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Understanding Behavioral Health Stigma Within the Healthcare Workforce

Jason Robert Martin
Walden University

Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral study by

Jason Martin

has been found to be complete and satisfactory in all respects,
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Review Committee
Dr. Frederica Hendricks-Noble, Committee Chairperson, Psychology Faculty
Dr. Christine Sopa, Committee Member, Psychology Faculty
Dr. John Schmidt, University Reviewer, Psychology Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
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Abstract

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MS, Johns Hopkins University, 2010

BS, Messiah College, 1999

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Psychology in Behavioral Health Leadership

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Abstract

Individuals who seek mental health treatment in the United States face significant barriers. One such barrier is the belief that those seeking mental health treatment are subpar people with some moral failure. One area where this phenomenon exists is the behavioral healthcare workforce. This study was conducted to understand the phenomenon of stigma that behavioral healthcare leaders exhibit toward behavioral healthcare patients using the Baldrige framework as its conceptual framework. Using a qualitative approach and case study design, interviews were conducted with 6 leaders within a large healthcare system in the suburbs of a major metropolitan area to evaluate their understanding of stigma. Additionally, the study involved a review of historical data on patient experiences, employee engagement, and turnover rates within the system to gain a deeper understanding of the issue. This study used both manual and software transcription of data, followed by multi-level coding and triangulation, to establish themes concerning relationships between patient experience, staff engagement, and perceived stigmatization of behavioral healthcare patients. Recommendations from the study included: use of the lens of a peer-support model of care, include those with lived experience in governance position, ensure that person-centered language and methods are used, and integrate stigma reduction into process improvement. Focusing on the reduction of stigma within behavioral health will have a positive social impact on those seeking behavioral health services by making care more client-focused and sensitive to patient needs, thereby breaking down socially stigmatizing barriers to receiving and participating in treatment.

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Dedication

This study is dedicated to the staff at XX Healthcare, who work tirelessly to improve the outcomes for those suffering from mental healthcare challenges. Their dedication, tenacity, and passion are inspirational to their coworkers, leaders, and community.

Acknowledgments

I would like to acknowledge all the individuals who assisted me throughout my journey. To all the people at Walden University, including my chair, Dr. Tasha Browning, and second committee member, Dr. Frederica Hendricks-Noble, thank you for putting up with my endless questions and freakouts around this study. To my family, thank you for bearing with me throughout the last 3 years as I worked to complete my studies. I want to especially thank my two daughters, Hannah and Zoe, who tolerated my absence at home while working hard to get to this point in my education. I also want to thank a specific individual who helped me during some of the darkest hours while I was completing my research. I could go on and on but wanted to highlight those most important during this process.

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Section 1a: The Behavioral Healthcare Organization

Introduction

XX Healthcare is the largest healthcare system in the suburbs of a large metropolitan area. It has more than 5,500 employees and an annual budget of over $900 million. It is also the second-largest provider of acute psychiatric care in its suburban metro area, offering a full continuum of behavioral healthcare services. XX Healthcare prides itself in its mission "to extend God's care through a ministry of physical, mental, and spiritual healing." The system consists of two acute-care hospitals, various rehabilitation services, and a myriad of community-based care offerings, such as home health, specialty cancer care, and a special needs school for behaviorally challenged youth.

According to its website, XX Healthcare is sponsored by the Seventh-Day Adventist Church and its members serve in many organizational governance positions. Being tied to a larger organization with a mission and vision helps the system stay on track. XX Healthcare staff prides itself on doing excellent work to support the community holistically. Moreover, while the system serves to keep people physically healthy, the organizations workforce also strives to prioritize patients' spiritual and mental health needs.

Practice Problem

The practice problem for this study was the need to understand the phenomenon of XX Healthcare leaders' stigmatization of behavioral health patients served by the system. There is significant evidence that behavioral health patients experience stigma

within healthcare settings as a whole (Corrigan, Druss, & Perlick, 2014; Knaak, Mantler, & Szeto, 2017; Ungar, Knaak, & Szeto, 2016). Mental health stigma may lead to individuals choosing not to reach out for assistance before a crisis hits, therefore impacting their families and loved ones negatively (Thornicroft et al., 2016). Stigmatization by the healthcare workforce is a significant barrier to treatment for individuals with mental health issues and may impact XX Healthcare's mission to serve its community (Sickel, Seacat, & Nabors, 2014). Furthermore, stigma directed toward behavioral healthcare patients affects quality metrics because people who experience it are frequently unwilling to participate in follow-up care (Clement et al., 2015; Thornicroft et al., 2016; Van Boekel, Brouwers, Van Weeghel, & Garretsen, 2013). Consequently, it is helpful to study the phenomenon of stigma that behavioral healthcare leaders exhibit toward behavioral healthcare patients.

Purpose

The purpose of this study was to explore how the phenomenon of stigma exhibited by behavioral healthcare leadership impacts behavioral healthcare patients. It also addressed how this stigma influences the care that individuals with mental health issues receive in an acute-care setting. The Baldrige framework (National Institute of Standards and Technology [NIST], 2017) provides a perspective that is helpful in gaining a better understanding of the workforce performance issues that cause or result from stigma directed toward behavioral healthcare patients and how they impact the quality of care that these patients receive. This information may help XX Healthcare's leaders make

decisions about behavioral health patients' treatment and resource allocation around workforce development and staffing strategies.

Sources of Evidence and Data-Collection Strategies

It was advantageous to examine several types of data sources for this study, including employee engagement surveys, staff retention rates, and patient satisfaction surveys, to determine if employees were happy in the workplace and if patients received the care they deserved. These data were available through the XX Healthcare data site with the assistance of an external consultant. These data sources align with the Baldrige framework's areas of impact (NIST, 2017). Each dataset provided baseline data for the study and was supplemented with primary-sourced data-collection methods, including surveys, interviews, and reviews of internal policies and procedures, to show the levels of stigma exhibited within the work setting under review. Interviewing senior leaders within the system provided significant data around stigma in the workplace and what XX Healthcare does to address this issue.

Significance

Contribution to the System's Practice and Leadership

The practice problem identified for this study involved the phenomenon of stigma that XX Healthcare leaders exhibit toward people with mental health issues. The Baldrige framework (NIST, 2017) has standardized best practices around behavioral health issues. The staff of XX Healthcare may benefit from this study by learning appropriate methods to standardize and replicate practice throughout the system.

Potential Contribution to Positive Social Change

This study is of significant value to XX Healthcare, as understanding how caregivers think about a specific population (in this case, people with mental health challenges) may lead to strategies to improve their care. Fox, Smith, and Vogt (2018) pointed out the relationship between increased stigma associated with mental health issues and individuals not seeking healthcare. This topic is of significant interest to XX Healthcare because early intervention into mental health issues demonstrates both higher efficacy rates and lower costs (Bohlmeijer, Fledderus, Rokx, & Pieterse, 2011). Improving mental health outcomes, increasing employee engagement (Sharma, Titus Tak, & Kingshott, 2016), and lowering costs associated with treatment (Osumili et al., 2016) are all positive effects of understanding the relationship between stigma and the behavioral healthcare leaders who may exhibit it. Understanding this relationship may also assist in resolving the more significant impact of mental health stigma on society, thus creating positive social change for all.

Improving outcomes for those in the behavioral healthcare system is a significant aspect of positive change for leaders within these systems. Historically, though, these outcomes have been difficult for behavioral healthcare organizations to identify, as there has been limited agreement on metrics (Kilbourne et al., 2018). Evidence also suggests that the most commonly used metrics do not track specific symptoms of illnesses or barriers to successful treatment (Pincus, Scholle, Spaeth-Rublee, Hepner, & Brown, 2016). The combination of these issues leads to outcomes not being used in treatment to measure efficacy, which directly impacts the stigma that behavioral healthcare patients

experience because they may not see the results that they want from treatment and providers may not have evidence to support changing treatment regimens (Irwin, Li, Craig, & Hollenstein, 2019; Oexle, Feigelman, & Sheehan, 2020). In understanding the issue better, leaders can make choices that impact the quality metrics that they measure and help identify barriers earlier in treatment, thus creating positive social change.

Value to the System

This study presents many benefits for XX Healthcare, the primary one being the implementation of standard practices using the Baldrige framework (NIST, 2017) to help achieve better outcomes for patients. The Baldrige framework (NIST, 2017) provides guidance for achieving organizational goals through a structured management approach, offering organizations advice on how to manage their workforces, assist leaders in facilitating change, and create outcome measures for process-improvement initiatives. Kim and Oh (2012) pointed out the importance of using best practices to implement process-improvement programs, specifically noting the Baldrige framework's (NIST, 2017) validity in improving mental health services. This study used aspects of the Baldrige framework (NIST, 2017) to help standardize the approach that healthcare workers may take with behavioral health patients. By focusing on leadership competencies, XX Healthcare can implement a structured approach to change while motivating the individuals served. Focusing on customers and the workforce also assists the system in understanding the dynamic of stigma, how it impacts patient care, and the steps required to make positive change. In using the Baldrige framework (NIST, 2017), with a specific focus on leadership, human resources, and customers, XX Healthcare may

be able to change more effectively the organizational culture, thus leading to better patient health outcomes.

Summary and Transition

XX Healthcare is the second-largest provider of behavioral healthcare services in a suburban metropolitan area. It may be helpful to identify what role, if any, the stigma associated with behavioral health patients plays in the caregiving that behavioral healthcare staff provide. By using the Baldrige framework (NIST, 2017) in this study, I sought to help those in the system to build a strategy to address how stigma affects patient outcomes and care. Identifying strategies to improve patient care may benefit the community as a whole and help XX Healthcare create an atmosphere in which individuals with behavioral health conditions feel free to accept services without shame.

Section 1b provides a profile of XX Healthcare and includes an in-depth discussion of the system, including key aspects of governance, operations, and affiliations that make it unique. A discussion of this study's importance to the system follows, with an emphasis on workforce and organizational culture. I also examine how the system fits into local and state contexts, with specific emphasis on fiscal and compliance issues.

Section 1b: Organizational Profile

Introduction

There is significant concern regarding how XX Healthcare and its entities provide care to their patients, specifically those receiving behavioral healthcare services. One aspect of providing quality care is treating people with dignity and respect, which often does not occur within the behavioral health workforce. Therefore, it is crucial to understand the phenomenon of stigma that behavioral healthcare leaders exhibit toward behavioral health patients. This section includes a brief introduction to XX Healthcare and critical factors unique to the system as a significant provider of behavioral healthcare services. Further, I provide a discussion of the system's background, including governance and financial aspects, in order to develop a more robust understanding of the healthcare organization.

Organizational Profile and Key Factors

According to XX Healthcare's website, the system's mission is to extend God's care through physical, mental, and spiritual ministry The system's most recent annual report indicates that it reaches this mission through a vision of achieving excellence with the following six pillars: people, quality and safety, patient experience, growth, finance, and population health management. The system defines its values through the acronym RISES, which stands for respect, integrity, stewardship, excellence, and service.

Workforce Culture

XX Healthcare's culture represents a system maintaining fiscal responsibility while meeting the community's and workforce's needs. The system's culture is

influenced heavily by its sponsoring organization, the Seventh-Day Adventist Church. According to XX Healthcare's website, this affiliation and commitment helps the system achieve its core competencies, specifically around its leadership, and create a culture of faith in its workforce.

From a leadership perspective, organizational culture is of great importance because it sets the tone for the services that frontline staff render. There is evidence that culture impacts direct-care staff members' attitude, longevity, and buy-in (Stearns & Benight, 2016). Further evidence suggests that organizations in which there is a disconnect between leadership and direct-care staff around the status of workplace culture also suffer from higher rates of burnout, staff turnover, and compassion fatigue (Brabson, Harris, Lindhiem, & Herschell, 2020; Stearns & Benight, 2016). XX Healthcare notes a significant push toward creating a more positive workforce in its annual report and online recruiting efforts. There is limited evidence, however, that these efforts have cascaded down to direct-care staff, as the annual report shows that workforce engagement scores remain in the 45th percentile of hospitals surveyed nationwide.

Community Impact

XX Healthcare is a faith-based nonprofit organization dedicated to establishing healthy communities and providing excellent healthcare and disease management. XX Healthcare's integrated healthcare system includes four nationally accredited acute-care and specialty hospitals, behavioral healthcare services, home health agencies, urgent-care centers, primary-care offices, and imaging centers. XX Healthcare is the second largest

provider of behavioral health services in a large suburb of a major metropolitan area, with more than 120 acute-care beds and a full continuum of services in an outpatient setting.

The community where XX Healthcare operates is in a state of rapid change. According to the system's *Community Benefit Report* (2020), the community is becoming a minority-majority one, with a large increase in the population of Spanish-speaking families leading to the need to shift resources and change programs to meet local needs. Furthermore, the number of payer sources in the community has increased significantly. The combination of these two dynamics has changed some of the system's priorities to focus more on prevention initiatives for the Spanish-speaking community.

Governance

XX Healthcare's governance starts locally, with each facility being chaired by its own senior executive. According to the system's website and initial interviews with senior leaders, the Seventh-Day Adventist Church's local conference leadership assigns facility vice-chairs who report to the XX Healthcare board of trustees, which has the power to carry out the system's mission through standardized governance and subcommittees. XX Healthcare's president reports to this board, which then reports to the mid-Atlantic regional board of trustees. Organizational charts demonstrate a sophisticated and hierarchical governance system in which XX Healthcare manages an extensive system with more than 7,700 employees, physicians, and volunteers.

Organizational Background and Context

Need for Study

XX Healthcare was founded in 1907 and is located in the suburbs of a major metropolitan area. The system has changed significantly over the years, most recently through its acquisition of other facilities outside the local community. The system has also shifted to utilizing a more holistic approach with patients, treating the whole person instead of individual parts. According to XX Healthcare's annual report and historical documents, this shift includes integrating behavioral healthcare services with primary-care and other specialty services to ensure the best care and treatment outcomes for patients and the community.

Institutional Context

One area that patients consistently give low ratings in XX Healthcare's monthly quality-of-care survey is acute-care psychiatry and care received from staff. Complaints about rudeness, abrupt speech, and dismissive answers to requests are frequently brought to the attention of the system's patient advocate. Regulatory bodies and fundamental medical ethics require organizations to provide care to all members of the community, regardless of their diagnoses. Thus, it is imperative to create an environment in which all patients, including those with behavioral health conditions, receive quality care and treatment.

According to XX Healthcare's annual report, there are significant concerns within the system about the volume of clients with behavioral health conditions whom it treats. XX Healthcare is the second-largest provider of acute-care behavioral health services in

the state, with more than 120 acute-care beds. It also operates one of a handful of hospitals in the region that serves the behavioral health needs of children and adolescents. Another area of context is XX Medical Center's (XXMC) geographic location because it is the closest hospital to the County Crisis Center (CCC), which is the busiest crisis intervention service in the county and provides more than 100,000 services a year to county residents. Many patients who use CCC go to the emergency room for urgent behavioral health evaluations, which may lead to psychiatric admission to the hospital. Because of XXMC's location, CCC refers a high number of behavioral health clients to it.

Compliance and Finance

XX Healthcare is regulated by the Center for Medicaid and Medicare Services (CMMS) and accredited by the Joint Commission for Healthcare. XX Healthcare has developed specific rules for its behavioral health services because it operates a separate facility for behavioral health clients that specifically addresses the needs of behavioral health patients outside typical hospital accreditation standards. XX Healthcare regularly reviews current and new legislation to ensure proper implementation of mental health laws as they change at federal, state, and local levels. XX Healthcare's legal team includes special counsel for behavioral health issues, including involuntary commitments and guardianship issues, among other legal matters.

XX Healthcare provides substantial financial oversight to its individual facilities and systems. Every year, each facility develops a full budget that operates on a traditional calendar year. Fiscal resource planning occurs at all levels, with approval at the facility

board level and eventually by the system's larger board of trustees. Economic planning includes implementing new technologies and/or considering legislation that requires increased financial oversight or investment. Local facility leaders engage with the government affairs advocate in the system's legislative affairs department to promote and educate staff about changes or opportunities that arise from new legislation or changes to existing laws.

State and Local Contexts

The state where XX Healthcare operates is currently under an exemption from CMMS's requirement that hospital reimbursements include implementing global budgets for all acute-care hospitals (Roberts et al., 2018). With global budgets in place, hospitals are incentivized financially to create environments where acute-care patients are not readmitted to the hospital for avoidable reasons. One concern about the stigmatization of mental health clients is that they often refuse to participate in follow-up care because of the stigma that they encounter in the acute-care setting, including emergency rooms and departments into which they are admitted (Naeger, Mutter, Ali, Mark, & Hughey, 2016; Riblet et al., 2019). This concern increases the importance of addressing patient stigmatization for financial reasons, in addition to its being an ethical caregiving matter. It heightens the need to understand stigma levels within XX Healthcare's workforce so it can provide quality care for patients while remaining fiscally viable.

Summary and Transition

XX Healthcare is a large healthcare system that supports a large metropolitan area by providing vital services. Complicated issues within the system impact its workforce

and their desire to treat patients well. The behavioral healthcare workforce is one area in which difficulties continue to occur. Understanding behavioral healthcare stigma may help XX Healthcare positively impact patients' long-term health outcomes and the larger community.

Section 2 addresses the importance of researching the phenomenon of stigma among senior leadership and how it impacts patient care. A review of existing literature and a brief explanation of how relevant literature was obtained follows. There is also a discussion of how organizational strategies impact the population of patients with mental health concerns identified in the community. Finally, I discuss the tools I used and how qualitative inquiry fit into the study.

Section 2: Background and Approach—Leadership Strategy and Assessment

Introduction

Stigma toward behavioral health clients has presented a significant difficulty for those seeking mental health services for years (Fox et al., 2018), which often leads to people not seeking treatment until a crisis occurs (Thornicroft et al., 2016). Stigma is observed at a higher rate among healthcare providers, including those caring for behavioral health patients, than within the general population (Jones & King, 2014). This phenomenon may be due to staff seeing patients when their illness is most acute rather than when their symptoms are less severe. There is further evidence that those who experience stigma may not follow treatment recommendations or participate in follow-up care (Clement et al., 2015; Thornicroft et al., 2016; Van Boekel et al., 2013). Through this study, I sought to understand the phenomenon of stigma that behavioral healthcare leadership exhibited toward behavioral health patients.

Purpose

The purpose of this study was to understand the phenomenon of leadership staff exhibiting stigma toward behavioral health patients at XX Healthcare, as well as the impact that stigma has on patient care in the system. By implementing the standardized processes found in the Baldrige framework (NIST, 2017), large healthcare systems can focus on delivering quality care most effectively. Using data collected via interviews with various levels of staff leadership led to a better understanding of how stigmatizing behavioral health patients may impact their health outcomes, which is an important aspect of the Baldrige framework (NIST, 2017). Understanding this phenomenon may

also help those within the healthcare system integrate the Baldrige framework (NIST, 2017) into the system of care through standardized work processes.

Supporting Literature

I used several research databases in the Walden University library, including Science Direct, Research Gate, Sage Premiere, PsycARTICLES, Academic Search Complete, ProQuest, and Medline, to identify current sources of evidence and data to support the study. These tools helped me find appropriate sources and narrow down the study's purpose. I focused initially on the term *behavioral health stigma*, which yielded many results. Additional terms such as *stigma within healthcare* also produced significant results, although the terms *Baldrige* and *behavioral health* did not. While many sources dealt with acute behavioral healthcare, a limited number of sources addressed leadership staff and their thoughts about stigma toward behavioral health patients. Other vital terms included *stigma, behavioral health follow-up, person-centered care, burnout in behavioral health, disclosure in behavioral health, acute inpatient psychiatry,* and *patient experience in behavioral health*.

Existing Literature

Existing literature shows an extensive correlation between stigma and negative outcomes among behavioral health patients (Link, Struening, Rahay, Phelan, & Nuttbrock, 1997; Mehta et al., 2015; Thornicroft et al., 2016). Stigma toward behavioral health patients influences whether they seek treatment when problems initially surface, attend follow-up appointments, and follow through on treatment after the initial visit (Ungar et al., 2016; Van Boekel et al., 2013). These challenges often complicate

treatment outcomes and may result in admissions to acute-care facilities like XX Healthcare (Ungar et al., 2016). There are significant concerns regarding reimbursement and readmission or avoidable admissions to acute-care facilities, primarily regarding payments and quality metrics that CMMS monitors (Burgess & Hockenberry, 2014). Thus, from both a financial and quality perspective, it is worthwhile to investigate the phenomenon of stigma that behavioral health leaders exhibit toward behavioral health patients.

Several studies have addressed the relationship between mental health providers and patients as it relates to stigma. Knaak et al. (2017) stated that stigma that behavioral healthcare practitioners exhibit leads to a workforce culture where it is normalized. Charles and Bentley (2018) indicated that stigma impacts provider choices in treatment options, as well as attitudes toward patients as individual persons. Wahl and Aroesty-Cohen (2010) stated that the social acceptance aspect of stigma impacts mental health professionals more than other elements. All of these studies suggest that stigma directed toward behavioral health patients by mental health professionals exists and is detrimental to patient care.

There is limited research on stigma related to acute inpatient hospitals and behavioral health patients. Boyd, Zeiss, Reddy, and Skinner (2016) stated that stigma in the Veterans Administration (VA) system is quite prevalent and impacts patient care. Munroe and Baker (2007) discussed nursing staff members' negative beliefs in a behavioral health acute-care setting. Wise-Harris et al. (2017) stated that frequent emergency room patients with behavioral health-related conditions regularly complain of

poor care and are discharged without the desired treatment or support. While research on the prevalence of stigma within an acute-care setting is limited, there appears to be a need for significant understanding of this issue because it directly impacts patient care.

There is also limited research regarding how behavioral health leadership impacts stigma toward behavioral health patients. Some evidence suggests that leaders in nonhealthcare settings who implement evidence-based tools to combat stigma have seen positive results, thus creating a work environment where behavioral health issues are more understood and accepted (Dimoff, Kelloway, & Burnstein, 2016). Military leaders have also come a long way in creating environments where behavioral health conditions are better tolerated and treatment is less stigmatized (Hamilton, Coleman, & Davis, 2017). Although the VA has done a great deal of work within its system of care, there is limited research on how leaders' perspectives impact stigma toward behavioral health patients within that specific healthcare system. Evidence does suggest that leaders' significant interpersonal relationships with employees often lead to higher levels of employee engagement (Hansen, Byrne, & Kiersch, 2014). While there is limited research on this topic, initial findings show that implementing an interpersonal leadership approach with an understanding of stigma's negative consequences may positively impact care delivery (Hansen et al., 2014).

Sources of Evidence

Key Sources

Interviews conducted with senior leaders in an acute behavioral health setting for this study may assist the leaders of XX Healthcare in understanding the research

question. The leaders interviewed for this study included administrators, nurse managers, department directors, and psychiatry leaders. An audio recording of each interview helped me code and ensure that data collected matched with what the behavioral health professionals intended to communicate.

Semistructured interviews were the most impactful way to address this research problem. Thus, predetermined questions were used to begin the discussion because they held the possibility of leading to further conversations around the topic of stigma and interviewees' specific beliefs about how stigma impacted their work and successful outcomes for the people they served. Secondary sources of evidence, such as organizational dashboards, patient-experience survey results, and employee engagement scores, helped me identify further trends and stigma-related phenomena within the healthcare system.

Data analysis and interview coding helped me understand the phenomenon of stigma toward behavioral health patients in this particular care setting. Triangulation is an analytical tool used to help synthesize qualitative data and discover common themes among different sources of evidence (Rubin & Rubin, 2012; Saldaña, 2016). By coding the information provided in discussions, researchers can detect common ideas and beliefs about the topic being studied. In this case, coding helped me identify common themes among leaders within an acute healthcare setting about the stigmatization of behavioral health patients. Coding may also identify specific beliefs among various levels of the leaders interviewed. Understanding these differences may help us understand better the

phenomenon of behavioral healthcare leaders exhibiting stigma toward behavioral healthcare patients.

Leadership Strategy and Assessment

Leadership and Governance

XX Healthcare implements its leadership model with a standardized management approach that involves the use of a set of pillars to identify key work areas within the system. This standardized approach includes several initiatives to align these pillars with the system's vision. Figure 1 shows this approach in a basic schematic that the system uses to communicate its style to employees and customers alike. Initiatives such as establishing a centralized strategic-planning process help executives and frontline managers implement their success plans in the coming year. This document is revisited yearly via a strengths, weaknesses, opportunities, and threats (SWOT) analysis to ensure that the system continues to meet its goals and work toward achieving its overall mission.

Figure 1. XX Healthcare's leadership model. Image provided by XX Healthcare. Used with permission.

This standardized management approach is vital to creating an environment for success for the healthcare system. Those implementing this approach seek to help the system achieve its goals while engaging clients and staff in the process. Organizational leaders use this framework in their monthly meetings with staff, highlighting key areas as defined by the schedule that senior leaders implement to ensure discussion of all critical aspects of the system's strategic plan.

This organizational governance model features multiple levels of checks and balances to maintain a fiscally viable and ethical system that meets community needs

while working to achieve XX Healthcare's mission. Each individual facility has its own governing board that reports to the larger system's board of trustees. This board oversees the chief executive officer (CEO) and seeks accountability for the system through a standardized, systematized review of agreed-upon performance metrics. The board's strategic-planning committee manages these metrics and reviews them annually, and these annual reviews trigger recommendations to the larger system's board of trustees regarding modifications to the systemwide strategic plan.

Strategy Identification and Implementation

According to internal policies and procedures documents, XX Healthcare uses a six-step strategic-planning process with both long- and short-term tasks. The long-term process takes place over 5 years and currently identifies the system's 2022 vision. This vision identifies the system's overarching goals, which then cascade down to each facility. These entities then establish their short-term plans for a 1-year period to incrementally reach each pillar's long-term goal.

XX Healthcare identifies community needs through a community needs assessment completed every 3 years. The community needs assessment is mandated by the state for all health systems to ensure that they are meeting the population's needs (Gray & Schlesinger, 2009). The assessment mandates that the system's strategic priorities meet the needs of the communities served. The evaluation then aids in the strategic-planning process and helps leaders identify current and emerging community needs. By identifying community needs frequently, the system can quickly adapt to meet the needs of the people it serves.

Clients/Population Served

XX Healthcare serves the suburban community of a large metropolitan area. The behavioral health setting within the system assists individuals across the behavioral health continuum. The system also addresses the needs of children ages 4 years through adulthood. It serves primarily individuals in acute crisis who need specific treatments to ensure their safety or mitigate their significant behavioral health impairments. Specifically, the system specializes in serving those with psychotic disorders and co-occurring disorders; the hospital houses individual units to tend to people with these behavioral health challenges. Furthermore, the system contains one of only three hospitals within a 100-mile radius that treats children on an inpatient level.

Analytical Strategy

This research study lent itself to a qualitative analysis because its main focus was analyzing the phenomenon of stigma demonstrated by a behavioral health workforce toward people with mental health concerns. Triangulating data helped me synthesize information gained through individual interviews and other data sets, such as patient-experience scores and staff-engagement scores. As such, the research focused on individual thoughts, feelings, and beliefs of senior-level staff in one acute-care hospital in the system, including senior administrators, nursing managers and directors, therapy directors, and other key leaders. Walden University's IRB has approved this study (approval # 06-12-19-0726610). This study group represents a significant number of leaders within XX Healthcare's behavioral acute-care units.

The research focused on interviewing senior leaders to ascertain their understanding of stigma toward behavioral health patients and how they think it impacts these patients' treatment. Standardized questions (see Appendix A) show the items used to elicit conversation around the topic of stigma and how it impacts both direct-care workers and the patients they serve. Participants were asked about specific diagnoses and how knowing someone had received these diagnoses impacts the way they care for patients and how they view them as people. The management team helped me identify appropriate staff for the interviews to ensure minimal bias.

For this qualitative study, interviews with senior system leaders provided the main source of primary data. Interviews included a wide range of leadership professionals to gain a variety of perspectives on the issue of stigma within the workforce. This approach also helped me reach data saturation while gaining information from different disciplines and professions (Saldaña, 2016). After obtaining consent to record the interviews and hold the meetings, the discussions were fully transcribed and combined with individual notes taken. Completion of multilevel coding helped me ascertain common themes between professionals and narrow down specific topics identified in the interviews. This information was then compared with other easily accessible system data around patient experiences and staff engagement to identify trends.

Summary and Transition

There is significant evidence that individuals with behavioral healthcare challenges have difficulty facing stigmas associated with these issues, which eventually impacts their care. There is further evidence that healthcare leaders contribute to the

stigma directed toward these patients, which may lead to adverse outcomes for the people they serve. Therefore, it is of paramount importance to inquire about the relationship between these two positions, specifically in the most acute settings, as it may have negative implications for how patients participate in care. This study focused on the phenomenon of stigma that behavioral health leaders exhibit toward behavioral health patients at XX Healthcare.

In Section 3, I discuss in more detail the study's organization and data-analysis and process-improvement methods. Specific attention is given to data on workforce engagement and patient satisfaction, as well as how XX Healthcare's improvement strategies have impacted patient care. Finally, there is a brief discussion about how the system manages its data processes and knowledge assets.

Section 3: Measurement, Analysis, and Knowledge-Management Components of the System

Introduction

Challenging obstacles exist in many aspects of behavioral healthcare operations. One element at the core of treating individuals with behavioral healthcare concerns is creating an environment of healing while helping them achieve their goals. One of a behavioral healthcare professional's many roles is to help create space where healing begins and positive treatment outcomes occur. The behavioral healthcare workforce has a tremendous responsibility in this regard and must have appropriate beliefs about behavioral health conditions for these outcomes to occur.

The stigmatization of behavioral healthcare patients in the larger society is well documented, which is why many individuals do not seek the treatment they need (Hirsch, Rabon, Reynolds, Barton, & Chang, 2019). As noted previously, ample literature suggests that stigma exhibited by behavioral healthcare professionals toward the individuals they are charged with serving can be similar to, if not elevated above, general social stigmas (Stubbs, 2014). Therefore, it is imperative to understand this phenomenon in acute-care settings. Understanding this issue may lead to a better understanding of stigma, at the same time creating an environment in acute-care settings in which more favorable treatment outcomes may occur.

Analysis of the System

XX Healthcare has a strong interest in ensuring patients achieve positive health outcomes and have positive experiences in the acute-care setting. Regulatory bodies,

funders, and other stakeholders continue to pressure healthcare organizations to create positive results, tying reimbursement to these metrics (Roberts et al., 2018). Direct-care employees provide the foundation on which the system can build these goals. Creating a workforce in which there is health equity, nondiscrimination, and high engagement may assist the healthcare system in meeting these goals.

Workforce Environment

According to XX Healthcare's recruiting website, the system engages its workforce in a myriad of ways to ensure that patients are cared for in the most appropriate ways by well-trained professionals. Staff within the health system prides itself on creating a supportive workforce environment that is transparent, in which leaders communicate appropriately with all staff. One aspect of this communication is a weekly message from the system's president reflecting on life's pressing matters while humanizing the work that employees do each day. This message is further developed through a monthly employee newsletter published both online and in print to communicate important announcements and highlights from the previous month. This newsletter helps staff stay informed about what happens outside their primary work areas and keeps them engaged around the system's mission and values. These tools help the system keep employees up to date with relevant information while highlighting exceptional work done throughout the system.

High-Performance System

XX Healthcare is on a journey to become a high reliability/performance system. It has implemented several process-improvement initiatives to help staff at all levels create

an environment of success. The system uses a standardized management approach called "The Main Thing." According to the chief operations officer at XX Healthcare, "The Main Thing" is a document that explains each department's main priorities, processes, and outcome measures. This standardized approach has helped to create a system in which all departments use the same vernacular while creating unique work processes and data.

XX Healthcare has also implemented the Define, Measure, Analyze, Improve, and Control (DMAIC) process-improvement tool. Bartholomew, Gildar, Carrick, Saafigueroa, and Cook (2018) stated that the DMAIC process is well suited for healthcare process improvement, specifically in psychiatric care, because of its focus on the recovery model of care. DMAIC is a standardized approach to solving complex problems that feature multiple variables. XX Healthcare has implemented this process to create an environment of continuous process improvement. NIST (2019) has stated that one of the most critical aspects of creating a highly reliable workforce is engaging all levels of the workforce in process improvement. XX Healthcare has effectively implemented this specific process-improvement methodology, which has helped staff become or remain positive, engaged employees who want to provide excellent care.

Process Improvement

The DMAIC framework that has allowed XX Healthcare to standardize its process-improvement efforts comes from Lean Six Sigma (Jabbarpour, 2016). Using this standardized approach helps establish consistency and reliability within the process-improvement program, thereby making it more familiar to staff during implementation

(Trakulsunti & Antony, 2018). It also allows all staff to become involved in XX Healthcare's improvement. Each DMAIC team includes direct-care staff who know the realities of working in healthcare and specific aspects of the work that might need improvement (Chiasera, Creazzi, Brandi, Baldessarini, & Vispi, 2008). Involving direct-care staff in the process-improvement aspect of their work may also encourage higher levels of staff engagement and provide improved patient health outcomes (Berg, 2018). By using this type of program, XX Healthcare ensures that its process-improvement function remains practical and prudent.

While DMAIC has assisted XX Healthcare in improving its processes, there are significant issues related to its implementation and effectiveness. Deniz and Çimen (2018) stated that the large infrastructure within healthcare settings often becomes a barrier to fixing issues quickly. This problem is paramount in healthcare, as processes may need to change quickly to address significant community health needs. Further, there are concerns that while direct-care staff are represented in the DMAIC process, not all staff are included because DMAIC meetings tend to focus more significantly on leadership personnel. XX Healthcare has identified lack of staff participation as a major source of concern for their DMAIC projects, but it has not yet successfully modified the process to include more direct-care staff who can report progress to leadership.

Leadership Effectiveness

XX Healthcare uses a standardized management approach, which helps to ensure that leadership is attuned to what happens in direct-care settings while helping to create transparency in communication from leadership to direct-care staff. XX Healthcare staff

utilize a standardized document for monthly staff meetings. This format allows messaging to be consistent across all departments, from the executive to the direct-care staff levels (Kumar & Khiljee, 2016). Thus, staff have a direct line of communication with the system's executives and may communicate further with leadership in a yearly staff-engagement survey and other regularly scheduled town halls with executives.

Knowledge Management

Knowledge Assets

XX Healthcare has a large number of assets in the form of information about patients and staff. According to the system's website, significant emphasis is placed on electronic health records (EHRs) and data security. Thus, the system invests significant resources in keeping data safe from potential hackers. XX Healthcare has established safety measures throughout the system to prevent external threats, including secure servers for all EHRs and human resources files, various email server protection levels, and increased security around dangerous websites. This level of protection is standard for healthcare settings and is required by both federal regulators and accrediting bodies.

Summary and Transition

Staff in the organization prides itself on how it operates in the community it serves. Executive leadership takes great satisfaction in its greatest asset, its workforce, and works hard to keep staff members engaged and educated in their professions. One way that leadership attempts to engage staff is through process-improvement initiatives that involve team members from all system levels. This effort situates the system as a high-performance organization and helps leaders achieve the goal of being consistent in

their management approach across the system. This level of organizational sophistication helped me develop this study's primary focus of seeking to understand the phenomenon of behavioral health leaders exhibiting stigma toward behavioral health patients.

In the next section, I discuss findings related to a detailed analysis of organizational policies, procedures, and data available for review. These data focus on client programs and initiatives, as well as client- and workforce-centered, management-focused, and financial and marketplace results, followed by the study's strengths and limitations. Common themes are identified and discussed, along with implications for practice at XX Healthcare related to behavioral health leaders' stigmatization of behavioral health patients.

Section 4: Results—Analysis, Implications, and Preparation of Findings

Introduction

XX Healthcare's workforce has a significant responsibility for helping clients achieve their health goals. One aspect that may interfere with this goal is stigma toward behavioral healthcare patients. Thornicroft et al. (2016) has stated that stigma in behavioral healthcare settings impacts long-term mental health outcomes and may contribute to immediate mental health crises because individuals with mental health issues do not feel supported and therefore do not reach out for services early. Healthcare leaders have a responsibility to create healing environments and establish processes that help the system achieve its mission. Leaders are also responsible for maintaining appropriate workplace culture and implementing strategies to improve healthcare outcomes. Thus, it is imperative to understand the phenomenon of behavioral healthcare leaders exhibiting stigma toward behavioral healthcare patients, as well as the impact of this stigma on care.

In this study, multiple sources of evidence around a single research question were reviewed and compared. These sources included policies and procedures, client satisfaction results, staff-engagement survey results, and quality-improvement materials. Data analysis provided insight into how XX Healthcare leaders understand stigma and address it through official policies and procedures. This study involved the implementation of a qualitative approach using case-study research via interviews and records review to gather firsthand information from XX Healthcare leaders about their understanding of stigma and its impact on behavioral healthcare patients. Based on

interviews with six mid- to senior-level XX Healthcare leaders, themes were identified concerning their knowledge of stigma and other aspects of their work that may impact patient care. These themes helped me understand the implications of stigma for entire communities, including the healthcare system, community members, patients, and employees.

Analysis, Results, and Implications

Client Programs, Services, and Initiatives

XX Healthcare has a robust program for tracking data related to client programs and initiatives. The system collects data from multiple sources, including patient-experience surveys, quality metrics, population metrics, and CMMS data about the care provided at various facilities. As noted on the system's website (2020), XX Healthcare received a 5-star CMMS rating in 2019. Further, the Maryland Patient Safety Center recognized the system for quality-improvement projects in 2019, specifically for a process-improvement project within the behavioral healthcare service line. Leaders within the system attributes these accomplishments in part to its robust data-collection system and its standardized process-improvement method.

Although the data-collection process for the organization is robust in certain areas of the system, it is lacking in the behavioral healthcare service line. Leaders at XX Healthcare have struggled to identify specific measures that can help them improve patient care and patient-experience scores. According to the monthly dashboard that the quality team presents to leaders, the organization has met or exceeded its patient-care goals, but the environment in which patients experience this care has not improved.

While not overt, this dynamic may be the result of how leaders understand patient care and the stigmatizing beliefs that they hold about behavioral health patients. According to the chief operating officer, XX Healthcare currently does not include behavioral health patient representation on any of the leadership boards that approve the quality metrics measured and influence the direction of quality initiatives within the system. Other service lines, including cancer care and emergency services, are represented on these boards. The lack of representation within these important decision-making bodies is an example of stigmatizing behaviors from a leadership perspective (Aarons, Ehrhart, Farahnak, Sklar, & Horowitz, 2017), and it may account for the discrepancy between patient-experience scores and high-quality internal metrics.

XX Healthcare collects data with the intention of positively impacting patient care and employs many staff who help to collect, organize, analyze, and distribute these metrics across the system. These individuals also support establishing targets and comparing system data with those of other healthcare systems. According to monthly and departmental meeting records, the system achieved its target goals for patient readmissions for fiscal years (FY) 2017-2019, reaching world-class status with a readmission rate of 8.1% in FY 2019. I obtained this information through the template that staff use at their monthly meetings.

Although the entire system has performed well in readmission statistics, the behavioral health service line has struggled. According to annual quality-review documents reviewed from the system's quality-assurance department, the behavioral health service line has a readmission rate of 10.1%, which is significantly higher than its

target rate of 9%. Multiple initiatives have contributed to lowering this rate throughout the last 4 years, but the system continues to struggle.

Several new initiatives and programs have contributed to expanding the availability of behavioral healthcare in the community. The most substantial service addition occurred when the acute-care department built a new patient unit in 2019. This venture added 20 inpatient behavioral health beds, which a community-health needs assessment had identified previously as a significant community need. XX Healthcare has also identified coordinated care between the behavioral health and general medical acute-care units as an initiative for the coming years. The system developed an internal team to assist with standardized workflows and throughput to aid in this venture. Integrating a care team into the health system may help to create a more integrated system, which is one of the system's strategic priorities.

While these initiatives are helpful, they do not fully address the reasons for high readmission rates in the behavioral health service line. These initiatives help XX Healthcare achieve the goal of decreasing readmissions for many patients, but they do not address the systemic issues present that create a dynamic for high readmissions in the first place. Machado, Leonidas, Santos, and Souza (2012) identified a correlation between poor quality care and readmissions to acute-care settings, which may apply in XX Healthcare's behavioral health service line. Further, Machado et al. (2012) also stated that most readmission prevention measures do not evaluate systemic issues such as homelessness, joblessness, and other social determinants in addressing high readmission rates. The readmission initiatives that XX Healthcare has undertaken cater more to acute-

care needs than they do patients' long-term health. This type of intervention may be explained by underlying structural stigmas within the health system. Corrigan et al. (2014) pointed out that structural stigma is widespread in society but often goes unnoticed. This type of stigma is often woven into the fabric of an organization, making it difficult to identify and address. The combination of a lack of systemic review with the possibility of lower quality care for patients with higher readmission rates may be a result of organizational leaders' stigma toward behavioral healthcare patients.

Internal quality team members provide a snapshot of specific metrics during their daily meetings with the system's leaders, called the *daily dashboard*. It includes recent incidents, daily discharges, and month-to-date quality information, all of which is aggregated and reported to senior and executive leaders at the health system's monthly quality meetings, where issues are discussed, trends are identified, and process improvement measures are developed and reported. The quality team also completes unscheduled audits of units for physical plant issues, which are reported monthly to the facilities team with appropriate follow-up as required. This information is also discussed with the entire health system leadership team at a monthly meeting.

Supervisors and directors are responsible for reviewing each other's quality metrics, as the members of the quality team are often not behavioral health professionals. This qualitative review assists the system in making sure that information solicited on specific forms is documented. Reviews are performed daily, with all supervisors responsible for reviewing at least 30 charts per month. This information is also discussed with the quality team and taken back to the individual service provider to ensure that he

or she is coached on proper documentation and commended if he or she has performed well. This process also ensures that leaders understand workflows and provide staff with opportunities to communicate areas they notice that need improvement and recognize good performance, impacting their individual quality of service to patients.

While the file review process is an important aspect of clinical care, these reviews are often qualitative in measure and do not review the actual care provided to patients, only what is documented in the EHR. While this review is important in addressing regulatory concerns because it ensures that all parts of the patient's file are complete, it does not focus on the individual patient care received. Kilbourne et al. (2018) stated that using patient-centered metrics is critically important because it ensures that clinical staff provide high-quality services. Leaders could benefit from validation beyond checking the EHR and doing face-to-face interviews with clients to ensure that the documentation actually records what occurred. The lack of a patient-centered approach to quality is an example of institutional stigmatization because it does not take the client's voice into consideration when reviewing for quality care. While XX Healthcare allows patients to review their overall quality of care at discharge in the form of a patient survey, this survey is not connected to quality checks and balances reported to the leadership team.

Client-Focused Results

XX Healthcare utilizes several tools and methods to collect client-satisfaction data, including hiring an external group to manage its customer-satisfaction data collection methods. This group specializes in working with acute-care hospitals and helps them collect, analyze, and develop plans for data. Presentation of data occurs at regular

intervals throughout the system and at various meetings to ensure that all staff are aware of both system-level and unit-specific client-satisfaction information. These data lead teams to develop specific plans to address areas of concern through a standardized process-improvement plan.

Client satisfaction is of vital importance to XX Healthcare, as it impacts many facets of the healthcare system. Client experience is one factor considered within the state's total cost-of-care model (Garfinkel et.al, 2016), which links patient satisfaction scores to reimbursement models in the acute-care setting (Elliot et al., 2016). Patient experience leads to the development of long-term healthcare relationships, which are beneficial to both the system and the person served (King, Linette, Donohue-Smith, & Zane, 2019). According to notes from monthly leadership meetings, XX Healthcare has never received a bonus for its reimbursement based upon meeting patient satisfaction goals.

XX Healthcare has also made little effort to identify aspects of stigma present in its workforce and how it may impact patient-experience scores. Evidence suggests that there is a link between perception of poor patient care and stigma toward behavioral health patients (Henderson et al., 2014; Shrivastava, Johnston, & Bureau, 2012). According to process-improvement plans from the behavioral health service line, there was no identification of stigma toward behavioral health patients as one of the root causes of poor patient-experience scores. Further, the external consultant who collected data and assisted with data analysis did not mention stigma as a possible barrier. This lack of awareness on the part of both leaders and the consultant demonstrates that addressing

stigma toward behavioral health patients is not a priority for XX Healthcare's leaders and may further indicate the level of stigma that leaders exhibit.

XX Healthcare has implemented numerous strategies to improve both participation in and results of patient satisfaction surveys. According to the quality department's daily dashboard, the system receives surveys from approximately 30% of patients discharged from the acute-care setting. According to the system's patient-experience leadership team, which includes the vice president of patient experience, these data are sufficient to support making substantial changes in the system's caregiving approach so that it can improve its low patient-experience scores.

Behavioral health patients are given a survey before discharge, which is collected before they leave the building. The survey consists of 42 questions regarding care; the patient scores each item on a Likert-type scale from 1 (lowest) to 10 (highest). Additionally, there is a comment section at the end of the survey where patients can write specific thoughts about their experiences in the hospital. The data collected are anonymous, with the only demographic information collected being the unit from which the patient was discharged and the dates of admission and discharge. Data are sent in a sealed envelope directly to the external consultant, who then aggregates and publishes them to a secure website in real time. According to the consultant, the average turnaround time between a patient's discharge from the hospital and his or her responses being added to the system is about 15 business days.

While participation has improved with these measures, the measures taken to improve the scores are not in line with the methods that the rest of the system outside

behavioral health uses to collect data. In the general acute-care hospital, XX Healthcare mails surveys postdischarge and calls patients to remind them to complete and return the surveys. If a patient provides his or her email address at discharge, the system emails a link. Finally, some departments outside behavioral health provide the survey to patients on a tablet just before discharge so that they can complete it before they leave. These tactics are not used in the behavioral health service line, which may be an example of stigmatizing behavior integrated into XX Healthcare because a different level of care and resources is provided to individuals seeking care in the general hospital setting than to those in the behavioral health setting.

According to the consultant, XX Healthcare's behavioral health division has consistently scored between the 10th and 15th percentile in patient experience since the consultant began organizing the data. According to the consultant and XX Healthcare leaders, the most critical metric discussed within the survey is the question "Are you likely to recommend this hospital to others?" because it is used to provide a general sense of overall satisfaction with services received. According to the consultant's report, 45% of patients are likely to recommend XX Healthcare's behavioral health services, putting the system in the 7th percentile. According to the consultant, to be in the 50th percentile, the system would need to raise this score to 65%.

XX Healthcare has made significant investments in resources to increase these scores in the behavioral health setting, but these efforts have had minimal impact. The system has employed individuals such as the vice president of patient experience and facility-based patient-experience staff with the duty of improving patient-experience

scores. Executive leaders have worked to develop engagement training for all staff, assuming that increased staff engagement would translate into higher patient-experience scores. Further, the system has integrated a structured approach into monthly staff meetings, giving midlevel managers a template to ensure that discussions cover important system-wide initiatives. Relevant topics such as patient experience are provided with significant space in the template, which leaders believe will help move these ratings upward.

Nevertheless, XX Healthcare has made little effort to elicit patients' actual voices about their experiences outside the survey provided. According to the system's 2019 annual report, there is community representation on the board of directors in the form of previous patients who received care at the general acute-care hospital, but not from the behavioral health service line. While behavioral health service line leaders sit on the board, they do not hear the voices of patients in this setting. A review of the training materials developed by patient-experience staff revealed that the general theme of these materials relates to the general acute-care hospital, not to the behavioral healthcare setting. Neither behavioral health patients' experiences nor the involved processes that these patients encounter in admission to the unit are discussed. This gap may provide further evidence of how XX Healthcare has integrated stigmatizing practices into its procedures, specifically among those in leadership roles.

Workforce-Focused Results

There is significant evidence that staff burnout, employee engagement, and patient-experience scores are related to each other in the healthcare setting. Csipke et al.

(2016) identified this correlation, while Montgomery, Todorova, Baban, and Panagopoulou (2013) discussed the relationship between quality of care, organizational culture, and burnout. White, Aalsma, Holloway, Adams, and Salyers (2015) stated that there was a significant relationship between staff suffering from burnout and stigmatizing behaviors such as name-calling and lack of empathy toward juveniles with behavioral health issues. Thus, the research suggests that there may be a relationship between staff engagement (or lack thereof), patient experience, and stigmatizing behaviors.

XX Healthcare facilitates an annual employee engagement survey and culture-of-safety survey throughout its entire system. An external consultant manages this process by collecting survey results and delivering them to the system. This consultant also helps the system develop initiatives based on scores to improve employee morale and engagement. The consultant utilizes an approach that allows supervisors, managers, directors, and executives to see data from each of their respective management levels. For example, a nursing unit supervisor can see data related only to her group, whereas the director of nursing can see both that group's data and an aggregate for all the programs she directs. This access allows leaders to develop engagement initiatives around specific items within their work areas. The engagement and culture-of-safety surveys focus on aspects of job satisfaction and how safe employees feel at work. Employee engagement is determined from four questions (see Figure 2). According to the external consultant, these four questions provide a strong synopsis of employee engagement. The other questions in the survey expand on the initial four, exploring details about which areas

impact employee engagement. Engagement levels are ranked as *engaged, content, ambivalent*, and *disengaged*.

Figure 2. Engagement questions. Image from XX Healthcare's *Engagement and Culture of Safety Survey Results: Behavioral Health and Wellness* (2019). Used with permission.

Overall, XX Healthcare scored in the 20th percentile of all hospitals nationwide in terms of staff engagement. In the behavioral health service line specifically, 36% of staff were defined as engaged, 31.4% were content, 21.6% were ambivalent, and 11% were disengaged. However, the system has a stated goal of being in the 50th percentile of all hospitals in employee engagement scores. Overall, 75% of the system's employees participated in the survey, with 82% of the behavioral health service line participating.

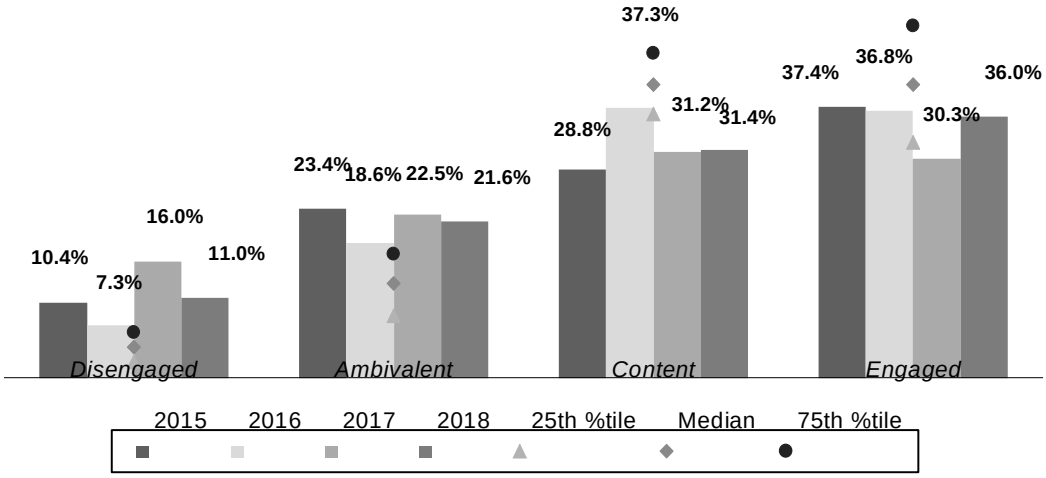

Figure 3. Staff engagement at XX Healthcare. Image from XX Healthcare's *Engagement and Culture of Safety Survey Results: Behavioral Health and Wellness* (2019). Used with permission.

After collecting the data, the system uses a standardized approach to improve upon areas they consider most critical. The external consultant identifies national benchmarks and determines which intervention categories may be most helpful in increasing employee engagement, with the expectation that organizational leaders on all levels will use the DMAIC framework to implement new strategies to improve employee engagement from year to year. Leaders facilitate discussions with their employees and identify focus areas for the coming year. In collaboration with leaders, staff develop specific action plans and leaders assist in developing the metrics to measure the plan's completion and performance. These action plans are tracked and reported to individual workgroups during their monthly staff meetings. During the control phase, leaders

monitor each action plan and make changes as needed to ensure the group remains focused and meets its goal.

While XX Healthcare collects, analyzes, and implements process change around employee engagement, there remains a lack of upward movement around this significant metric. The organization has used its external consultant to establish initiatives to improve staff engagement, while trying to learn from specific departments that have high levels of engaged staff. Zaninotto et al. (2018) identified the highly complex relationship between stigma and staff burnout, pointing out that simplistic initiatives to improve the relationship may fail due to staff personality and organizational culture. XX Healthcare leaders have not significantly addressed stigma throughout the behavioral health service line, so it is not clear what, if any, impact the current process-improvement plans may have on this dynamic. If leaders focus on addressing stigma at a systematic level, the chance of culture change may improve, also improving employee engagement and patient satisfaction.

Management-Focused Results

As part of this study, I conducted interviews with mid- and senior-level managers and directors and analyzed their responses to understand better the dynamic of behavioral healthcare leaders' stigma toward patients. Interview participants held various leadership positions within the organization and included two directors, three managers, and one team leader. Four of the interviewees had been promoted to their positions from direct-care positions in the hospital. The group's average tenure was three years, with a range of 18 months to six years. The participants came from various areas within the hospital

setting, but each of them was a master's-trained licensed behavioral health professional. There were four licensed clinical social workers, one licensed clinical professional counselor, and one licensed expressive therapist. Prior to participating in the interviews, each of the six participants were provided with an informed consent form and copies of Walden University's and XX Healthcare's respective Institutional Review Board (IRB) approval letters. The consent document also mentioned that XX Healthcare's executive leadership supported the study. Interviewees were provided with random numbers (P1-P6) to protect their anonymity and agreed to being audio-recorded for later transcription.

Interviews were transcribed and uploaded to NVivo l2 (2018) coding software. Transcribed interviews were reviewed, clustered, and coded for common words and phrases to assist in identifying themes. I listened to recordings multiple times to ensure accurate transcription and reviewed them against identified themes. I reviewed and manually coded transcriptions for tracking and identification with NVivo l2. These codes were then triangulated with interview notes and software analysis. The following key phrases were identified consistently throughout the review process: *stigma*, *person-centered, strengths-based, personality disorders, low staff engagement, recovery,* and *poor discharge follow-up*.

Emerging Theme 1: Leadership's understanding of stigma. The theme of how system leaders understood stigma emerged from the review of all data, including interviews, a document review, and a review of data collected by external consultants. Terms from the interviews associated with this theme included *crisis, stigmatization, stigmatizing language, lack of understanding,* and *training*. During the interviews, four

respondents discussed the stigmatizing impact of crisis services on patients, specifically how stigmatizing the hospital admission process can be for patients. Five respondents noted that a poor admission process may lead to poor treatment outcomes and reduced patient desire to follow up with treatment after discharge from the hospital. Upon further questioning, each participant stated that a lack of training for admission staff on mental health issues had created some of these issues.

There were mixed statements regarding how leaders had worked to address stigma throughout the healthcare system. P1 and P6 stated that the system works hard to implement training and advocacy on mental health issues, especially in May, which is Mental Health Awareness Month. While P1 and P3 stated that mental health awareness activities were beneficial for community members, P2, P4, P5, and P6 stated they were not specific to stigma or to how behavioral healthcare leaders could impact stigma within the behavioral health setting. P6 said it is vital for XX Healthcare to train other leaders on stigma and its impact on behavioral healthcare patients, since from her perspective, it "will add to staff understanding, which will improve patient care and their desire for treatment." P6 also stated, "Staff is not equipped to handle some of the patients we work with. They have empathy towards them, but often in a crisis that is not enough."

Each participant believed leadership must address stigma more directly. P4 stated that staff education should be more consistent throughout the system, specifically in behavioral health. P4 and P6 said training often starts well but is not integrated fully within the system, though it is clear from staff training documents that the concepts of stigma and recovery are covered in new staff orientation. P4, P5, and P6 stated that

stigma is not addressed on a corporate level but that executive leadership should discuss the topic in town halls or regular staff meetings.

I found a significant disconnect when comparing statements given during interviews to patient-experience and process-improvement data. Leaders I interviewed reported understanding that patients are stigmatized and that institutional processes influence the level of stigma patients experience. It was clear that leaders interviewed believe stigma is a significant issue, but there have been no process-improvement projects that directly address stigma toward behavioral health patients. Data collected from patient-experience scores further demonstrate the lack of trust and poor treatment patients felt they got while receiving services, but there is a lack of depth in the patient-experience data-review process in that stigma is not addressed specifically.

Throughout the interviews and data review, it became clear that executive leadership has not addressed the aspect of stigma and how it relates to both patient experience and staff engagement. One of the key drivers mentioned in the staff-engagement survey is how leadership and the organization inspires staff to work hard. The data collected show a low engagement score, possibly due to staff not feeling they need to or should work hard since the organization continues to employ disengaged staff. Rossler (2012) reported a strong correlation between staff burnout, stress, job dissatisfaction, and staff members' stigmatizing behaviors in behavioral healthcare settings. Endriulaitienė, Markšaitytė, Žardeckaitė-Matulaitienė, Pranckevičienė, Tillman, & Hof ((2016) further reinforced that behavioral health professionals who experience burnout are more likely to experience stigma themselves when they seek help for their

own behavioral health issues, which in turn increases the likelihood they will stigmatize their patients by not providing adequate care. By not addressing the staff engagement issue fully, leadership continues to allow stigmatizing behaviors within the acute-care setting, leading to patient dissatisfaction with the care received and a lack of client engagement in behavioral health services, both of which reinforce stigma.

Emerging Theme 2: Stigma and behavioral health outcomes. The second theme relates to how stigma impacts behavioral health outcomes, specifically metrics related to patient satisfaction and follow-up care. Each participant noted that patient experiences in the acute-care setting are directly related to a patient's desire to continue treatment post-discharge. P5 stated, "I remember when I was not in a leadership role and worked directly with patients daily, how many patients would say that their experience in the hospital was poor and that they would never seek help voluntarily again." P1, P2, and P6 stated that patients frequently discuss the dehumanizing nature of the admissions process, concluding that this negative experience often leads to individuals not wanting to follow up with care post-discharge. Previous research suggests that lack of post-discharge follow-up often leads to poor outcomes for behavioral health patients, including readmission to the acute-care setting (Thornicroft et al., 2016).

Participants also mentioned their belief that low staff engagement may impact patients' post-discharge outcomes. Each participant said that less-engaged frontline staff often treat patients poorly. Five of the six participants listed specific examples in which they had noticed frontline employees treating patients poorly, specifically when patients were in acute crisis. When asked how she responded to these observations, P2 stated she

spoke directly to the staff member involved and asked them what they could have done differently in the situation; she followed up by mediating a discussion between the patient and the staff member. P6 stated she often hears about these situations secondhand and reaches out to the leader in charge of the specific area to discuss incidents when she learns about them. P3, P4, and P5 each stated they reached out to the leader of the unit in which they had witnessed the event; however, they would not intervene directly unless a patient under their charge was involved. Each leader agreed that low staff engagement is linked to low patient satisfaction scores. P2 went further, stating that highly engaged staff often provide excellent care to patients, leading to higher patient satisfaction in the moment; however, she was not aware if this led to higher patient satisfaction scores.

Patient satisfaction scores reviewed in this study demonstrate a link between patients' satisfaction with services and their perceptions of direct-care staff members' efforts. Table 1 shows data taken from patient-experience surveys within different units at XX Healthcare. These data indicate that the unit and treatment team with higher scores (psychiatry) received much higher scores in patients' overall ratings for care and likelihood to recommend. This result supports respondents' comments that where staff are perceived as contributing more effort and help, clients are more likely to report a positive assessment of their stay. It also supports the respondents' statements that patients who feel they are not helped and do not have a quality treatment team give lower ratings for overall care.

Table 1

Patient-Experience Scores From Two Different Units Within XX Healthcare

	Unit A	Unit A	Unit B	Unit B
Question	Percentage	Percentile	Percentage	Percentile
a. Courtesy of psychiatrist	81%	93	43%	3
b. Helpfulness of time w/ psych	78%	97	43%	9
c. Psych info re: medication	76%	90	39%	2
d. Psych info re: condition	68%	86	40%	3
Treatment team	67%	62	45%	2
a. Overall rating of social worker	73%	79	51%	6
Overall assessment	53%	18	40%	1
a. Overall rating of care	56%	27	41%	1
b. Likelihood to recommend	58%	30	39%	1

Note. Data from XX Healthcare's 2019 patient-experience surveys.

Emerging Theme 3: Individual leaders' practice theory. Each leader interviewed for this study discussed his or her philosophical approaches to treatment and how he or she guides teams around these approaches. Five of the six respondents noted they take a person-centered approach and believe their teams treat people with the same principled approach. These participants made similar statements concerning what a person-centered approach looks like and how they implement it with their teams. These leaders believe a person-centered approach looks at each individual differently and helps create treatment options that support the individual in the manner they prefer. Each participant stated that empathy is essential to this approach and that they instill this belief in staff they directly supervise.

All respondents stated their experiences as professionals have directly impacted their ability to practice their theoretical approaches in the manner they like. When asked

how they believe their experiences have affected their ability to work in different settings, most agreed their experiences in an acute-care setting might have changed their ability to work effectively in different environments. P1 and P4 stated that the acute-care setting had made them slightly less empathetic and created a dynamic in which they do not believe they could work effectively in a less-restrictive environment. P3 stated she thinks it would be challenging to return to a traditional outpatient-care setting because she enjoys the fast pace of acute care and the ability it offers to work with patients only for a short amount of time.

Each participant noted that working in the acute-care setting made it difficult for him or her to work with individuals with a specific diagnosis in any care setting due to repeated bad experiences and difficult-to-treat symptoms. P1, P2, P3, P4, and P6 each stated they would have difficulty working with individuals with personality disorders in any environment and would refuse to work with this population in a traditional outpatient setting. P5 stated she would have trouble working with individuals with substance-use disorders in any setting and would never work with a program that served this population. All respondents stated that their time in the acute-care setting had impacted this belief, as they each had many stories of individuals with the specific diagnosis they mentioned that would make it difficult to work with those populations again.

In reviewing policies and procedures within XX Healthcare, specifically regarding patient treatment planning, discharge planning, and policies around seclusion and restraint, there is a significant disconnect between the organization's stated policy and the treatment philosophy of the leaders interviewed. The policies are not written

using a person-centered approach and do not lend themselves to person-centered procedures. For example, the language of the policy on treatment planning is prescriptive about what staff and the patient must do for a treatment team to be considered complete. The treatment-planning process does not allow for natural supports, such as family or friends, to participate. Further, there is a clear directive given to address all medical issues on the treatment plan, even if the patient is not interested in treatment for these conditions. This approach reinforces the idea that the service provider is the expert on the patient and that the patient must comply with the treatment the provider offers.

A person-centered approach allows the patient to participate in direct care and decide what issues he or she wants to work on or not (Smith & Williams, 2016). Further, the organization's seclusion and restraint policy dictates that the treatment plan be updated with specific goals around decreasing aggression after a seclusion or restraint event without consulting the treatment team or patient, a directive that also opposes the person-centered approach. Policies and procedures are dictated at the organization's highest leadership level, with creation of and changes to these documents needing executive leaders' approval. However, the disconnect between the executive leadership team and mid-level managers is evident in their differing treatment philosophies, which further impacts stigmatization of behavioral health patients. Leaders continue to stigmatize individuals through formalized organizational structures by mandating care with minimal patient interaction.

Emerging Theme 4: Stigmatizing language. The last theme that emerged from data review concerned behavioral healthcare leaders' use of stigmatizing language,

including identifying an individual by his or her diagnosis, using demeaning terms to identify someone with a mental illness, and using words that convey an attitude of superiority or control over a person with mental illness (Alex, Whitty-Rogers, & Panagopoulos, 2013; Cuttler & Ryckman, 2019). Five of the six respondents used words that could be considered stigmatizing in their interviews, including *compliant, schizophrenic, chronic, borderline, alcoholic, frequent flyer*, and *crazy*, in discussing the individuals with whom they have worked.

P1, P2, P5, and P6 each shared several stigmatizing words during their interviews. When asked about specific diagnoses that were difficult for them to treat, P1 stated, "I will never work with a borderline again, I mean if I have the choice." P2 said similarly, "I would not prefer to work with borderlines; they are manipulative." When asked about the term *recovery*, P6 stated, "I mean, maybe a schizophrenic can have some quality of life." In contrast, P1 and P5 both said that working with "chronic" individuals makes recovery more difficult.

The stigmatizing language was used frequently when interviewees were asked about how stigma may impact follow-up after a patient is discharged from an acute-care setting. The topic of post-discharge care elicited a large number of stigmatizing words and phrases, many of which were associated with readmission rates and the fact that people with significant mental illnesses return to the hospital because they do not follow up with their outside providers after discharge. P1 stated, "This is very difficult for substance abusers. We want them to follow up with care, but if they don't, they will relapse. […] Lots of difficult things can happen if they do not comply with treatment." P2

stated, “It is, you know, common that people who are chronically mentally ill, that they don’t follow up with treatment.” P6 stated, “Individuals leave, they get drunk, they get high, then they come back to the hospital again. They say they follow up, but they are back in the ER the next day with the same problem.” These phrases imply individuals are defined by their illnesses and that to be successful in treatment, people with mental illness must obey mental health professionals’ orders.

While stigmatizing language in organizational policies and procedures was limited, these guidelines expressed underlying belief systems about behavioral health patients that may increase stigmatizing behaviors toward them. In the seclusion and restraint policy, for example, significant language is directed toward the behavioral health patient, though it is missing in other systemwide policies, which may imply behavioral health patients are more apt to need this level of intervention, thus encouraging the belief that behavioral health patients are more aggressive and violent. Swanson, McGinty, Fazel, and Mays’ (2015) statistical review demonstrated that people with mental health issues are much more likely to be victims of violence than perpetrators of violence. While XX Healthcare must address the possibility of violence by behavioral health patients within the acute-care setting, it may be more beneficial to describe in associated policies and procedures that behavioral health patients are generally not violent and that concerns about violence within the acute-care setting may not always be attributed to a patient’s behavioral health condition.

Financial and Marketplace Results

XX Healthcare holds a significant share of the local healthcare market, making up two of six hospitals in a large suburban marketplace. According to XX Healthcare's website, the system has just over 400 acute-care beds in a county that averages 1,100 available acute-care beds. XX Healthcare continues to grow its share of behavioral health offerings as it increases its number of acute behavioral health beds, which currently stands at 138, far exceeding the 24 beds offered by its closest competitor in the county, which has only 24 beds. XX Healthcare continues to be the only regional provider for acute adolescent inpatient services. It is one of three in the entire state to provide services for children in an acute-care setting.

XX Healthcare continues to grow its subacute-care offerings within the behavioral health service line by offering partial hospitalization and intensive outpatient services to both adults and adolescents. These services provide crisis stabilization and intensive treatment when clinically appropriate and safe. XX Healthcare is the only provider of partial-hospitalization services to adolescents and the largest provider of partial-hospitalization services for adults in the county, offering two different sites for treatment. The system also continues to grow its footprint in the traditional outpatient behavioral health services market, offering services on the grounds of the acute-care hospital. Finally, XX Healthcare has two schools for individuals with learning differences and difficulties, allowing students to maintain a regular graduation progression in a traditional, albeit smaller, school setting.

Over the last three years, XX Healthcare has significantly improved its ability to manage costs and remain financially viable. During this time, it merged its behavioral health service line with the local medical acute-care hospital. As stated earlier, XX Healthcare operates in a state with an all-payer model in which a global, capitated budget is used to fund acute-care settings. This merger improved the behavioral health service line's financial outlook because it increased revenues while maintaining the same costs. Senior system leaders focused significant efforts on this merger because it offered the best arrangement for both the community and the hospital.

XX Healthcare continues to exceed its year-on-year revenues, sustaining a significant financial margin. In 2017, the system exceeded its goal of a 5% margin, achieving 5.45%. In 2018, this figure slipped to 4.84%; however, there was a significant contribution to capital expenses that year, including renovating a unit within the behavioral health service line. According to regional financial reports, XX Healthcare is in line with its competitors in the community, which averaged a 4.9% margin for 2018. The system continues to maintain significant reserves, with more than 200 days of cash on hand. It also reported an annual operating revenue across all service lines above $840 million for FY 2018.

In maintaining such a large share of the behavioral health market within the community it serves, it is paramount that XX Healthcare be a leader in providing patient care and improving access to behavioral health services. Leadership plays a significant role in making sure individuals who need help managing their behavioral health concerns have the opportunity to do so in a manner that leads to positive outcomes. XX Healthcare

leaders have the duty to ensure patients under their care get the treatment they need in a respectful, dignified, and caring manner. Both from a provision-of-care and institutional or procedural context, stigmatization does not provide behavioral health patients the care they need effectively. By focusing on reducing stigma toward behavioral health patients, XX Healthcare will position itself for continued success in the coming years and positive financial and operational margins.

Individual, Systemic, and Community Implications

There are significant implications for individuals who receive and provide services related to stigma in behavioral healthcare settings. It is clear from the data reviewed that at XX Healthcare, there is a correlation between patient experience scores and staff engagement scores. Staff providing less-than-high-quality care may be the result of organizational stigma toward behavioral health clients. Simultaneously, clients receiving poor care may not follow up with community-based care because of those negative experiences, thus reinforcing stigma within their own treatment. The organization has a duty to its clients to eliminate stigma both among the patients they serve, and in the community at large.

Although XX Healthcare leaders understand how low employee engagement may lead to low patient experience scores, the organization has yet to make a well-documented, coordinated approach to tackle this issue systemically. Analysis of internal documents, patient experience scores, and staff interviews imply that this area is of significant concern for staff; however, there is a lack of integrated efforts to address the issue. Evidence suggests that patient experience and employee engagement are linked

strongly to each other (Van Bogaert et al., 2013). Internal documents from XX Healthcare's quality-assurance department show several process-improvement projects associated with increased patient experience scores; however, there has been minimal movement on scores and a lack of consistent follow-through. Further, there is a lack of evidence showing the integration of staff engagement and patient satisfaction into the process-improvement plan.

There are also significant implications for the greater community if XX Healthcare leaders do not address stigma within its operations quickly and efficiently. Organizations throughout the behavioral health continuum have transitioned to using the recovery model as their framework for treating patients (Cruwys, Stewart, Buckley, Gumley, & Scholz, 2020; O'Donnell & Shaw, 2016). Leadership has a significant interest in modifying its programming and creating cultural change to address issues around stigmatization of behavioral health concerns, as the community may utilize other care options and/or seek care elsewhere if change does not occur. It is also noted that since XX Healthcare has such a large share of the behavioral health market in the community, it would serve the organization well to change so they may be seen as a leader within the behavioral health community.

Social impact. XX Healthcare is required to complete a community health needs assessment every three years and create community-based programming that addresses this assessment. The system has identified behavioral health services as a significant community need and has provided training like mental health first aid to community-based organizations to help community members learn more about mental health issues

and understand what to do if someone they care for shows signs of a mental health emergency. However, according to staff education department records, only a few mental health first aid sessions have been offered to the general public, and those have been sparsely attended. The best-attended events focused on how teachers and other educational professionals could help teenagers in a school setting.

Understanding stigma toward behavioral health patients may have a significant impact on society. Specifically, if leaders understand the impact they have as change agents within a larger system and how stigma impacts the care provided, there may be a significant shift in how behavioral healthcare is viewed within the system, thereby impacting the community positively. Implementing this study's recommendations may produce a positive impact on both employee engagement and patient satisfaction, which are both essential metrics to the healthcare system. Further, there may be a significant community benefit: If patients appreciate the care they receive, others in the community who are currently not seeking help may do so in the future, thereby improving the community's health and wellness.

Strengths and Limitations of the Study

Strengths

This study exhibits strength in several areas, primarily in the robust saturation of data and its application to a specific healthcare system. Data were collected from mid- to upper-level managers, all of whom are master's-trained clinical leaders, which led to a detailed explanation of the problem and provided further insight into how behavioral health leaders reflect stigma. Saturation occurred because 85% of the clinical leaders

within the service line were interviewed, giving significant depth to the data collected (Rubin & Rubin, 2012). Further, as the researcher, I maintained a disciplined approach when reviewing internal documents, research interviews, external reports, and policies. Data were triangulated to find themes and generalities, which assisted me in answering the research question. The Baldrige framework (NIST, 2017) was used as a standardized approach to an organizational operation, adding to the study's strength. This framework assisted me in identifying specific areas of discussion throughout the study within both the healthcare system's leadership and results. The Baldrige framework (NIST, 2017) also helped me focus on specific metrics (patient experience and staff engagement) to incorporate best practices within the research.

This study used a qualitative approach with several elements to provide credibility and dependability. The study used reflexivity to ensure personal bias was limited (Ravitch & Carl, 2016). I identified and reflected on my own values and beliefs throughout the research study. Further, this study used collaborative engagement, which supported criticality (Ravitch & Carl, 2016; Rubin & Rubin, 2012) and relied heavily on sources such as the research chair to assist in maintaining reflexivity by engaging in clear dialogue about the research questions and ensuring both minimal bias and maximal rigor.

QSR's NVivo 12 software automatized and organized data throughout the study. This strategy was coupled with manual coding to identify themes while providing tools to analyze the data collected. NVivo 12 enabled me to review audio recordings and highlight common concepts while I reviewed handwritten notes and transcripts. Using

this software added significantly to the study's rigor and helped me navigate the complexity of the data-analysis process.

Limitations

There were some limitations to this research study, as well. Most notable was the relatively small sample size and the study's focus on operations in a unique setting. Such a specific sample may lead to a lack of generalizability (Smith, 2018). Focusing on a small group of people who work together daily may make the study difficult to generalize across similar facilities. While not always a goal of qualitative research, generalization is essential to ensuring the population identified for the study was accurately understood and that concepts could be generalized across that group (Ravitch & Carl, 2016).

Another limitation of the study may be its validity, specifically interpretative validity. It was impossible to read body language during the interview process since all interviews were completed remotely via telephone. Despite what participants said, their body language could have revealed more of their thoughts and feelings on a particularly difficult topic like stigmatizing behavioral health patients. My inability to read body language may have impacted my interpretation of the data presented, therefore putting into question the study's interpretive validity (Ravitch & Carl, 2016).

One additional limitation may be my past employment relationship with the study site. I was employed by XX Healthcare from 2015 to 2019 as the director of clinical services and thus may be biased toward the system. I practiced reflexivity to assist with this dynamic and continuously reviewed myself to ensure I was as unbiased as possible during the interview and data-review process (Rubin & Rubin, 2012). Further, I

implemented other qualitative strategies such as conducting checks during the interview process to validate respondents' statements and reflecting my interpretations back to them to ensure accurate content (Ravitch & Carl, 2016). Although this process improved reliability, evaluative validity is still a limitation in this research.

Summary and Transition

This section addressed the review, analysis, and synthesis of data obtained through research completed at XX Healthcare. Each subsection focused on the implications of behavioral healthcare leaders' stigma toward behavioral health patients An identification of emerging themes revealed several common issues related to the stigmatization of behavioral health patients by different levels of leadership at XX Healthcare. These themes led to a discussion of study strengths and limitations.

The final section discusses several recommendations to XX Healthcare to help the organization address behavioral health leaders' stigma toward behavioral health patients in the organization. Specific recommendations focus on patient service and workforce issues to help increase employees' understanding of stigma, leaders' role in promoting stigmatizing behaviors, and address these issues for patients' benefit. Future research considerations are also discussed, with an aim to better understand the dynamic of behavioral healthcare leaders' stigma toward behavioral healthcare patients.

Section 5: Recommendations and Conclusions

This study's purpose was to understand behavioral healthcare leaders' stigmatization of behavioral healthcare patients. While there is limited research on this specific phenomenon, there is evidence that stigma has significant health consequences for those who experience it. This study aimed to address how leaders impact the concept of stigma toward behavioral health patients within the behavioral healthcare setting. Having a better understanding of stigma and its impact on patients may lead to better health outcomes for those with behavioral health challenges.

This study used semistructured interviews with mid- to senior-level leaders at XX Healthcare to examine how stigma impacts its workforce and its role in patients' postdischarge health outcomes. An analysis of internal documents, including patient satisfaction scores, staff engagement scores, and internal policies, assisted me in this research. Reviewing these data helped me identify strengths and challenges within the system while identifying themes of concern for leaders relating to stigma and its impact on patients. Comparing the data found within policy and current initiatives and triangulating them with interview responses helped me create themes and develop recommendations for possible next steps.

Patient Service Recommendations

Recommendation 1: View Behavioral Healthcare Through the Lens of a Peer-Support Model of Care

XX Healthcare continues to provide care at acceptable standards, has continued to maintain its Joint Commission accreditation, and is in good standing with the state in

which the system is located. However, while the organization achieves standards set by accrediting bodies, patient-experience data show that patients are not happy with their experiences in the acute-care setting. During the interviews, leaders consistently mentioned the relationship between patients' experiences and health-related outcomes. Although it is clear that leaders understand the dynamic around patient experience and health outcomes, it is unclear whether the healthcare system has taken steps to pursue interventions specific to the behavioral healthcare setting.

There are also discrepancies around the stigmatization of behavioral health patients and steps that the system is taking to address this issue. Emerging Theme 1, which relates to how leadership addresses stigma, identified several areas in which the organization could develop a plan to address stigmatization of behavioral health patients at both corporate and programmatic levels. Most respondents identified stigma as an essential topic of discussion, but they simultaneously appeared to make minimal efforts to address the issue on a larger facility-wide scale. Five participants specifically mentioned that the admissions process into the behavioral healthcare setting is stigmatizing from the beginning.

System leaders have a strong desire to care for patients and help address the issue of stigma in the acute-care setting. All respondents stated that they believed that stigma was real in the behavioral health setting and thus was a vital topic to address. While they understood why it is important from a patient-care perspective, it did not appear clear to leaders how it may be important from a financial perspective as well. Interviewees demonstrated a lack of understanding of the state's all-payer program and how the global

budget impacts care at both acute and community-based levels. There was a general understanding that readmissions to the hospital were not positive, but there was not an understanding of how readmission can impact the organization financially. The leaders interviewed all stated that they wanted to end stigma within their facilities. Nevertheless, there was a limited understanding of how stigma impacts patient care and all other aspects of hospital operations.

Taking the above into consideration, XX Healthcare may benefit from viewing behavioral healthcare through the lens of a peer-support model of care. Peer support has gained prominence and relevance recently and is seen as a best practice in behavioral healthcare (Stratford et al., 2019; Watson, 2019; Weir, Cunningham, Abraham, & Allanson-Oddy, 2019). Evidence of improved health outcomes and higher patient satisfaction rates has demonstrated the benefit of peer-support services in behavioral healthcare settings, particularly in acute care (Pfeiffer et al., 2019). Using the data collected via patient-experience scores and interviews, peer support may be one method of helping combat stigmatization of behavioral health patients within the acute-care setting, as leaders can strategize and implement programs that address this issue.

The VA has worked on strategies to incorporate peer support into both its patient-care and staffing models (Harris et al., 2019). The model program, named "It's Just Us," uses peer support to address stigma within VA behavioral health settings. Harris et al.'s (2019) preliminary research has shown promise in lowering staff stigmatization toward other staff with behavioral health challenges and toward the patients they serve. This model could be an important resource within a community-based acute-care setting.

"It's Just Us" focuses on training staff in a traditional didactic style while exposing staff to peers who are currently in recovery from their illness (Harris et al., 2019). This approach aligns with that favored by most of the leaders interviewed for this study, in that five out of six claimed to use a person-centered approach when training new staff and in their treatment philosophy when working directly with patients. The program includes regular exposure to peers, showing that those with lived experiences have a unique perspective on treatment for individuals in acute crisis. These peers are trained as peer-support staff who offer their assistance to patients and share their lived experiences (Knaak & Patten, 2016).

Recommendation 2: Include Those With Lived Experience in Governance Positions

Implementing training and programming for staff and clients is a good start for implementing peers with behavioral health issues into programming, but it does not address the lack of peer advocacy at the organization's governance level. XX Healthcare currently has board members from the community who are previous patients of the general acute-care hospital but no representatives from the behavioral health service line. It would benefit the organization greatly to have more representation from people with lived behavioral health experiences and their families in the corporate governance structure. Doing so would benefit XX Healthcare by giving a different voice to those who have had poor patient experiences while providing the health system with valuable insight into other patient areas. Byrne, Stratford, and Davidson (2018) pointed out the importance of making more leadership roles available to those with lived experiences, both to assist the organization and to support the person maintaining his or her own

recovery. Those with lived experiences offer significant viewpoints and may be able to help the organization move forward where stigma within the behavioral health setting is concerned.

Governance leaders with this level of lived experience can assist XX Healthcare in developing programs, allocating resources, and meeting specific needs in the behavioral health acute-care setting. The knowledge that former patients possess would be even more helpful in addressing the cultural shift that may need to occur at XX Healthcare around systemic stigmatization found within its policies and procedures. Inviting peers into governance positions may also assist the organization in providing currently engaged staff with insight that leaders within XX Healthcare genuinely want to shift perspectives within the behavioral health service line and support staff with the resources required.

Recommendation 3: Review Policies and Procedures to Ensure That Person-Centered Language and Methods Are Used in Patient Treatment Plans

In reviewing XX Healthcare's policies and procedures, I found several examples of writing that did not use person-centered language in discussing patients with behavioral health concerns. Data from staff interviews also revealed that most staff believed that they used a person-centered approach in treatment. A review of policies, specifically around treatment planning, discharge planning, and seclusion and restraint, demonstrated increased bias toward these patients, though, and did not firmly establish patient choice as a priority throughout the treatment process.

This recommendation falls in line with the previous one regarding persons with lived experience being engaged in the organization's corporate governance. It is possible that in inviting these voices to the table, the organization may be able to review more fairly and modify policy language that treats people as individuals rather than their diagnoses. Ammon and Fink (2013) highlighted the importance of person-centered language implementation in policy as a framework for actual procedural change within the operation of an acute-care hospital. Changing the policy language is a positive first step to ensure that XX Healthcare reduces its stigmatizing culture toward people with behavioral healthcare issues.

After policies are reviewed and changed as needed, XX Healthcare should work with the staff education department to ensure proper training and implementation of new patient-care processes. Leaders must support training the workforce in this area, in that without their guidance, support, and leverage, such training may not be taken seriously and considered just another initiative that will fade over time. Implementation of person-centered language in treatment, staff, and larger leadership meetings will help the organization change its culture to one that utilizes a more person-centered model of care.

Workforce Recommendations

Recommendation 4: Integrate Stigma Reduction Into the Process-Improvement Methodology

The data collected in the document-review process and interviews with leaders demonstrate that XX Healthcare is working hard to improve staff engagement and morale. Multiple process-improvement projects were identified in the document review

where staff engagement was the critical metric that the system pushed forward. Van Bogaert et al. (2013) stated that there is a correlation between staff engagement, healthy work environments, and patient outcomes. A review of the success of the process-improvement projects at XX Healthcare revealed that the most successful projects were those in which staff at all levels, from direct care to leadership, had significant input. The DMAIC system that XX Healthcare uses as its primary process-improvement protocol is helpful when it includes representation from all levels of people impacted by the process, including patients (Bartholomew et al., 2018). However, this component is missing in many process-improvement projects at XX Healthcare, which tend to include leaders and exclude frontline staff such as psychiatric technicians, social workers, and nurses. Further, projects seem to be fragmented in that they focus on particular disciplines and do not bring all staff, including psychiatrists, nurses, psychiatric technicians, social workers, and leaders, together at the same time to use the framework. It may also benefit the system to continue eliciting patients' perspectives on each of these projects, given that they have been missing in most process-improvement projects.

In the interviews, leaders also consistently mentioned the need for integrated training. P4 and P5 explicitly stated that training around stigma and its impact on patients would significantly assist staff who are not aware of the recovery model and how stigma impacts patient outcomes over the long term. This training should also address the theme of stigmatizing language. It may be helpful to engage peer-support groups from the community to assist with conducting formal training; participating in the recovery

model's informal, ongoing implementation; and reducing stigmatizing language throughout the system.

Recommendation 5: Invite External Peer-Support Organizations to Formally Participate in Unit Operations

XX Healthcare, especially its leaders, would benefit significantly from building relationships with community groups that focus on recovery and resilience, such as On Our Own (OOO) and the Federation of Families (FOF). Both organizations are peer led and have a significant history in the community where XX Healthcare is located. OOO staff are frequently in the hospital visiting members and providing informal peer support to some patients. XX Healthcare would benefit from partnering with OOO and FOF to ensure that training is not just completed but fully integrated into the system of care.

Integrating both peer-support models would require significant buy-in from leadership, from executives to supervisors, to ensure the healthcare system integrates fully a peer-recovery model of care. While "It's Just Us" is a framework used to decrease stigmatizing staff behaviors to improve patient satisfaction and care, implementing a transformational approach using peers requires significant visioning, planning, implementation, and follow-through for success. Merging the "It's Just Us" framework with OOO and FOF volunteers may lead to improved patient experiences and employee engagement and an overall decrease in stigma throughout the system.

XX Healthcare uses the DMAIC framework to implement process improvement throughout the system. It would benefit everyone involved to complete a DMAIC project that focuses on reducing stigma and involves staff members across the system. A project

this large would require significant buy-in from leaders, as it may be necessary to change formal policies and procedures to ensure the DMAIC framework can be utilized appropriately. During the DMAIC process, it would be helpful to engage OOO and FOF members to ensure that patients' voices are heard and that countermeasures are person centered and recovery oriented.

Future Research

The research completed with XX Healthcare is the first step in understanding the phenomenon of behavioral healthcare leaders' stigmatization of behavioral healthcare patients. A good next step may be to work with leaders from different disciplines, such as nursing and physician leaders, who work with patients to see if they have a similar understanding of stigma. This step may ensure a more thorough, robust understanding of the concept of stigma within the acute-care setting with professionals from different training backgrounds who work with patients. Further, it may be helpful to complete a twin study in a smaller acute-care setting with a smaller behavioral health unit, which may lead to understanding further how leaders impact stigma in the acute-care setting and suggest different themes reflecting various professional perspectives, such as those of nurses, social workers, physicians, and technicians. It may also be beneficial to conduct similar studies in different geographic areas or in hospitals with higher patient experience ratings to see what staff in these environments do differently and if stigma has other implications that were not discovered in this initial inquiry.

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Appendix A: Interview Questions

1. What is your position within the organization?
2. How long have you been employed with the organization?
3. In what role did you start out at in the organization?
4. When you hear that an individual is diagnosed with a significant mental illness, what is your initial response to that person?
5. How would you define your philosophy of working with your patients?
6. What is your own philosophical/theoretical orientation?
    a. How does that orientation help define mental illness?
7. How has working within the behavioral health field shifted your opinion of individuals with behavioral health issues?
8. What issues do you see for individuals not continuing their treatment post discharge?
    a. How do you think their experience within the behavioral health system has impacted their ability or desire to continue treatment?
9. What specific diagnoses have caused you to re-think your ability or desire to work with someone with the same diagnosis in the future? Please explain.
10. How has working within an acute care setting impacted your ability to work with BH patients in other settings?
11. What aspects of an acute care setting make it more difficult or less difficult to adequately care for the BH patient?
    a. How does that impact you as a professional?

12. What does the term recovery mean to you?
13. How do you think recovery impacts the behavioral health patient?
14. How do you think you and your staff's understanding of recovery impacts their ability to serve patients?
15. What do you think is the correlation between low patient experience scores and lower than desired staff engagement scores?
16. How do you think staff can assist patients with improving their outcomes post discharge?
17. What strategies does the organization use to measure and improve upon these outcomes?
18. What has leadership done to assist with the issue of stigma?
19. What evidence of stigma do you see within your specific work area?
20. What initiatives can you (or have you) as a leader institute (d) to help address these issues?