvorlig depresjon, panikk anfall, schizofreni, demens, spiseforstyrrelser samt alkohol - og narkotikaavhengighet. Menn hadde mer negative holdninger enn

kvinner til alle inkluderte pasientgrupper, med unntak av de rusavhengige. Rusavhengige personer møtte flest negative holdninger. Vår studie er ikke rettet mot spesielle diagnoser, men samler all psykisk lidelse under ett. Rus av noe slag er ikke inkludert. Hensikten med vår studie var å undersøke sykepleieres holdninger til pasienter med psykiske lidelser. Det ble ikke funnet noe norske studie som måler pasientenes opplevelser i et akuttmottak. Det finnes heller ikke noe norsk studie som kartlegger sykepleieres holdninger til pasienter med psykiske lidelser i et akuttmottak. Derimot er det gjort en omfattende studie av Sørensen et.al. (2013) som så på den generelle befolkningens syn på mennesker med mental sykdom over tid i utkantstrøk og sentrale områder. Hensikten med den studien som ble gjort på tre forskjellige steder med seks datainnsamlinger i perioden 1983 til 2010 var å se om Community Attitude toward Mentally Ill (CAMI) var et valid verktøy som kunne måle holdninger ovenfor mentalt syke over tid og store geografiske områder. Befolkningens holdninger var ikke fokus i denne studien.

2.2 Holdninger til personer i norske akuttmottak i 2017 – resultater fra min undersøkelse

I denne studien fant vi at sykepleiere i akuttmottak har generelt positive holdninger til pasienter med psykisk lidelser. Vi fant ingen signifikant sammenheng mellom holdninger og bakgrunnsvariablene. Alle svaralternativ på alle spørsmål i spørreskjema var besvart, med unntak av ett. Det var en tydelig polarisering mot det positive svaralternativet på de fleste spørsmål. Uavhengig av bakgrunnsvariablene kunne man se av resultatene at spørsmål som dreier seg om å ha psykiatriske pleietilbud i nærmiljøet skaper en reservasjon i besvarelsene. Polariseringen var ikke like tydelig her (tabell 3, vedlegg 11). Funnene er utdypet i den vitenskapelige artikkelen.

3.0 Metode og metodediskusjon

3.1 Metodevalg

Oppgaven ble gjennomført som en beskrivende tverrsnittstudie med kvantitativt design. Et tverrsnittstudie har som mål å beskrive et fenomen på et bestemt tidspunkt, eller i det tidsrommet som datainnsamlingen skjer (Polit & Beck, 2008). Tverrsnittstudie regnes som et beskrivende studie, eller et ikke- kausalt studie (Lund, 1996). Valg av kvantitativ metode i studiet ble gjort for lettere kunne sammenligne resultatet med andre studie fra andre land der tilsvarende metode og design er benyttet. Spørreskjemaene som anvendes i disse studiene er ofte standardiserte og mye brukt. Dette gjør det enklere å se om norske sykepleiere skiller seg fra andre. I tillegg vil man kunne finne eventuelle statistiske sammenhenger mellom bakgrunnsvariabler og et fenomen som holdninger. Utvalg, analyse og statistiske sammenhenger er beskrevet i artikkelen. På bakgrunn av andre studier der CAMI spørreskjema var benyttet, ble det vurdert å bruke faktoranalyse. Dette ble testet i SPSS. Vi valgte å gå bort fra dette da det viste seg lite hensiktsmessig for våre forskningsspørsmål. CAMI er blitt benyttet i studier uten at faktoranalyse ble anvendt (Schafer, Wood, & Williams, 2011; Winkler et al., 2016)

3.2 Validitet

Et sentralt begrep ved bruk av spørreskjema er begrepet validitet. Validitet innebærer at man kan trekke gyldige slutninger om det man har satt seg fore å undersøke. Det beskrives fire typer validitet som utdypes nedenfor. Et viktig spørsmål i drøfting av studien min er om det spørreskjemaet jeg har brukt virkelig sier noe om personers reelle holdninger til personer med psykiske lidelser. I det følgende vil jeg se om det foreligger noe i denne studien som kan true validiteten, for så å diskutere resultatene opp mot dette.

3.2.1 Begrepsvaliditet

Det var ikke entydig for respondentene i denne studien hva som lå i begrepet ”pasient / person med psykisk lidelse”. Hvis det ikke er tydelig hva som måles kan man si at begrepsvaliditeten er lav (Lund, 1996). Begrepsvaliditet er nødvendig for at resultatet skal være meningsfullt, tolkbart og generaliserbart.

3.2.2 Ytre validitet

Den ytre validiteten sier noe om hvorvidt resultatet av undersøkelsen kan overføres fra utvalget til populasjonen (Johannessen, Christoffersen, & Tufte, 2010). Den ytre validiteten kan være styrket i undersøkelsen. Prosentvis fordelingen mellom respondentene og non- respondentene ser ut til å være tilnærmet like om man ser bort fra videreutdanning. En klart høyere andel av sykepleiere med videreutdanning svarte på undersøkelsen, enn de som unnlot å svare.

3.2.3 Indre validitet

CAMI skjema er nøye testet, og den indre validiteten anses å være god. I utarbeidelsen av skjema ble det foretatt pilotundersøkelser (Taylor & Dear, 1981). I tillegg er CAMI benyttet i mange år. Et spørsmålstegn var allikevel skjemaets store kulturelle og geografiske utbredelse. Selv om det lages lokale varianter som tilpasses kulturelle forhold, er det begrenset hvor langt fra originalen man kan bevege seg. Holdninger er kulturelt betinget. Hva som regnes som akseptabelt Er det kulturelt akseptabelt for en sykepleier i Norge å svare noe annet enn det mest positive?

3.2.4 Statistisk validitet

Statistisk validitet sier om det er tilstrekkelig statistisk grunnlag for å trekke de konklusjonene vi gjør. Større utvalg i tillegg til en utvalgsmetode som gir det

mest representative utvalget gir bedre statistisk validitet. Er utvalget representativt for populasjonen? Statistisk validitet er å kunne trekke konklusjoner som statistisk gyldige (Johannessen et al., 2010). I vår studie hadde vi en svarprosent på 57,8, og det var ingen grunn til å tro at de inkluderte akuttmottakene skilte seg fra andre.

3.3 Operasjonalisering

Holdning ikke har noen klar verdi. Dette gir en utfordring ved valg av kvantitative forskningsmetode. Holdninger fremstår for den enkelte som noe subjektivt, eksistensielt innenfor den fenomenologiske og humanistiske forståelsen. For å ha en mulighet til å måle dette må begrepet settes inn i rammer og gis verdier. Som man ser av den fem-delte Likert skalaen som ble brukt i vår studie, har respondenten kun fem mulige svar på et spørsmål. En kvalitativ studie ville kunne inneholde mange fler nyanser og tolkninger. Ikke alle bakgrunnsvariablene som er med i spørreskjema blir brukt i analysen. Variabelen som omhandlet språk, og landet der språket brukes, er slått sammen til en. Tidspunkt for norsk godkjenning er ikke tatt med fordi gruppen med respondenter uten vest- europeisk bakgrunn var for liten (N=3).

3.4 The Community Attitude toward Mentally Ill spørreskjema

Taylor og Dear (1981) publiserte CAMI spørreskjema i 1981 (vedlegg 7). Tanken bak spørreskjema var å lage et verktøy som hadde sterk validitet ved gjentagende undersøkelser av nærmiljøets/befolkningens holdninger til lokale institusjoner som behandlet psykisk syke. Taylor og Dear sa i sin artikkel at spørreskjema hadde god ytre, indre og begrepsvaliditet. De understrekte også at skjema er tiltenkt tverrsnittstudier, og visste derfor ikke hvor følsomt det var i forhold til endring av holdninger over tid. I sin artikkel påpeker Sørensen et. al. (2013) forståelse av begrepet ”psykisk syk”. Sørensen gjennomførte til sammen seks tilsvarende studier mellom 1983 og 2010 og passet på å ha sammen definisjon av begrepet i samtlige. I motsetning til det som ble gjort i vår studie, informerte altså Sørensen sine respondenter på forhånd slik at begrepet ”psykisk syk” skulle forstås likt. Mangel på dette skapte litt usikkerhet blant

respondentene i vår studie. Högberg et.al (2008) oversatte og tilpasset CAMI til svenske forhold i 2008. Selv om de kun benyttet 20 av de opprinnelig 40 spørsmålene, konkluderte han med at ni av 10 spørsmål fra Taylor og Dear sin versjon fortsatt kunne vært brukt som før på grunn av god validitet.

I mange studier blir CAMI også brukt sammen med andre spørreskjema for å gi et mer eksakt bilde av respondentens holdninger. Spørreskjema som ble brukt i andre studier sammen med CAMI var blant annet: Reported and Intended Behaviour Scale (RIBS) (Aznar-Lou, Serrano-Blanco, Fernández, Luciano, & Rubio-Valera, 2016) som retter seg mot den generelle befolkningen for å kartlegge adferd og erfaringer rundt psykisk helse. Kunnskap om dette, mener forfatterne, ville gi et bedre utgangspunkt for intervensjoner mot negative holdninger og stigma rettet mot psykisk helse (Evans-Lacko et al., 2011). The Attitude Towards Acute Mental Health scale (ATAMH) (Munro & Baker, 2007), The Bogardus scale of social distance (BSSD) and Psychiatric knowledge survey (PKS) (Finkelstein, Lapshin, & Wasserman, 2008), og Fear And Behavioural Intensions (FABI) (Buizza et al., 2005; Markström & Gyllensten, 2009). Disse ga et mer utfyllende bilde av situasjoner som kunne være med på å skape stigmatisering.

Noen av sykepleierne i vår studie hevdet at det var umulig å ha en klar oppfattelse av pasienten uten at det forelå en spesifikk diagnose. Det finnes utallige diagnoser og hver diagnose har flere variasjoner, samt at disse variasjonene varierer fra pasient til pasient. Om begrepet: ”Pasienter med psykiske lidelser” hadde vært byttet ut med en bestemt diagnose, ville det vært lettere å nyansere svarene. Et eksempel er spørsmål nummer 12 i spørreskjemaet -”*Pasienter med psykiske lidelser bør ikke gis noe ansvar*”, er dette vanskelig å svare på for noen som har kunnskap om psykiske lidelser. Hvis man derimot definerte begrepet ”pasienter med psykiske lidelser” som den gruppen som omfattes av §3 i lov om psykisk helsevern, tvunget psykisk helsevern (Helse- og omsorgsdepartementet, 1999 - 2017), altså pasienter som befant seg i en psykosetilstand ville spørsmålet hatt større relevans. Noen av spørsmålene i CAMI kan fremstå som meningsløse uten en spesifisering av diagnose. På den andre siden er skjema likt for alle.

4.0 DISKUSJON

4.1 Økt behandlingsbehov og færre plasser.

I perioden 1996 til 2004 ble antall døgnplasser for voksne pasienter redusert fra 1,9 døgnplasser per 1000 innbyggere, til 1,5 per 1000 innbyggere. En nedgang på cirka 18% (Ottersen, 2005). Pasientene skulle tilbakeføres til sine respektive kommuner. Behandling og pleie skulle så langt det lot seg gjøre foregå der pasienten befant seg. Opptrappingsplanen for psykisk helse (St. prp. nr. 63 (1997-98), 1997) forespeilet å bygge ut døgnpasstilbudet ved lokale distriktpsykiatriske sentre (DPS) etter at staten overtok ansvaret for de fylkeskommunale sykehusene og spesialhelsetjenesten fra 1. Jan 2002. I følge tall fra Statistisk Sentralbyrå (SSB) sank det totale antallet døgnplasser fra 4332 i 2010, til 3567 i 2016 (Statistisk Sentralbyrå, 2017). Antallet med lokale DPS døgnplasser har allikevel økt slik selv om det totale har sunket. I 1. tertial i 2017 fikk 97000 voksne helsehjelp for psykiske lidelser. Dette var en økning på 3% fra forrige måling (Helsedirektoratet, 2017). Disse tallene indikerer at et større antall pasienter med psykiske lidelser befinner seg utenfor en behandlingsinstitusjon nå enn tidligere. Hvor mange av disse kan man forvente kommer til et akuttmottak? Marynowski-Traczyk et.al (2011) konkluderer med at det er en økning i antallet personer med psykiske lidelser som kommer til et akuttmottak. Sykepleierne føler at tid og rammebetingelser til å ivareta denne pasientgruppen ikke er på plass. Eksakte tall fra Norge er vanskelig å få. Når vi undersøkte dette med de involverte sykehusene fikk vi vite at mange av disse pasienten legges inn med ikke- psykiatriske diagnoser, og blir derfor vanskelig finne igjen som pasient med psykisk lidelse. Pasienter som er kjent med sin psykiske lidelse vil i mange tilfelle ha kunnskap om hvor man skal henvende seg når sykdommen forverrer seg. Da er ikke alltid et akuttmottak førstevalget, men det kan avhenge av diagnose og personens evne til egenomsorg. For mennesker som enda ikke har fått en diagnose kan akuttmottaket være et mer naturlig valg. Det er døgnåpent, og har som regel kortere ventetid enn legevakten. Noen psykiske lidelser gir også til dels voldsomme fysiske symptomer. Et angstanfall kan fortone seg som et begynnende hjerteinfarkt.

I Norge lever mennesker med psykiske lidelser 15 – 25 år kortere enn befolkningen generelt. Den viktigste årsaken ser ut til å være dårlig oppfølging av somatiske sykdommer. Denne pasientgruppen blir sjeldnere akuttinnlagt ved komplikasjoner tilknyttet diabetes, og henvises sjeldnere til mammografi (St.meld nr. 19 (2014 - 2015), 2014). Pasientens selvstigmatisering kommer også inn som en utfordring i forhold til å søke hjelp. En amerikansk studie viser at tiden det tar fra en person blir klar over en psykisk lidelse til vedkommende oppsøker profesjonell hjelp ligger mellom 6 og 8 år for stemningslidelser, og 9 til 23 år på angstlidelser. Mange tar aldri kontakt (Schafer et al., 2011; Wang et al., 2005). Negative holdninger og stigmatisering blant både sykepleiere og pasienter kan fungere som en barriere for å søke behandling. De personene som oppsøker et somatisk akuttmottak med en psykisk lidelse vil ofte være mennesker med selvskadingsproblematikk som trenger behandling av fysiske skader. I tillegg kommer selvmordsforsøk, simuleringer, demens, rus, forvirringstilstander som følge av infeksjon, hodeskade eller cerebralt insult, og pasienter med psykiske lidelser som trenger behandling for somatisk sykdom eller skade.

4.2 Holdninger

Hummelvoll (Hummelvoll, 2012) bruker begrepene profesjonell, terapeutisk og medmenneskelig om holdninger, og understreker at den medmenneskelige delen er til pasientens beste. Empati, tydeliggjøring av trygghet og velgjørenhet vil øke muligheten for en god relasjon mellom pasient og pleier. Hummelvoll (2012) påpeker videre at det kan være flere former for profesjonelle holdninger. En er å fremstå som nøytral og objektiv. Man skille mellom fag og privatperson. Som fagperson skal man ikke vise for mye følelser, da dette kan flytte fokus fra pasienten. En annen form er å balansere mellom nærhet og avstand. Vite når man skal støtte og når man skal utfordre. Hummelvoll (2012) gjennomførte en undersøkelse i 1990 der pasienter i etterkant av et dagopphold ble spurt om hva de oppfattet som positive og negative holdninger hos personalet.

Holdninger som oppleves som positive var:

- Personlig omsorg
- Innlevelsesevne
- Åpenhet og evne til å vise seg som person
- Håp og optimisme
- Likeverdighet
- Fleksibilitet og evne til nytenkning
- Gi trygghet og støtte
- Humoristisk sans

Holdninger som oppleves som negative var:

- Manglende innlevelsesevne
- Moralisering og ”bedre-vitende-holdning”
- Travelhet
- Passivitet og ”snillhet”
- Manglende evne til å skille mellom egne og pasientens problemer

I følge Clarke et. al. (2007), oppfatter mange pasienter at helsepersonell ikke klarer å skjule den følelsesmessige delen av holdningen sine selv om den fysiske pleien er god og adekvat i forhold til innleggelsesårsak.

Thornicroft et al. (2007) hevder at holdninger er en del av stigmabegrepet som igjen kan deles inn i tre problemområder. Problemer med kunnskap (uvitenhet), problemer med holdninger (fordommer), og problemer med adferd, (diskriminering). De mente videre at problemet med kunnskapen kommer av for dårlig forskning på holdninger og stigma. I tillegg er det for dårlige begreper og definisjoner av aspekter innen stigma, for eksempel var det sjelden det kommer frem hva man legger i begrepet pasient med psykisk lidelse. Dette underbygges av Sørensen (2013) og Björkman (2008). Erfaringer fra vår studie er at uklare begreper kan gjøre det uklart hva man får svar på. Et eksempel på betydningen av kunnskap er hentet fra et studie rettet mot den generelle befolkningen i England, der 55% mente at en person med psykiske lidelser kunne beskrives som en som ikke kunne bli holdt ansvarlig for sine handlinger (Department of Health, 2003). Det kom også fram at 63 % av de spurte trodde at færre enn

10% av befolkningen ville oppleve en form for psykisk lidelse i løpet av livet. I England så man en endring i den generelle befolkningens syn på personer med psykisk lidelse etter at det ble satt i gang en rekke tiltak for å øke kunnskapen rundt tema. Paradokset var at holdningene endret seg i både positiv og negativ retning. Andelen som mente at de kunne skille mentalt friske fra mentalt syke, bare ved å se på dem, sank fra 30 til 20%. Andelen som mente det ikke ville utgjøre en fare å ha et psykiatrisk helsetilbud i deres nabolag sank fra 70 til 55%. Sykepleiere har som regel bedre kunnskap om psykisk lidelse enn den generelle befolkningen. Når man vet mer, øker altså skepsisen for å ha denne pasientgruppen i sitt nærområde i følge Thornicroft et. al (2007). Tendenser til skepsis på spørsmålene vedrørende pasienter og behandlingsinstitusjoner i sitt nærmiljø kan man også se i dette studie, uavhengig av bakgrunnsvariablene. Selv om en skulle tro at bedre kunnskap om psykiske lidelser vil gi et mer avslappet forhold pasienter med psykisk lidelse, er ikke dette nødvendigvis tilfelle.

Det er vanskelig å vite om sykepleiere svarer slik de selv tror det er forventet av dem i den rollen de innehar og den arbeidskulturen som råder. En studie om leger og sykepleieres barrierer til postoperativ smertelindring, viste at helsepersonell visste hva som var best praksis, men at deres lojalitet til egne personlige verdier og arbeidsrelaterte holdninger fikk dem til å handle i strid med sin egen kunnskap (Coulling, 2005). Dette underbygger at det ikke nødvendigvis er samsvar mellom sykepleieres atferd og den kunnskapen de har. Graden av kunnskap om pasienter med psykiske lidelsene er heller ikke en garanti for hvilke holdninger man har. Nordt et al. (2006) gjennomførte en studie i 2009 der de sammenlikner flere gruppers syn på pasienter med psykiske lidelser, som viste at psykiatere skårer dårligst på holdninger ovenfor pasientgruppen. Dernest kom den generelle befolkningen. Best ut kom annet psykiatrisk helsepersonell. Det er ingen enighet, eller forståelse av hvilke faktorer som danner og vedlikeholder positive og negative holdninger til psykisk lidelse og pasienter med psykiske lidelser, men det er sannsynlig at det er knyttet til kunnskap (Chambers et al., 2010).

Problemer med negative holdninger og fordommer, sier Thornicroft (2007), er at det nesten ikke er publisert noen studier som fokuserer på de følelsesmessige

reaksjonene vi får i møte med pasienter med psykiske lidelser om vi ser bort fra redsel for å bli utsatt for vold. Følelser som er negative kan også være sinne, avmakt, fiendtlighet, engstelse, avsmak og vemmelse. Högberg et.al. (2008) sier at for å få troverdige resultater når man forsker på holdninger, er det viktig holdningen er knyttet til en konkret situasjon. En må måle respondentens holdning til et objekt (for eksempel en pasient) på generelt grunnlag, men også måle holdninger til objektet når respondenten samhandler med det.

En grunn til at man unngår mennesker med psykiske lidelser kan være ubehaget ved ens egne reaksjoner. En av de få studiene som er gjort på dette ble gjennomført i USA av Graves et. al. (2005), viser tydelige fysiske stresstegn som svette håndflater, spent øyebryns – muskler (corrugator supercilii) og økt hjerterytme. Studentene som deltok i studiet ble vist bilder av en rekke personer, noen med, og noen uten schizofreni. Bildene var tilfeldig merket slik at noen bilder av friske mennesker var merket som schizofrene, og omvendt. I tillegg var noen merket riktig. Studien antok at forventninger og fordommer styrte de følelsesmessige reaksjonene våre. De mener også at våre fysiske reaksjoner representerer en del av de holdningene vi har i møte med mennesker med psykisk lidelse, i dette tilfelle schizofreni. Studentene beskrev selv at de følte mer ubehag når de forestilte seg et møte med en som var merket som schizofren, i forhold til et møte med en person som ble presentert som frisk.

4.4 Hva kan påvirke sykepleieres holdninger og adferd i et akuttmottak?

I en australsk reviewartikkel (Johnston et al., 2016) kom det frem noen punkter som påvirker sykepleiernes adferd i et akuttmottak. Artikkelen inkluderte 31 studier, hvorav 24 var kvantitative – beskrivende studier, fire blandede beskrivende / sammenliknende (ikke randomiserte kontrollundersøkelser), og tre kvalitative studier. Studiene kom fra flere land (for det meste europeiske), og tok for seg arbeidsforholdene til alt medisinsk personell i et akuttmottak. De faktorene som viste seg å ha betydning var:

- Ledelse
- Arbeidsmengde og tidspress
- Følelse av avmakt
- Kulturelt mangfold

4.4.1 Ledelse

Liten delaktighet i beslutningstagning og avstand til ledelse ble oppfattet som en stressfaktor hevder Johnston et.al (2016). Det samme gjaldt når vaktene ble satt sammen av få erfarne og mange uerfarne helsearbeidere, og hvis det var lite tilgang på leger. Kollegial faglig støtte og felles beslutningstagning ga en mer harmonisk arbeidssituasjon mente sykepleierne.

4.4.2 Arbeidsmengde og tidspress

Arbeidsmengden til sykepleiere er et tema som stadig er oppe til debatt også her i Norge. I Nasjonalt kunnskapssenter for helsetjenesters rapport om forholdene i norske akuttmottak (Krogstad, 2015) kom det frem at overbelastning og knapphet på ressurser var en betydelig utfordring. Mange innrapporterte hendelser hadde dette som hovedårsak. Noen av disse hendelsene hadde en svært alvorlig karakter. I et akuttmottak vil driftskostnader stå opp i mot beredskapen. Sykepleiere som jobber i akuttmottak vet at noen tidspunkter på døgnet kan være travle, mens andre er rolige. For avdelingens og sykehusets ledelse vil dette være et dilemma der de må balansere mellom ansvarlighet ovenfor pasienten, og ansvaret for økonomien. Marynowski et. al. (2011) fant at sykepleiere hadde store tidsmessige utfordringer i møte med pasienter med psykisk lidelse. I denne australske studien kom det igjen frem at et av hovedproblemene var tidsmangel. Respondentene sa at de gjerne skulle hjulpet pasientene på en bedre måte, men at de ikke hadde tid. Hele grunnlaget for en terapeutisk samhandling forsvant. Clarke et.al. (2007) bekreftet at pasientene følte at sykepleiere ikke hadde tid. Selv om sykepleierne forsøkte å gjøre så godt det var mulig, oppfattet pasientene stress hos sykepleieren.

Pasientene følte da at deres problem ikke ble regnet som viktig nok uten at dette ble direkte uttalt. Selv om viljen til å hjelpe var der, satte altså de ytre rammene og arbeidssituasjonen sykepleierne i en situasjon der de ble stresset. Sykepleierne i Marynowski et.al (2011) sitt studie opplevde at personer med psykiske lidelser forlot venterommet før de fikk behandling fordi de følte seg oversett, nedprioritert, og ikke orket å være der over tid. Ved høyt arbeidspress, vil muligheten, tiden, og den enkelte sykepleiers evne til å inngå en god relasjon til pasienten reduseres (Johnston et al., 2016). Sykepleiere i akuttmottak vil i liten grad kunne følge pasientens helhetlige pleie. Pasienten overføres raskt til en spesialavdeling for videre behandling og pleie. Hvis sykepleieren mener at de ikke klarer å utføre en god jobb under dette korte møte fordi det er for mye å gjøre, vil man kanskje distansere seg emosjonelt fra pasienten for å beskytte seg selv. Dette kan komme til uttrykk i form av blikk, avmålt språk og lite tilstedeværelse. Den følelsesmessige delen av våre holdninger uttrykker seg i slike tilfelle gjennom den adferdsmessige delen. Skårderud et.al (2010) mener at mangel på kunnskap hos sykepleieren kan gjøre at forståelse for handlinger i mange tilfelle uteblir, og at sykepleieren i stedet viser følelser som frykt, sinne og fortvilelse.

4.4.3 Følelse av avmakt

Sykepleierne i følte at de ikke klarte å hjelpe pasienter med psykiske lidelser på en tilfredsstillende måte. Denne følelsen av utilstrekkelighet som enten grunnet i tidspress, mangel på kunnskap, hjelp fra kolleger og forståelse fra ledelsen, førte til at de til tider trakk seg følelsesmessig tilbake fra samhandlingssituasjoner med pasienter for å beskytte seg selv (Johnston et al., 2016). Mangel på forståelse for pasientens situasjon kan også virke demoraliserende på sykepleieren. Pasienter som kommer tilbake om og om igjen uten at men føler at det endrer noe (Marynowski-Traczyk & Broadbent, 2011). Kulturelle utfordringer i form av skikker og behov som føles fremmed for sykepleieren kan gi følelsen av tilkortkommenhet og usikkerhet. Uforutsigbarhet og usikkerhet er en kilde til stress, som igjen kan fremme dårlige holdninger. Herunder kommer også utfordringer knyttet til kommunikasjon. Selv om man

har en oppfatning av at sykepleiere er trent til å forstå pasienter, og at dette nærmest er gitt, føler ikke sykepleierne det slik bestandig (Johnston et al., 2016).

4.5 Også et menneske

Psykiske lidelser ser ut til å være et økende problem i det norske samfunnet. Sykepleiere ser ut til å ha generelt gode holdninger når det gjelder psykiatri og psykiske lidelser når de blir spurt. Forskning på holdninger har ofte som mål å bedre det tilbudet som pasienten får. Mennesker, uansett bakgrunn eller lidelse, skal møtes med respekt og verdighet. De som skal utøve denne respekten og verdigheten er også mennesker. De har behov for å utføre sitt yrke på en meningsfull måte. Når sykepleieren føler at forutsetningen for å utføre yrkesoppgavene blir redusert eller faller bort, vil følelser som avmakt, irritasjon, likegyldighet, generalisering, stigmatisering, sinne og redsel kunne gjøre seg gjeldene. Selv om disse følelsene har et subjektivt opphav i sykepleieren, og ikke nødvendigvis har så mye med den objektive sannhet å gjøre, kan mangel på kunnskap, trening og erfaring med denne pasientgruppen gi holdninger som er negative. I tillegg kan noen pasienter ha dårlig erfaring med helsevesenet og/eller urealistiske forventninger til helsepersonell, pleie og behandling.

5.0 Konklusjon og anbefalinger for videre forskning

Selv om man kan se en generell god holdning blant sykepleiere i dette studiet og liknende studier fra utlandet, vil årsakene til det som påvirker negativt variere. Man kan på ingen måte utelukke at sykepleiere i gitte situasjoner vil la negative holdninger komme til syne i sin praksis. Vi må kanskje lete andre steder for å finne hva som er årsaken til de eventuelle negative holdningene da resultatene varierer fra studie til studie. Negative holdninger vil, om vi skal tro på tidligere forskning, kunne medføre fare for pasientene. Videre forskning på tema holdninger er derfor anbefalt.

CAMI er et mye brukt og godt validert spørreskjema som gir oss et bilde på om det er generelt positive eller negative holdninger hos gruppen som undersøkes. Om det spesifiseres hvilken diagnose, eller tilstand det forskes på. Vil det kunne oppstå større variasjoner i resultatene. En oppfølgingsstudie med kvalitativ design, der man benytter seg av intervjuer vil muligens gi et mer nøyaktig bilde. Ved forskning på den kognitive og adferdsmessige delen holdninger kan kvantitativ metode være et fornuftig valg. Når det kommer til den følelsesmessige komponenten, som består av mange subjektive nyanser hos respondenten, vil muligens en kvalitativ tilnærming være mer egnet. I litteraturen så vi at sykepleierens opplevelse av egen arbeidssituasjon, kunnskap om de utfordringene som møter en, følelse av trygghet og kontroll, samt aksept for fokus på ikke- somatiske lidelser spiller en stor rolle. Man kan anta at sykepleiere generelt vil det beste for alle pasienter, men at de positive holdningene ikke får så stor plass som de burde i en krevende arbeidssituasjon. Det bør være åpenhet rundt frustrasjon knyttet til møte med psykisk lidelse. Veiledning av sykepleiere, samt øvelser som trener personalet i vanskelige situasjoner bør komme på treningsprogrammer på lik linje med resusciteringstrening og traumeøvelser. Flere sykehus har allerede gode simulerings / øvings- senter hvor dette bør bli en del av tilbudet.

Å utøve gode handlinger som bygger på positive holdninger ser ut til å være avhengig av mange faktorer. Det er vanskelig å trekke noe som helst slutning av dette studiet rent bortsett fra at den generelle viljen til å møte pasienter, uansett lidelse, på en verdig måte ser ut til å være til stede blant sykepleierne.

Referanser/litteraturliste

Aznar-Lou, I., Serrano-Blanco, A., Fernández, A., Luciano, J. V., & Rubio-Valera, M. (2016). Attitudes and intended behaviour to mental disorders and associated factors in catalan population, Spain: cross-sectional population-based survey. *BMC Public Health, 16*, 1-12. doi:10.1186/s12889-016-2815-5

Björkman, T., Angelman, T., & Jönsson, M. (2008). Attitudes towards people with mental illness: a cross-sectional study among nursing staff in psychiatric and somatic care. *Scandinavian Journal of Caring Sciences, 22*(2), 170-177 178p.

Buizza, C., Pioli, R., Ponteri, M., Vittorielli, M., Corradi, A., Minicuci, N., & Rossi, G. (2005). Community attitudes towards mental illness and socio-demographic characteristics: an Italian study. *Epidemiologia e Psichiatria Sociale, 14*(3), 154-162.

Chambers, M., Guise, V., Valimaki, M., Botelho, M. A., Scott, A., Staniuliene, V., & Zanotti, R. (2010). Nurses' attitudes to mental illness: a comparison of a sample of nurses from five European countries. *International Journal of Nursing Studies, 47*(3), 350-362. doi:http://dx.doi.org/10.1016/j.ijnurstu.2009.08.008

Clarke, D., Usick, R., Sanderson, A., Giles-Smith, L., & Baker, J. (2014). Emergency department staff attitudes towards mental health consumers: a literature review and thematic content analysis. *International Journal of Mental Health Nursing, 23*(3), 273-284. doi:http://dx.doi.org/10.1111/inm.12040

Clarke, D. E., Dusome, D., & Hughes, L. (2007). Emergency department from the mental health client's perspective.

Coulling, S. (2005). Nurses' and doctors' knowledge of pain after surgery. (0029-6570).

Department of Health. (2003). *Attitudes to Mental Illness 2003 Report*. London.

Evans-Lacko, S., Rose, D., Little, K., Flach, C., Rhydderch, D., Henderson, C., & Thornicroft, G. (2011). Development and psychometric properties of the reported and intended behaviour scale (RIBS): a stigma-related behaviour measure. *Epidemiology & Psychiatric Science, 20*(3), 263-271.

Finkelstein, J., Lapshin, O., & Wasserman, E. (2008). Randomized study of different anti-stigma media. *Patient Education and Counseling, 71*(2), 204-214. doi:http://dx.doi.org/10.1016/j.pec.2008.01.002

Graves, R. E., Cassisi, J. E., & Penn, D. L. (2005). Psychophysiological evaluation of stigma towards schizophrenia. *Schizophrenia Research, 76*(2-3), 317-327. doi:https://dx.doi.org/10.1016/j.schres.2005.02.003

Lov om etablering og gjennomføring av psykisk helsevern (psykisk helsevernloven), (1999 - 2017).

Helsedirektoratet. (2015). *ICD-10: Den internasjonale statistiske klassifikasjonen av sykdommer og beslektede helseproblemer 2015*. Oslo: Helsedirektoratet Retrieved from https://helsedirektoratet.no/Lists/Publikasjoner/Attachments/743/Icd-10-den-internasjonale-statistiske-klassifikasjonen-av-sykdommer-og-beslektede-helseproblemer-2015-IS-2277.pdf.

Helsedirektoratet. (2017, 28.07.2017). Psykisk helsevern og rus - antall pasienter, diagnoser og behandling. Retrieved from https://helsedirektoratet.no/statistikk-og-analyse/statistikk-fra-norsk-pasientregister/psykisk-helsevern-og-rus-antall-pasienter-diagnoser-og-

behandling
Hummelvoll, J. K. (2012). *Helt - Ikke stykkevis og delt*. Oslo: Gyldendal Akademisk.
Högberg, T., Magnusson, A., Ewertzon, M., & Lützén, K. (2008). Attitudes towards mental illness in Sweden: adaptation and development of the Community Attitudes towards Mental Illness questionnaire. *International Journal of Mental Health Nursing, 17*(5), 302-310.
Johannessen, A., Christoffersen, L., & Tufte, P. A. (2010). *Introduksjon til samfunnsvitenskapelig metode* (4. utg. ed.). Oslo: Abstrakt.
Johnston, A., Abraham, L., Greenslade, J., Thom, O., Carlstrom, E., Wallis, M., & Crilly, J. (2016). Review article: Staff perception of the emergency department working environment: Integrative review of the literature. *Emergency Medicine Australasia, 28*(1), 7-26. doi:10.1111/1742-6723.12522
Kluit, M. J., Goossens, P. J., & Leeuw, J. R. (2013). Attitude disentangled: a cross-sectional study into the factors underlying attitudes of nurses in Dutch rehabilitation centers toward patients with comorbid mental illness. *Issues in Mental Health Nursing, 34*(2), 124-132. doi:http://dx.doi.org/10.3109/01612840.2012.733906
Krogstad, U. L., Anne Karin; Saastad, Eli; Hafstad, Elisabeth. (2015). *Akuttmottak – risikosone for pasientsikkerhet*. Oslo: Nylenna, Magne.
Lund, T. (1996). *Metoder i kausal samfunnsforskning - En kortfattet og enkel innføring*. Oslo: Universitetsforlaget AS.
Markström, U., & Gyllensten, A. L. (2009). Attitude towards mental illness among health care students at Swedish universities. *Nurse Education Today, 29*, 660 - 665.
Marynowski-Traczyk, D., & Broadbent, M. (2011). What are the experiences of Emergency Department nurses in caring for clients with a mental illness in the Emergency Department? *Australasian Emergency Nursing Journal, 14*(3), 172-179. doi:http://dx.doi.org/10.1016/j.aenj.2011.05.003
McCann, T. V., Clark, E., McConnachie, S., & Harvey, I. (2007). Deliberate self-harm: emergency department nurses' attitudes, triage and care intentions. *Journal of Clinical Nursing, 16*, 1704 - 1711.
McCarthy, L., & Gijbels, H. (2010). An examination of emergency department nurses' attitudes towards deliberate self-harm in an Irish teaching hospital. *International Emergency Nursing, 18*, 29– 35. doi:http://dx.doi.org/10.1016/j.ienj.2009.05.005
Munro, S., & Baker, J. A. (2007). Surveying the attitudes of acute mental health nurses. *Journal of Psychiatric & Mental Health Nursing, 14*(2), 196-202.
Nordt, C., Rossler, W., & Lauber, C. (2006). Attitudes of mental health professionals toward people with schizophrenia and major depression. *Schizophrenia Bulletin, 32*(4), 709-714. doi:https://dx.doi.org/10.1093/schbul/sbj065
Norsk Sykepleierforbund. (2011). Yrkesetiske rettningslinjer for sykepleiere. Retrieved from https://www.nsf.no/Content/785285/NSF-263428-v1-YER-hefte_pdf.pdf
Ottersen, I. H. (2005). Syv år med opptrappingsplanen for psykisk helse - hvor står vi nå? *Samfunnsspeilet, 2005/5*.
Polit, D. F., & Beck, C. T. (2008). *Nursing research : generating and assessing evidence for nursing practice* (8 ed.). Philadelphia, Pa: Wolters Kluwer/Lippincott Williams & Wilkins.
Schafer, T., Wood, S., & Williams, R. (2011). A survey into student nurses' attitudes

towards mental illness: implications for nurse training. *Nurse Education Today, 31*(4), 328-332. doi:http://dx.doi.org/10.1016/j.nedt.2010.06.010

Skårderud; Haugsgjerd; Stänice. red. (2010). *Psykiatriboken sinn-kropp-samfunn*. Oslo: Gyldendal Akademisk.

St. prp. nr. 63 (1997-98). (1997). *Om opptrappingsplan for psykisk helse 1999 - 2006. Endringer i statsbudskjettet for 1998*. Oslo: Sosial- og helsedepartementet Retrieved from http://www.regjeringen.no/.

St.meld nr. 19 (2014 - 2015). (2014). *Folkehelsemeldingen - Mestring og muligheter*. Oslo: Det Kongelige Helse- og Omsorgsdepartement Retrieved from http://www.regjeringen.no/.

Statistisk Sentralbyrå. (2017). Tabell: 04511: Psykisk helsevern for voksne. Døgnplasser. Retrieved from https://www.ssb.no/statistikkbanken/SelectVarVal/saveselections.asp

Svartdal, F. (2016, 16.12.2016). Holdning. Retrieved from https://snl.no/holdning

Sørensen, T., & Sørensen, A. (2013). Dimensions of Attitudes towards the Mentally Ill in the General Population Stability and Change over Time at Urban and Rural Sites. *Psychiatry Journal Print, 2013*, 319429. doi:http://dx.doi.org/10.1155/2013/319429

Taylor, S., & Dear, M. J. (1981). Scaling community attitudes toward the mentally ill. *Schizophrenia Bulletin, 7*(2), 225-240.

Thornicroft, G., Rose, D., Kassam, A., & Sartorius, N. (2007). Stigma: ignorance, prejudice or discrimination? *British Journal of Psychiatry, 190*, 192-193. doi:https://dx.doi.org/10.1192/bjp.bp.106.025791

Wang, P. S., Berglund, P., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Failure and delay in initial treatment contact after first onset of mental disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 603-613. doi:https://dx.doi.org/10.1001/archpsyc.62.6.603

Winkler, P., Mladá, K., Janoušková, M., Weissová, A., Tušková, E., Csémy, L., . . . Csémy, L. (2016). Attitudes towards the people with mental illness: comparison between Czech medical doctors and general population. *Social Psychiatry & Psychiatric Epidemiology, 51*(9), 1265-1273. doi:10.1007/s00127-016-1263-y

Vedlegg 1: Informasjonsskriv til deltakere i studien

Forespørsel om å delta i spørreundersøkelse

Jeg er masterstudent i klinisk psykisk helsearbeid ved Høgskolen i Sørøst-Norge, Avdeling for sykepleierutdanning. Som del av studiet skal jeg skrive masteroppgave med temaet ”Sykepleieres holdninger til pasienter med psykiske lidelser i et somatisk akuttmottak”. Veileder er Prof. Hilde Eide, Institutt for sykepleievitenskap, Campus Drammen, Høgskolen i Sørøst-Norge. Jeg vil foreta en spørreundersøkelse blant ca. 2 - 300 sykepleiere ansatt ved tre somatiske akuttmottak. Som ansatt ved en av disse avdelingene inviteres du herved til å delta i studien. Du deltar ved å fylle ut vedlagte spørreskjema, som er beregnet til ca. 10 - 15 minutter.

Det er helt frivillig å delta i studiet.

Ved å levere det utfylte spørreskjemaet i lukket konvolutt, eller i en forseilet kasse, samtykker du til at informasjonen du gir kan benyttes i studien. Dataene som blir innsamlet vil bli brukt i min masteroppgave. Ved prosjektets slutt, makuleres alle spørreskjema. De samlede resultatene vil bli lagret elektronisk for senere bruk, men alt datamateriale anonymiseres. Innsamlede data er da umulig å spore tilbake til deg som respondent. Det kan bli aktuelt å publisere en vitenskapelig artikkel på bakgrunn av masteroppgaven.

Dataene i studien vil bli oppbevart og behandlet i henhold til gjeldene etiske og faglige retningslinjer. Prosjektet er meldt til NSD – Norsk senter for forskningsdata, og er godkjent av Personvernombudet ved inkluderte sykehus. Prosjektet avsluttes etter planen i løpet av våren 2017.

Svarfrist er 2 uker. Utfylt spørreskjema leveres til avtalt kontaktperson på din post. Selv om du har levert inn spørreskjemaet, vil alle få en påminnelse etter en uke og kanskje en gang senere. Dersom du har spørsmål, kan jeg kontaktes på telefon: 900 74 331 eller e-post: wibenyblin@hotmail.com

Vennlig hilsen Geir Nyblin, Sykepleier/masterstudent

Vedlegg 2: Påminnelsesbrev til deltakerne i studien

Påminnelse om spørreundersøkelse

For en uke siden fikk du en invitasjon til å delta i studien ”Sykepleieres holdninger til pasienter med psykiske lidelser i et somatisk akuttmottak” sammen med et spørreskjema.

Bakgrunnen for studien er at det ikke er gjort norske studier som kartlegger somatiske sykepleieres holdninger til pasienter med psykiske lidelser i Norge. Ved å delta i studien, bidrar du til ny kunnskap.

Dataene i studien vil bli oppbevart og behandlet i henhold til gjeldene etiske og faglige retningslinjer. Prosjektet er godkjent av Norsk Senter for Forskningsdata (NSD).

Utfylt spørreskjema leveres kontaktperson på din enhet.

Jeg minner om at fristen for å delta i studien er 1. November 2016. Dersom du har spørsmål, kan jeg kontaktes på telefon 900 74 331 eller e-post

wibenyblin@hotmail.com

Vennlig hilsen Geir Nyblin. Sykepleier/masterstudent

Vedlegg 3: Forespørsel og informasjons til akuttmottak som deltar i studiet

Forespørsel om å gjennomføre en spørreundersøkelse i deres avdeling.

Jeg er masterstudent i klinisk psykisk helsearbeid ved Høgskolen i Sørøst-Norge, Avdeling for sykepleierutdanning. Som del av studiet skal jeg skrive masteroppgave med temaet ”Sykepleieres holdninger til pasienter med psykiske lidelser i et somatisk akuttmottak”. Veileder er Prof. Hilde Eide, Institutt for sykepleievitenskap, Campus Drammen, Høgskolen i Sørøst-Norge.

Jeg vil foreta en spørreundersøkelse blant ca. 2 - 300 sykepleiere ansatt ved tre somatiske akuttmottak. Deres avdelingene inviteres herved til å delta i studien. Sykepleierne deltar ved å fylle ut vedlagte spørreskjema, som er beregnet til ca. 10 - 15 minutter. Jeg ønsker å inkludere alle sykepleiere og spesialsykepleiere ansatt ved akuttmottaket for å få en mest mulig representativ gruppe.

Det er helt frivillig å delta. Spørreskjemaet er fullstendig anonymisert.

Ved å levere det utfylte spørreskjemaet, samtykker sykepleieren til at informasjonen vedkommende gir kan benyttes i studien. Dataene som blir innsamlet vil primært bli brukt i min masteroppgave. Ved prosjektets slutt, makuleres alle spørreskjema. De samlede resultatene vil bli lagret elektronisk for senere bruk. Det kan bli aktuelt å publisere en vitenskapelig artikkel på bakgrunn av masteroppgaven. Avdelingen vil få tilgang på resultatet av studiet når den blir publisert.

Dataene i studien vil bli oppbevart og behandlet i henhold til gjeldene etiske og faglige retningslinjer. Prosjektet er meldt til NSD - Norsk Senter for Forskningsdata AS. Prosjektet avsluttes etter planen i løpet av våren 2017. Spørreskjemaene blir da makulert. Datamateriale anonymiseres ved prosjektslutt.

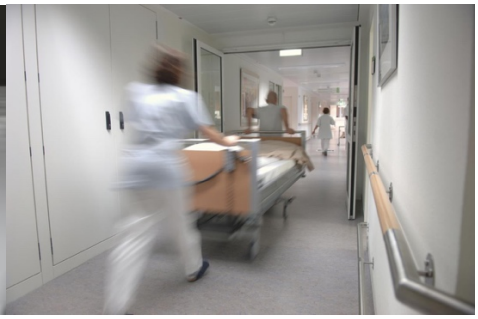
Svarfrist er 2 uker. Det er ønskelig å ha en kontaktperson i avdelingen, gjerne fagutviklingssykepleier. Utfylt spørreskjema vil i så fall kunne samles inn og oppbevares av vedkommende før innsendelse. Alle får en påminnelse etter en

uke selv om de har levert inn spørreskjemaet. Dersom du/dere har spørsmål, kan jeg kontaktes på telefon: 900 74 331 eller e-post: wibenyblin@hotmail.com

Vennlig hilsen Geir Nyblin, Sykepleier/masterstudent

Vedlegg 4: Plakat til påminnelse om studien

VIL DU BIDRA TIL NY KUNNSKAP?



Da kan du delta i studien:

”Sykepleieres holdninger til pasienter med psykiske lidelser i et somatisk akuttmottak”.

Se etter spørreskjema i posthyllen din!

(Det tar kun 10 – 15 min å fylle ut)

Vennlig hilsen

Geir Nyblin

Sykepleier/masterstudent

Vedlegg 5: Spørreskjema bakgrunnsvariabler

Spørreundersøkelse om holdninger til pasienter med psykiske lidelser.

Kode innsamlingssted:

Bakgrunnsdata

Alder < 24 år ☐ 24-29 år ☐ 30-39 år ☐ 40-49 år ☐ 50-59 år ☐

> 60 år ☐

Kjønn Mann ☐

Kvinne ☐

Trans- person ☐

Har du privat erfaring med psykiatri og/ eller psykisk helsevern som pårørende eller pasient? _____ (Ja/Nei)

Hvilke språk snakker du hjemme?_____
(Skriv språk og navnet på landet språket blir brukt i.)

1. Utdanning

Hvilket år ble du utdannet? _____ (Skriv årstallet)

Hvilket år fikk du godkjenning? _____ (Skriv årstallet)

Har du videreutdanning? _____(Ja/Nei) Hvis Ja, Evt. hvilken

_____

Er sykepleierutdanningen tatt i Norge?_____ (Ja/Nei)

2. Arbeidserfaring

Hvor mange år har du arbeidet som sykepleier? _____ år (skriv hele år)

Hvor mange års erfaring har du med pasienter med psykiske lidelser?
_____ år (skriv hele år)

Hvor mange år har du arbeidet ved nåværende avdeling? _____ år (skriv hele år)

Vedlegg 6: **The Community Attitudes towards the Mentally Ill (CAMI)**

		1	2	3	4	5	
Spørsmål: Sett ett kryss pr. utsagn	Nr.	Helt uenig	Delvis uenig	Usikker	Delvis enig	Helt enig	
Så snart en person viser tegn på å ha psykiske lidelser, bør han/hun legges inn på psykiatrisk sykehus.	1						K
Psykiatriske poliklinikker/daghospital bør ligge utenfor boligområder.	2						
Pasienter med psykiske lidelser bør isoleres fra resten av samfunnet.	3						A
Vi har et ansvar for å gi den best mulige omsorg og behandling til pasienter med psykiske lidelser.	4						P
Det er noe ved pasienter med psykiske lidelser som gjør det lett å se forskjell på dem og normale mennesker.	5						
En viktig årsak til psykiske lidelser er mangel på vilje og selvkontroll.	6						
Mer skattepenger skulle brukes på omsorg og behandling av pasienter med psykiske lidelser.	7						P
Beboere bør akseptere at det opprettes en psykiatrisk poliklinikk/daghospital i deres nabolag for å gi den service man har	8						P

behov for i kommunen.							
Vi bør bli mer tolerante overfor pasienter med psykiske lidelser i vårt samfunn.	9						P
Det brukes i dag for mange penger på å få pasienter fra psykiatriske sykehus tilbake til sine hjemsteder.	10						A
Det å ha en psykiatrisk poliklinikk / daghospital i et nabolag er ikke til fare for de som bor der.	11						
Pasienter med psykiske lidelser bør ikke gis noe ansvar.	12						A
Det ville være dumt av en person å gifte seg med en som har hatt psykiske lidelser, selv om det ser ut som om vedkommende er blitt helt bra igjen.	13						A
Jeg ville ikke like å være nærmeste nabo til en person som har hatt psykiske lidelser.	14						A
Pasienter med psykiske lidelser trenger samme slags tilsyn og oppdragelse som et barn.	15						A
De som bor i et område, har god grunn til å protestere mot at det blir opprettet en psykiatrisk poliklinikk / daghospital i deres nabolag.	16						A

The following statements express various opinions about mental illness and the mentally ill. The mentally ill refers to people needing treatment for mental disorders but who are capable of independent living outside a hospital. Please circle the response which most accurately describes your reaction to each statement. It's your first reaction which is important. Don't be concerned if some statements seem similar to ones you have previously answered. Please be sure to answer all statements.

a. As soon as a person shows signs of mental disturbance, he should be hospitalized.

SA A N D SD

b. More tax money should be spent on the care and treatment of the mentally ill.

SA A N D SD

c. The mentally ill should be isolated from the rest of the community.

SA A N D SD

d. The best therapy for many mental patients is to be part of a normal community.

SA A N D SD

e. Mental illness is an illness like any other.

SA A N D SD

f. The mentally ill are a burden on society.

SA A N D SD

g. The mentally ill are far less of a danger than most people suppose.

SA A N D SD

h. Locating mental health facilities in a residential area downgrades the neighbourhood.

SA A N D SD

i. There is something about the mentally ill that makes it easy to tell them from normal people.

SA A N D SD

j. The mentally ill have for too long been the subject of ridicule.

SA A N D SD

k. A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered.

SA A N D SD

l. As far as possible mental health services should be provided through community-based facilities.

SA A N D SD

SA=Strongly Agree A=Agree =Neutral D=Disagree SD=Strongly Disagree

m. Less emphasis should be placed on protecting the public from the mentally ill.

SA A N D SD

n. Increased spending on mental health services is a waste of tax dollars.

SA A N D SD

o. No one has the right to exclude the mentally ill from their neighbourhood.

SA A N D SD

p. Having mental patients living within residential neighbourhoods might be good therapy, but the risks to residents are too great.

SA A N D SD

q. Mental patients need the same kind of control and discipline as a young child.

SA A N D SD

r. We need to adopt a far more tolerant attitude toward the mentally ill in our society.

SA A N D SD

s. I would not want to live next door to someone who has been mentally ill.

SA A N D SD

t. Residents should accept the location of mental health facilities in their neighbourhood to serve the needs of the local community.

SA A N D SD

u. The mentally ill should not be treated as outcasts of society.

SA A N D SD

v. There are sufficient existing services for the mentally ill.

SA A N D SD

w. Mental patients should be encouraged to assume the responsibilities of normal life.

SA A N D SD

x. Local residents have good reason to resist the location of mental health services in their neighbourhood.

SA A N D SD

y. The best way to handle the mentally ill is to keep them behind locked doors.

SA A N D SD

z. Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for.

SA A N D SD

SA=Strongly Agree A=Agree N=Neutral D=Disagree SD=Strongly Disagree

aa. Anyone with a history of mental problems should be excluded from taking public office.

SA A N D SD

bb. Locating mental health services in residential neighbourhoods does not endanger local residents.

SA A N D SD

cc. Mental hospitals are an outdated means of treating the mentally ill.

SA A N D SD

dd. The mentally ill do not deserve our sympathy.

SA A N D SD

ee. The mentally ill should not be denied their individual rights.

SA A N D SD

ff. Mental health facilities should be kept out of residential neighbourhoods.

SA A N D SD

gg. One of the main causes of mental illness is a lack of self-discipline and will power.

SA A N D SD

hh. We have the responsibility to provide the best possible care for the mentally ill.

SA A N D SD

ii. The mentally ill should not be given any responsibility.

SA A N D SD

jj. Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services.

SA A N D SD

kk. Virtually anyone can become mentally ill.

SA A N D SD

ll. It is best to avoid anyone who has mental problems.

SA A N D SD

mm. Most women who were once patients in a mental hospital can be trusted as baby sitters.

SA A N D SD

nn. It is frightening to think of people with mental problems living in residential neighbourhoods.

SA A N D SD

SA=Strongly Agree A=Agree N=Neutral D=Disagree SD=Strongly Disagree

COMMUNITY ATTITUDES TOWARDS THE MENTALLY ILL

Vedlegg 8: Vitenskapelig artikkel

Emergency nurses attitude toward mental illness in three Norwegian acute wards and one intensive care unit.

A Cross – Sectional Study

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University College of

Southeast- Norway

Hilde Eide, PhD

University College of

Southeast- Norway

Abstract

Background: In Norway, the parliament decided to increase the

quality of mental health service. Many persons come to an acute ward with mental illness as their main problem, or as a result of behaviour caused by the illness. Persons with mental illness also comes to the acute ward on behalf of somatic problems. Some of the persons with mental illness need more attention than persons with exclusively somatic problems. Negative attitude toward mentally ill persons could represent a risk for the patent treatment. The purpose of this study is to explore emergency nurses attitude toward this patient group.

Participants and methods: The study has a cross – sectional design. 294 questionnaires were handed out to emergency nurses in three acute wards and

one intensive care unit. 173 responded. The Community Attitudes toward Mentally Ill (CAMI) questionnaire were used in a Norwegian 16 statement version.

Results: The nurses had an overall positive attitude. No significant correlation between the background variables and the attitude toward mentally ill were found.

Conclusion: We found that Norwegian nurses scores high on the CAMI scale. The CAMI scale is a thoroughly tested, and valid questionnaire, and is almost equal to everyone. We did not find any explanation on what influence on attitude among nurses in an acute ward. Further research on attitude, and possible factors who correlate with attitude among nurses, is recommended.

Keywords: Attitude, stigma, mentally ill, nurses, acute ward, emergency department

Introduction /background

Many persons with mental illness have their first meeting with health care in an acute ward[1,2]. Acute wards are available to patients all hours, and will function as an emergency solution for mentally ill patients and their family[1]. In addition to this, a number of persons who have harmed themselves and persons who tried to commit suicide, will sometimes need somatic care for their physical injuries[3]. Intoxication, strangulation and other self - inflicted wounds with a suicidal purpose, needs medical care and treatment in addition to psychiatric assessment. According to Clarke et. al.,[3] 10 to 15% of the patients who come to the acute ward are persons with mental illness or problems related to mental health. They further revealed that these patients were taken less seriously than other patients, and that health care personnel´s negative attitude toward this group of patients would result in lesser quality care. Clarke. et. al[4], found that mentally ill patient was triaged down in the acute ward. Some experienced to be triaged as mentally ill even if the purpose of the visit was a somatic problem. This led to longer waiting than necessary to get sufficient treatment.

We do not know how experiences from other countries relates to the Norwegian acute wards. In Norway, the hospitals are run by the state. In addition to this there are community emergency rooms which take less serious emergency issues, and treat them outpatient. These emergency rooms will treat many of the persons with mental health problems. Still many persons with mental health problems or illness as a primary or secondary problem come directly to the acute ward, or are referred by a general practitioner in the community emergency room. In 1997[5] specific interventions were decided by the Norwegian parliament to increase and improve the mental health service. A part of this intervention was attitude change in the general population, and increased competence among health personnel. World Health Organization (WHO) recommends integration of mental health services into primary health services,

however WHO claims that attitude of primary health care workers is one barrier to this[5]. Some hospitals in Norway have the psychiatric ward located in the same facilities as the somatic departments and the acute ward. Generally, psychiatric hospitals and facilities are placed on a separate location. To transfer a patient to the right department may become a time- consuming proses. These patients often stay longer than other patients in the acute ward and represent extra work and challenge for the nurses. The attitude of health personnel may have an impact on the treatment, safety and wellbeing in an acute ward. In Norway, there is little research on attitudes among nurses, non found from an acute ward. We aimed this study is to explore nurses attitude toward persons with mental illness in an acute ward.

Specific research questions were:

- What are nurses´ attitude toward persons with mental illness?
- How nurses´ attitude toward mental illness depend on the background characteristics of the responders?

Methods

The study uses a cross-sectional survey study of nurses working in acute wards[6].

Three large acute wards and one intensive care unit where included in the study. Of these, two where located in large local hospitals, and one in a university hospital. The intensive care unit included took care of many typical psychiatric related patients. Intoxication, deliberate self-harmers, suicide attempt and patient with cerebral impact attitude stands for more than half of their patients. All hospitals chosen where located in the south – eastern part of Norway due the high population rate in the area. The data material was collected between December 1. 2016, and January 31. 2017. Population in Norway, 1 January 2017 was 5 258 317 people[7]. The hospitals involved covered approximately 880.000 people.

Participants

All nurses in the included acute wards were invited to participate unregarded of their educational level. All participants had to have a Norwegian authorization, and be able to read and speak Norwegian. Nurses in maternity leave, in long term sick-leave and under education elsewhere were not included. The nurses were recruited through the department manager in the acute ward after permission from the hospital management. All participation was voluntary, and all nurses received written information about the study along with the questionnaire.

Questionnaire

The Community Attitudes towards the Mentally Ill (CAMI) scale was used to measure attitudes [8]. The CAMI scale was developed to measure the general populations attitude toward the mentally ill, but has in many occasions been used on medical personnel[9-11]. The CAMI scale has been used in a large number of countries around the world[10-23]. The original CAMI scale included 40 statements. In some studies, a modified version is used[9,20]. In this study, we used 16 statements. This 16 statements were recommended by professor Sørensen based on the experiences from their Norwegian population study[24]. The 16 items of the scale are rated on a Likert scale from 1 (strongly disagree) to 5 (strongly agree). For use in calculation CAMI - sumscore negative items were reverse coded so that higher scores indicated more favourable attitudes toward the patients[21]. The CAMI was translated into Norwegian and has been used in Sørensen et. al[24] studies of general population attitude toward mentally ill in urban and rural sites in Norway in the purpose to test the questionnaire over time. Some of the items have been modified into a more modern language, and some of the terms has been slightly rewritten to be gender neutral (item 13)[11].

Demographics

Demographic variables were chosen on the background of other studies based on what have been proven to correlate with attitude[11,25]. Age, gender, private experience with mentally illness (as a patient themselves, or as a dependent), if they come from western Europe or similar countries (ethnicity), when they became nurses, special training, if they have taken their nurse training in Norway, how many years practicing nursing, professional experience with mentally illness and the length of relation with the acute wards included in the study.

Research ethics

The study has been approved by The Norwegian Center for Research Data (project number 50011). The data protecting authority at the included hospitals gave their approval. Furthermore, all participants were informed in writing about the study when the questionnaire were handed out. The filling out was voluntary. The participants were informed that by returning the questionnaire, they approved their participation. A nurse in every department, helped with the collection and storing of the answers.

Statistical analysis

The result was computed by SPSS version 24[26]. Descriptive statistic correlation was used to describe distribution of demographic data. Cronbach´s Alpha was used to determine the degree of the scales internal consistency. Correlation analysis was used to explore associations between the scale sumscore and background variables[6].

Results

The samples (table 1 & 2) A total of 294 nurses were invited to the study. 178 questionnaires were filled out. Five were discarded due to lack of answers. Further three were discarded in the correlation test and marked as outlayers. Totally 170 scales were included. This gave a respond rate of 57.8%. Of these were 135 (78.0%) female, 35 (20.2%) male and three (1.7%) transsexual (marked as missing in table 1 and not included in the correlation test). The age ranged between 21 and 64 years, with a mean of 39,5 (standard deviation (SD), 10.5) and a median of 38. Seventy (40.5%) had private experience (personally or as a dependent) with mental illness, 18 (10.4%) had not received their nurse education in Norway. Only three (1.7%) did not have a West – European cultural background. In the non– responder group (N=121) was 94 (77.7%) female and 27 males. The mean age of the non– responder group was 38,4 years. Only 12 (9.9%) had special training and 8 (6.6%) did not have a West – European cultural background. Data on the sample characteristic about private experience with mental illness and nurse education completed in Norway, was not available for the non– responders. Except for the special training variable, the two groups have an almost similar percentage score on the background variables. Our data did not reveal any differences between responders and non-responders concerning any of the background variables except for level of education. About 1/3 of our responders completed special education, however only less than 10% did so for non-responders.

Tabel 3 shows the distribution of answers in the CAMI scale. There is a clear polarisation toward positive attitude. A majority of our responders scored high on CAMI, many of them reaching the highest possible values which in turn resulted in a ceiling effect. Given a small variation in our results it was difficult to reveal any possible association with selected background variables.

In questions containing localization of mental facilities and use of tax money, the answers are more spread. Item 2, 8, 11 and 16 shows attitude toward localisation of mental facilities. The responders seemed more positive to spend tax money on the care and treatment of the mentally ill (item 7), than using tax money to relocate people with mental illness from hospitals to their home

community (item 10). There is a positive attitude toward these questions as well, but not so clear. To calculate the sumscore (Sumscore = 65.97, Min =16, max = 90) items no. 1, 2, 3, 5, 6, 10, 12, 13, 14, 15 and 16 were reverse coded. High sumscore means positive attitude toward mentally ill.

A reliability test was run on the CAMI scale. Cronbach´s Alpha was 0,79. P value was set to 5%. Univariate analysis with frequency tables was performed on the items to see the distribution on the Likert scale. Bivariate analysis was used to find possible correlations between demographic variables and the CAMI items. A linear reduction analysis was tried with CAMISUM as dependent variable against all included background variables. There was no connection between the selected variables and the outcome (table 4).

Discussion

Based on this study, the Norwegian nurses had a positive attitude toward patients with mental illness. Comparing with other studies, using the same questionnaire, Norwegian nurses had a higher level of positive attitude. We could not find a uniform explanation in other studies what causes attitude to be positive or negative. In the studies evaluated, we found that background variables as age, gender, ethnicity, personally experience with mental illness as a patient or a dependent, and years of experience correlated with attitude[2,11,25,27,28]. The background variables impact on the result varied between the studies. Age could produce a positive outcome in one study, and a negative in another, depending on the diagnosis[11,25]. For the other background variables, we could see similar patterns. Understanding the terms in the scale came back as a problem. The positive attitude in our study could be explained by the government intervention from 1997[5], and the following increased focus on psychiatric care in nurse education. The higher percentage of nurses with special training answering the survey, could also be a possible explanation for the positive outcome[27]. The items regarding localization of mental institutions and facilities revealed that many responders place themselves in, or close to the - Neither agree, nor disagree- box in the CAMI scale. Even if we found no

correlation with the background variables, we can see that there is a little restriction among the nurses, in this study, having a psychiatric facility close to their home. A British government report concludes that after educational interventions to increase the knowledge about mental illness, it led to less stigmatization in general, in other hand, more people thought it would be dangerous to have mentally ill people living in their neighborhood[29]. In this report education and knowledge did not provide exclusively positive attitude. We may have to look elsewhere to find what causes attitude variations. The CAMI scale may be too wide in the characteristic of the term "patient with mental illness", but it is fairly validated. If used again it would be recommended to be clear on which diagnoses the study focuses on, or let the respondents define what the term means to them. CAMI may have a cultural challenge, and attitude are culturally determined. CAMI is used all over the world[10-23]. Is it possible to adjust it to capture all culture variations?

The CAMI scale was primary developed to measure the attitude of the general population. Even if it is used several times for different medical personnel, it may be inaccurate. Throughout six studies over a period of 27 years, Sørensen et. al.[24] urges to carefulness when comparing results from the CAMI scale over time even though the results from the studies showed small variation in results, the terms could be interpreted different over time. Sørensen tried to provide this by telling each of the respondents what was meant by the term "mentally ill". The same definition was used in all the studies. Björkman et. al.[25] support the importance of clear definitions. The scale does not differ between various psychiatric diagnosis, and placed all kind of patients with mental illness in the same group. Many of the respondents in this study commented this by writing on the returned scale. They said it was difficult to answer because different diagnosis need different approach, and meets different attitude and stigma[25]. Their professional knowledge about mentally ill patients made it difficult to answer. One of the three components in attitude is knowledge[30]. Other found the questionnaire unfit because it focused on their private, and not their professional attitude towards mentally ill patients, and that their professionality did not allow them to have a private attitude at work. The nurses said they acted on behalf of their knowledge and professionalism, not their feelings[30]. However,

the question whether their knowledge or their feelings led the majority of the respondents to an answer, still stands unanswered. The extra comments on the scale were too few to be taken in consideration for the result of this survey, but it should be noticed for later studies. In studies, using other scales, there were found more connections between background variables and attitude toward different mentally illness.[25] Nevertheless, all this taken in consideration, only Sørensen et. al. and Björkman et. al. commented on the terms. Compering with the other studies using CAMI and not specifying the terms, Norwegian nurses scores high. A follow up study with a qualitative design, especially to examine the emotional aspect of attitude, could give a more nuanced view on the challenges nurses meet in the acute ward, helping patient with mentally illness.

Study limitation

Some of the background data on the total population was not possible to get from the included acute wards (tab.1, tab.2). This could weaken the study toward representing the total population. The acute wards included was also geographic close to each other. Nurses working in rural areas was not asked to participate. Another possible bias could be that the responders answer what they think are expected of them as a nurse, and not what they really feel. On the background question about professional experience with mental illness, some of the nurses thought this was all kind of experience, and that they got this experience from working in an acute ward, others thought this was working in a mental institution.

Strength

A strength of the study is the high percentage of similarity between the responder group and the total sample because we got a much data about the non- responders. The total sample cover approximately 1/6 of the emergency healthcare service to the Norwegian population. There were also a low number of missing data on the returned sheets. Only eight were discarded. The

questionnaire used was thoroughly tested and validated.

Conclusions

In this study, we gave an overview of the attitude toward mentally ill persons among emergency nurses in three Norwegian hospitals. The nurses were asked questions that was related to them as members of the community, and not as nurses. The nurses had an overall positive attitude toward mentally ill patients. According to the CAMI scale, and the findings analysing, the data found no correlation with any of the background variables and a negative attitude toward mentally ill patients. Future research needs perhaps a wider perspective in the search for any causes who possible gives negative attitude among Norwegian nurses.

Acknowledgements

The authors thank all of the nurses who took part in this study, and to the hospitals involved. A special thanks to professor Tom Sørensen who gave me the translated version of the CAMI scale, and helped us pick out the items. Also thank to associate professor Milada Cvancarova Småstuen for her contribution to understand the statistics analysis.

Funding

This project has not been funded. All expenses is payed by the author.

Conflict of interest

No conflict of interest has been declared by the authors.

References

1. Marynowski-Traczyk D, Broadbent M. What are the experiences of Emergency Department nurses in caring for clients with a mental illness in the Emergency Department? *Australasian Emergency Nursing Journal.* 2011;14(3):172-179.

2. Munro S, Baker JA. Surveying the attitudes of acute mental health nurses. *J Psychiatr Ment Health Nurs.* 2007;14(2):196-202.

3. Clarke D, Usick R, Sanderson A, Giles-Smith L, Baker J. Emergency department staff attitudes towards mental health consumers: a literature review and thematic content analysis. *Int J Ment Health Nurs.* 2014;23(3):273-284.

4. Clarke DE, Dusome D, Hughes L. Emergency department from the mental health client's perspective. 2007.

5. St. prp. nr. 63 (1997-98). Om opptrappingsplan for psykisk helse 1999 - 2006. Endringer i statsbudskjettet for 1998. Oslo: Sosial- og helsedepartementet; 1997.

6. Polit DF, Beck CT. *Nursing research : generating and assessing evidence for nursing practice.* 8 ed. Philadelphia, Pa: Wolters Kluwer/Lippincott Williams & Wilkins; 2008.

7. Statistics Norway. Population in Norway. 2017; https://www.ssb.no/befolkning/nokkeltall/befolkning. Accessed 08.03.17, 2017.

8. Taylor S, Dear MJ. Scaling community attitudes toward the mentally ill. *Schizophr Bull.* 1981;7(2):225-240.

9. Högberg T, Magnusson A, Ewertzon M, Lützén K. Attitudes towards mental illness in Sweden: adaptation and development of the Community Attitudes towards Mental Illness questionnaire. *Int J Ment Health Nurs.* 2008;17(5):302-310.

10. Gang M, Song Y, Park SY, Yang S. Psychometric evaluation of the Korean version of the attitudes toward acute mental health scale. *J Psychiatr Ment Health Nurs.* 2014;21(10):939-948.

11. Chambers M, Guise V, Valimaki M, et al. Nurses' attitudes to mental illness: a comparison of a sample of nurses from five European countries. *Int J Nurs Stud.* 2010;47(3):350-362.

12. Vibha P, Saddichha S, Kumar R. Attitudes of ward attendants towards mental illness: comparisons and predictors. *International Journal of Social Psychiatry.*

2008;54(5):469-478.

13. Siqueira SRG, Abelha L, Lovisi GM, Sarucao KR, Yang L. Attitudes towards the mentally ill: A study with health workers at a university hospital in rio de janeiro. *Psychiatric Quarterly.* 2016:No Pagination Specified.

14. Sevigny R, Yang W, Zhang P, et al. Attitudes toward the mentally ill in a sample of professionals working in a psychiatric hospital in Beijing (China). *International Journal of Social Psychiatry.* 1999;45(1):41-55.

15. Igbinomwanhia NG, James BO, Omoaregba JO. The attitudes of clergy in Benin City, Nigeria towards persons with mental illness. *Afr J Psychiatry (Johannesbg).* 2013;16(3):196-200.

16. Barke A, Nyarko S, Klecha D. The stigma of mental illness in Southern Ghana: attitudes of the urban population and patients' views. *Soc Psychiatry Psychiatr Epidemiol.* 2011;46(11):1191-1202.

17. Ewalds-Kvist B, Hogberg T, Lutzen K. Impact of gender and age on attitudes towards mental illness in Sweden. *Nordic Journal of Psychiatry.* 2013;67(5):360-368.

18. Hogberg T, Magnusson A, Lutzen K, Ewalds-Kvist B. Swedish attitudes towards persons with mental illness. *Nordic Journal of Psychiatry.* 2012;66(2):86-96.

19. Bedaso A, Yeneabat T, Yohannis Z, Bedasso K, Feyera F. Community Attitude and Associated Factors towards People with Mental Illness among Residents of Worabe Town, Silte Zone, Southern Nation's Nationalities and People's Region, Ethiopia. *PLoS ONE.* 2016;11(3):e0149429.

20. Winkler P, Mladá K, Janoušková M, et al. Attitudes towards the people with mental illness: comparison between Czech medical doctors and general population. *Soc Psychiatry Psychiatr Epidemiol.* 2016;51(9):1265-1273.

21. Aznar-Lou I, Serrano-Blanco A, Fernández A, Luciano JV, Rubio-Valera M. Attitudes and intended behaviour to mental disorders and associated factors in catalan population, Spain: cross-sectional population-based survey. *BMC Public Health.* 2016;16:1-12.

22. Finkelstein J, Lapshin O, Wasserman E. Randomized study of different anti-stigma media. *Patient Education and Counseling.* 2008;71(2):204-214.

23. Venkatesh BT, Andrews T, Mayya SS, Singh MM, Parsekar SS. Perception of stigma toward mental illness in South India. *J.* 2015;4(3):449-453.

24. Sørensen T, Sørensen A. Dimensions of Attitudes towards the Mentally Ill in the General Population Stability and Change over Time at Urban and Rural Sites. *psychiatry j.* 2013;2013:319429.

25. Björkman T, Angelman T, Jönsson M. Attitudes towards people with mental

illness: a cross-sectional study among nursing staff in psychiatric and somatic care. *Scandinavian Journal of Caring Sciences.* 2008;22(2):170-177 178p.

26. *IBM SPSS Statistics* [computer program]. Version 24: IBM; 2016.

27. McCarthy L, Gijbels H. An examination of emergency department nurses' attitudes towards deliberate self-harm in an Irish teaching hospital. *International Emergency Nursing.* 2010;18:29– 35.

28. Schafer T, Wood S, Williams R. A survey into student nurses' attitudes towards mental illness: implications for nurse training. *Nurse Education Today.* 2011;31(4):328-332.

29. Department of Health. Attitudes to Mental Illness 2003 Report. In: Health Do, ed. London2003.

30. Thornicroft G, Rose D, Kassam A, Sartorius N. Stigma: ignorance, prejudice or discrimination? *Br J Psychiatry.* 2007;190:192-193.

Vedlegg: 9 Table 1. Sample Characteristic

Variables		Responders (N=173)		No-Responders (N=121)		Total sample (N=294)	
		N	%	N	%	N	%
Gender	Male	35	20.2	27	22.3	62	21.2
	Female	135	78.0	94	77.7	229	77.8
	Missing	3	1.7	0	0	3	1.0
Special training		56	32.4	12	9.9	68	23.1
West Europe cultural background		170	98.3	113	93.4	283	96.3

Vedlegg: 10 Table 2. Sample Characteristic

Variables	Responders				
	Mean	**Median**	**Min**	**Max**	**St.D**
Age	39.5	38.0	21.0	64.0	10.5
Years as nurse	12.0	10.0	1.0	40.0	8.8
Professional experience with Mental Illness	5.5	2.0	0.0	36.0	7.5
Years in included acute ward	6.0	4.0	0.0	36.0	6.2

Vedlegg 11: Table 3. Distribution of answers.

Table 3. Distribution of answers.

		Distribution of answers N=170 (%)					Mean / (SD)
Items #		Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	
1	**As soon as a person shows signs of mental disturbance, he should be hospitalized**	87 (51.2)	56 (32.9)	11 (6.5)	15 (8.8)	1 (0.6)	1.75 (0.96)
2	**Mental health facilities should be kept out of residential neighbourhoods**	49 (28.8)	55 (32.4)	32 (18.8)	27 (15.9)	7 (4.1)	2.38 (1.19)
3	**A patient with mental illness should be isolated from the rest of the community.**	128 (75.3)	33 (19.4)	3 (1.8)	5 (2.9)	1 (0.6)	1.35 (0.71)
4	**We have a responsibility to provide the best possible care for people with mental illness**	10 (5.9)	2 (1.2)	0 (0.0)	11 (6.5)	147 (86.5)	4.66 (1.00)
5	**There is something about people with mental illness that makes it easy to tell them from normal people**	58 (34.1)	64 (37.1)	9 (5.3)	34 (20.0)	5 (2.9)	2.20 (1.20)

6	**One of the main causes of mental illness is a lack of self-discipline and will-power**	**96 (56.5)**	**44 (25.9)**	**18 (10.6)**	**10 (5.9)**	**2 (1.2)**	**1.71 (0.99)**
7	**More tax money should be spent on the care and treatment of the mentally ill**	6 (3.5)	8 (4.7)	30 (17.6)	68 (40.0)	58 (34.1)	3.95 (1.01)
8	**Residents should accept the location of mental health facilities in their neighbourhood to serve the needs of the local community.**	4 (2.4)	18 (10.6)	30 (17.6)	69 (40.6)	49 (28.8)	3.79 (1.07)
9	**We need to adopt a far more tolerant attitude toward people with mental illness in our society**	3 (1.8)	3 (1.8)	10 (5.9)	59 (34.7)	95 (55.9)	4.39 (0.85)
10	**To much tax money are used to relocate mental patients from hospitals to their home community**	29 (17.1)	25 (14.7)	104 (61.2)	5 (2.9)	7 (4.1)	2.62 (0.94)
11	**Locating mental health services in residential neighbourhood does not endanger local residents.**	10 (5.9)	29 (17.1)	36 (21.2)	60 (35.3)	35 (20.6)	3.46 (1.17)

12	**People with mental illness should not be given any responsibility**	**94 (55.3)**	**65 (38.2)**	**5 (2.9)**	**4 (2.4)**	**2 (1.2)**	**1.56 (0.76)**
13	**A person would be foolish to marry someone who has suffered from mental illness, even though he seems fully recovered**	115 (67.6)	37 (21.8)	10 (5.9)	4 (2.4)	4 (2.4)	1.52 (0.91)
14	**I would not want to live next door to someone who has been mentally ill**	88 (51.8)	56 (32.9)	13 (7.6)	12 (7.1)	1 (0.6)	1.75 (0.95)
15	**Mental patients need the same kind of control as young children**	107 (62.9)	37 (21.8)	13 (7.6)	8 (4.7)	5 (2.9)	1.64 (1.01)
16	**Local residents have good reason to resist the location of mental health services in their neighbourhood.**	60 (35.3)	62 (36.5)	31 (18.2)	14 (8.2)	3 (1.8)	2.08 (1.03)
	Sumscore #					Sumscore =	**65.97 (7.80)**
	#Chronbach alfa = 0,79 To calculate the sumscore, items nr. 1, 2, 3, 5, 6, 10, 12, 13, 14, 15 and 16 were reverse coded. High sumscore means positive attitude toward mentally ill.						**Min=16** **Max=90**

Vedlegg 12: Table 4: Linear regression

Variable	B	CI	P
Age	0.05	-0.07 – 0.16	0.43
Gender	-1.44	-4.39 – 1.52	0.34
Private experience	1.59	-0.81 – 4.00	0.19
West Europe Cultural background	-0.25	-2.16 – 1.66	0.80
Special training	1.90	-0.61 – 4.42	0.14
Education received in Norway	-2.89	-6.72 – 0.93	0.14
Years as a nurse	0.09	-0.05 – 0.22	0.20
Professional experience with Mental illness	-0.08	-0.24 – 0.08	0.31
Years in included acute ward	0.12	-0.07 – 0.31	0.21

There is no linear connection between the selected variable and the outcome.

No P values < 0.10

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Pharm/Tox Corner Send to Allison A. Muller at acri.muller@comcast.net

Trauma Notebook Send to Kate Moore at: kmmoor4@emory.edu

Triage Decisions Send to Andi Foley at: andii42@yahoo.com

Preparation

Manuscript Preparation

Manuscripts must be typed using 12 font size and double-spaced. Research, Clinical articles, Integrative Evidence Review, Systematic Evidence Review, Meta-analysis, and Practice Improvement manuscripts are limited to 15 pages. Articles for special departments/sections including Case Review are limited to 5 pages. Letters to the Editor are limited to 1 page. Length restriction for all manuscripts includes text plus references, tables, charts, and illustrations.

All lines on manuscripts must be numbered. To do this, submitting authors can open their manuscript in Word, click on "File" at the top left of the computer screen to open selections, and then click on the selection that says "Page Setup." The page setup box will then appear, and then click on the "Layout" option at the top of the box. Go down to the bottom left of the box where it says "Line Numbers." Click on "Line Numbers" and a smaller box will appear. Click

on the box where it says "Add Line Numbering," and then click on the box toward the bottom that says "Continuous Numbering." Then click "OK" at the bottom of that box, and then "OK" at the bottom of the remaining box.

Title page The title page must include the manuscript title, full name(s) of author(s), academic degrees, position, institution, city, state, and if applicable the author(s) ENA chapter name. Designate the corresponding author. Include home address, business, and home telephone numbers, and e-mail address. NOTE: The title page should be uploaded as a separate document to ensure peer reviewers are blinded as to the author(s) identity.

Body of Text Standard abbreviations are to be used consistently throughout the article. Spell out unusual or coined abbreviations at first mention, followed in parentheses by the abbreviation. The policy of *JEN* is to abbreviate the term "emergency department" when it modifies a word (eg, "ED procedure") and to spell it out when it is used as a noun (eg, "in the emergency department"). The term "emergency nurse" should be used.

The generic name of a drug is to be used instead of the proprietary name whenever possible. If it is necessary to use a trade name for a drug, capitalize the name and insert it parenthetically after the generic name when first mentioned. Treat product names similarly, and the manufacturer's full name, city, and state should be cited in a footnote or in parentheses in the text.

Weights and measurements are to be expressed in metric units and temperature in degrees centigrade, followed with Fahrenheit degrees in parentheses.

References References are to be to the original sources of information in most instances. *JEN* requires AMA style, 10th Edition referencing. Cite references **by number only** in the text, consecutively, in the order of their mention. Type a numbered reference list double-spaced at the end of the text to correspond with the in-text reference citations.

Research and Practice Improvement Manuscripts

Preparation of Research Manuscripts

Research Manuscripts are to begin with the heading Contribution to Emergency Practice, followed by a bullet point stating how this research is new and what it adds to emergency nursing knowledge and up to 3 additional bullet points describing translation of the papers findings to emergency nursing practice. This is to be followed by a structured abstract of no more than 250 words in the following format: Introduction, Methods, Results, Discussion. Do not use abbreviations or referenced statements in the abstract. Up to 6 key words are to be provided following the abstract. The main body of the manuscript is to include the following headings: Introduction (describe the problem, significance, synthesize relevant literature, purpose of the study, research, questions or hypotheses), Methods (describe the study design, sample and setting, human subjects protection, measures, data analysis procedures), Results, Discussion, Limitations, Implications for Emergency Nurses, and Conclusions. All references must be cited in the text. References are to be the original sources of information in most instances. ***JEN* requires AMA-style referencing**. Cite references **by number only** in the text, consecutively, in the order of their mention. Type a numbered reference list double-spaced at the end of the text to correspond with the in-text reference citations. The total length of the manuscript is not to exceed 15 double-spaced pages, including all references, tables, charts, and figures. Reports of randomized controlled trials must address all items in the CONSORT checklist (http://www.consort-statement.org). Reports of qualitative studies should follow the COREQ checklist (http://www.equator-network.org/reporting-guidelines/coreq). An electronic copy of the actual IRB permission letter from the institution that granted permission to conduct the study must accompany the submission. If the IRB approval is not in English, an English translation must also be submitted.

Preparation of Integrative Evidence Review, Systematic Evidence Review, and Meta-analysis manuscripts

Practice Improvement

Preparation of Practice Improvement Manuscripts

Practice Improvement Manuscripts are to begin with the heading Contribution to Emergency Nursing Practice, followed by up to 3 bullet points stating how the papers findings have relevance for emergency nursing practice. An abstract (250 words or less) is to be included containing a brief description of the problem, methods, results, and discussion. Up to 6 key words are to be provided following the abstract. Original articles reporting quality improvement (QI) or evidence-based practice (EBP) projects or capstone projects may not be generalized beyond the authors organization but they may be of interest to JEN readers who have similar clinical issues in comparable institutions. Authors should use the SQUIRE guidelines (http://www.squire-statement.org) to prepare the manuscript. The main body of the manuscript is to include the following headings: Introduction, Methods, Results, Discussion, Implications for Emergency Nursing, and Conclusions. Please be advised that while much of the content in the Squire Guidelines is appropriate for inclusion, every numbered subject headings (1-19) may not be applicable to every manuscript.

Reports of projects involving human participants must include a statement explaining what type of oversight is required, or the ethical standards followed, at the authors organization to conduct QI or EBP projects. This may or may not include Institutional Review Board (IRB) review.

Practice Improvement manuscripts should be written in the first person. The manuscript is not to exceed 15 pages, including references, tables, and figures. Do not use abbreviations or referenced statements in the abstract.

References are to be the original sources of information in most instances. ***JEN* requires AMA-style referencing**. Cite references **by number only** in the text, consecutively, in the order of their mention. Type a numbered reference list double-spaced at the end of the text to correspond with the in-text reference citations.

Clinical Manuscripts

Preparation of Clinical Manuscripts

Clinical Manuscripts are to begin with the heading Contribution to Emergency Nursing Practice, followed by up to 3 bullet points stating how the paper informs emergency nursing practice.

Clinical manuscripts should be well organized in presenting information that summarizes current knowledge on a topic relevant to emergency nursing. Clinical articles need not include an exhaustive literature review nor must they include a rigorous evaluation of the level of evidence of the articles cited. Rather, clinical manuscripts should provide a broad overview of a selected topic. Cited references should be within the past 5 years with the exception of seminal articles. A section detailing the implications for emergency nursing practice as presented in the paper must be included prior to the papers concluding summary.

Reports of projects involving human participants must include a statement explaining what type of oversight is required, or the ethical standards followed, at the authors organization to conduct QI or EBP projects. This may or may not include Institutional Review Board (IRB) review.

Practice Improvement manuscripts should be written in the first person. The manuscript is not to exceed 15 pages, including references, tables, and figures. Do not use abbreviations or referenced statements in the abstract.

All references must be cited in the text. References are to be the original sources of information in most instances.***JEN* requires AMA-style referencing**. Cite references **by number only** in the text, consecutively, in the order of their mention. Type a numbered reference list double-spaced at the end of the text to correspond with the in-text reference citations.

Case Review Manuscripts

Preparation of Case Review Manuscripts

Case Reviews are to begin with the heading Contribution to Emergency Nursing Practice, followed by up to 3 bullet points stating how the paper informs emergency nursing practice. Case presentations should include new, unusual, or complex clinical problems, new therapies that were utilized, aspects that inspired improvements in care, and/or cases where emergency nurses/nursing were instrumental to the outcome. The disease or condition and the patients outcome should be briefly discussed. The case summary should focus on the emergency care phase and may include pre-hospital events, initial assessment, diagnostic process, interventions, and follow-up. The teaching message of the paper is to be supported by recent definitive references from original sources of information, such as published studies. Discussion should include how clinical presentation, diagnosis, and treatment relates to the current literature. Patients' names are not included nor are patient descriptors that are not integral to the case. ***JEN* requires AMA-style referencing**. Cite references **by number only** in the text, consecutively, in the order of their mention. Type a numbered reference list double-spaced at the end of the text to correspond with the in-text reference citations. The length of the manuscript is not to exceed 3-5 double-spaced pages, including references, tables, charts, and figures.

Links to Editorial Guidelines and Publication Standards recognized by the Journal of Emergency Nursing are listed below:

• Observational cohort, case control and cross sectional studies STROBE - Strengthening the Reporting of Observational Studies in Epidemiology, http://www.equator-network.org/reporting-guidelines/strobe/

• An open access publication fee is payable by authors or on their behalf, e.g. by their research funder or institution.

Subscription

• Quasi-experimental/non-randomised evaluations - TREND - Transparent Reporting of Evaluations with Non-randomized Designs, http://www.cdc.gov/trendstatement/

• Randomised (and quasi randomised) controlled trial - CONSORT - Consolidated Standards of Reporting Trials, http://www.equator-network.org/reporting-guidelines/consort/

• Study of Diagnostic accuracy/assessment scale - STARD - Standards for the Reporting of Diagnostic Accuracy Studies, http://www.equator-network.org/reporting-guidelines/stard/

• Systematic Review of Controlled Trials - PRISMA - Preferred Reporting Items for Systematic Reviews and Meta-Analyses, http://www.equator-network.org/reporting-guidelines/prisma/

• Systematic Review of Observational Studies - MOOSE - Meta-analysis of Observational Studies in Epidemiology, http://www.ncbi.nlm.nih.gov/pubmed/10789670

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Formatting Manuscripts

The text should be in single-column format. Keep the layout of the text as simple as possible. Most formatting codes will be removed and replaced on processing the article. However, do use bold face, italics, subscripts, superscripts etc. When preparing tables, if you are using a table grid, use only one grid for each individual table and not a grid for each row. If no grid is used, use tabs, not spaces, to align columns. The electronic text should be prepared in a way very similar to that of conventional manuscripts (see also the Guide to Publishing with Elsevier: http://www.elsevier.com/guidepublication). Note that source files of figures, tables and text graphics will be required whether or not you embed your figures in the text. See also the section on Electronic artwork.

To avoid unnecessary errors you are strongly advised to use the 'spell-check' and 'grammar-check' functions of your wordprocessor.

Essential title page information

• ***Title.*** Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible.

• ***Author names and affiliations.*** Please clearly indicate the given name(s) and family name(s) of each author and check that all names are accurately spelled. Present the authors' affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lower-case superscript letter immediately after the author's name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name and, if available, the e-mail address of each author.

• *Corresponding author.* Clearly indicate who will handle correspondence at all stages of refereeing and publication, also post-publication. Ensure that the e-

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Structured abstract

A structured abstract, by means of appropriate headings, should provide the context or background for the research and should state its purpose, basic procedures (selection of study subjects or laboratory animals, observational and analytical methods), main findings (giving specific effect sizes and their statistical significance, if possible), and principal conclusions. It should emphasize new and important aspects of the study or observations.

Keywords

Immediately after the abstract, provide a maximum of 6 keywords, using American spelling and avoiding general and plural terms and multiple concepts (avoid, for example, 'and', 'of'). Be sparing with abbreviations: only abbreviations firmly established in the field may be eligible. These keywords will be used for indexing purposes.

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Define abbreviations that are not standard in this field in a footnote to be placed on the first page of the article. Such abbreviations that are unavoidable in the abstract must be defined at their first mention there, as well as in the footnote.

Ensure consistency of abbreviations throughout the article.

Acknowledgements

Collate acknowledgements in a separate section at the end of the article before the references and do not, therefore, include them on the title page, as a footnote to the title or otherwise. List here those individuals who provided help during the research (e.g., providing language help, writing assistance or proof reading the article, etc.).

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List funding sources in this standard way to facilitate compliance to funder's requirements:

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It is not necessary to include detailed descriptions on the program or type of grants and awards. When funding is from a block grant or other resources available to a university, college, or other research institution, submit the name of the institute or organization that provided the funding.

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Footnotes should be used sparingly. Number them consecutively throughout

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Electronic artwork

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Legends must accompany each figure. List legends in the body of the manuscript after the references. If an illustration was previously published, the legend must give full credit to the original source.

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References

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Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full. Unpublished results and personal communications are not recommended in the reference list, but may be mentioned in the text. If these references are included in the reference list they should follow the standard reference style of the journal and should include a substitution of the publication date with either 'Unpublished results' or 'Personal communication'. Citation of a reference as 'in press' implies that the item has been accepted for publication.

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As a minimum, the full URL should be given and the date when the reference was last accessed. Any further information, if known (DOI, author names, dates, reference to a source publication, etc.), should also be given. Web references can be listed separately (e.g., after the reference list) under a different heading if desired, or can be included in the reference list.

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List: Number the references in the list in the order in which they appear in the text.

Examples:

Reference to a journal publication:

1. Van der Geer J, Hanraads JAJ, Lupton RA. The art of writing a scientific

article. J Sci Commun. 2010;163:51–59.

Reference to a book:

2. Strunk W Jr, White EB. The Elements of Style. 4th ed. New York, NY: Longman; 2000.

Reference to a chapter in an edited book:

3. Mettam GR, Adams LB. How to prepare an electronic version of your article. In: Jones BS, Smith RZ, eds. Introduction to the Electronic Age. New York, NY: E-Publishing Inc; 2009:281–304.

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Journal abbreviations source

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The following list will be useful during the final checking of an article prior to sending it to the journal for review. Please consult this Guide for Authors for further details of any item.

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• All tables (including title, description, footnotes)

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• Manuscript has been 'spell-checked' and 'grammar-checked'

• References are in the correct format for this journal

• All references mentioned in the Reference list are cited in the text, and vice versa

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___Title page (add reprint request line if desired or specify no reprints)

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___Tables (double-spaced)

___Illustrations, properly labeled

___Legends (double-spaced) in the body of the manuscript after the references

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After acceptance

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