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Service Providers' Perceptions of Stigma and its Impact on Mental Health Services

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This is to certify that the doctoral study by

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Abstract

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Abstract

Stigma is one of the most significant barriers to access and utilization of mental health services in the United States. Delays in receiving mental health services significantly contribute to health disparities and poor health outcomes. Social workers play an integral part in implementing best practices within health care settings and reducing health inequities impacting vulnerable populations. The purpose of this qualitative action research study was to explore social work service providers perceptions' toward stigma and how it affects mental health services among patients in California's Medicaid program. Stigma theory was applied to gain an understanding of how stigma interacts and affects health care services. Interview data were collected from a single focus group meeting with five social work service providers employed within integrated health care facilities. Thematic analysis was used to analyze the data. Findings indicated socio-cultural and administrative factors were the most significant barriers social workers perceived as impacting treatment services among stigmatized patients. Participants also identified an assortment of stigma reduction strategies to mitigate stigma within clinical settings. Recommendations from the researcher were identified in addressing perceived gaps between policy and practice. The findings may be used to strengthen patient-centered care services among vulnerable groups. The findings of this study may also be instrumental in bringing about social change through encouraging advocacy for training on stigma in health care settings to improve treatment outcomes among stigmatized groups.

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Dedication

I dedicate this dissertation to my Lord and savior Jesus Christ. My relationship with Jesus is the basis for my life and pursuit of social work. I consider Jesus to be the first social worker and an excellent model for our profession through his service, compassion, respect for all persons, and pursuit of social justice. As a survivor of sexual abuse and complex trauma, I battled with suicide ideation, low self-esteem, feelings of abandonment and neglect. However, because my faith and relationship with Jesus I found new hope and a reason to live. In the bible, it states, "The Spirit of the Sovereign Lord is on me, because the Lord has anointed me to proclaim good news to the poor. He has sent me to bind up the brokenhearted, to proclaim freedom for the captives and release from darkness for the prisoners" (New International Version, 2011, Isaiah 61:1). Therefore, I promise to use this degree to assist those who are hurting and make a difference in my daily life. May the Lord use my life as an inspiration for others.

Acknowledgments

I would like to acknowledge my Chair, Dr. Elizabeth Walker. She blessed me with her knowledge and expertise throughout this process. She was my second Chair during my dissertation and assisted in progressing my study. Her guidance and mentorship provided the foundation I needed to complete my academic goal. I would also like to mention a dear friend and sister in Christ, Beverly Rivera. She was doctoral student who was with me for the first part of this journey. We leaned on each other and encouraged one another during the most difficult and trying times. I thank her for her continued support and prayers.

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Section 1: Foundation of the Study and Literature Review

Introduction

Health disparities exist in the United States (Agency for Healthcare Research and Quality [AHRQ], 2014). Many factors appear to contribute to health inequities, including access to care, transportation barriers, language barriers, and health insurance coverage (Castañeda & Ojeda, 2012). Nevertheless, stigma is a significant reason for the differences in how individuals receive care, and the type of help received from others (Goffman, 1963).

Stigma negatively impacts an individual's physical health and the health care services they receive (Rao, 2015; Samaraskeare et al., 2012). The World Health Organization (WHO;2013) has identified stigma as a global threat toward service utilization for those seeking mental health services. In the United States alone, stigma has been linked with poor treatment outcomes and delayed care (National Alliance on Mental Illness, 2015). Delayed care for mental health disorders may lead to more significant risk factors for individuals. For example, research indicates stigmatized groups might have a higher tendency to neglect adherence to medication management and delay seeking treatment services benefitting their physical and psychological well-being (West et al., 2015; Wilson et al., 2013).

In California, there is a growing need for mental health services, but stigma continues to complicate treatment services for those with mental health needs. For example, Wong et al. (2015) found that stigma often complicates an individual's capacity for seeking help. Using data from the California Health Interview Survey, they found that nearly 70% of respondents reported intentions to conceal mental health needs due to stigma. Moreover, more than half of the participants expressed feeling misunderstood by others, and 90% of participants indicated experiencing discrimination due to a mental health problem. Their study supports other such findings in which stigma was a significant contributor toward the delay of care for those with identified mental health care needs (Lannin et al., 2015).

The California Department of Health Care Services (DHCS; 2015) reported that nearly $3 billion are needed to meet the mental health demands of all Californians insured under California's Medicaid health care program, also known as Medi-Cal. The demographic populous of the 13 million Medi-Cal subscribers are diverse and wide-ranging. For instance, there are nearly the same number of females (54%) and males (46%) covered by Medi-Cal. A significant number of young adults and children (20 years and under) also receive coverage through this type of health insurance (42%). Moreover, people of color account for nearly 70% of all Medi-Cal subscribers, with Latinos accounting for half of all total enrollees (50%). Regarding language, DHCS indicated that nearly 40% of the insured report a primary language other than English.

There are various challenges in providing mental health services for Medi-Cal consumers (Tran & Ponce, 2016). For instance, there are a limited number of mental health service providers, language barriers often impede or delay treatment service among patients, and a high rate of premature termination of mental health services exists (Guerrero et al., 2013; National Council of La Raza [NCLR], 2016). Stigma is another factor that significantly contributes to reduced service utilization and treatment services in California (Wong et al., 2015). For example, researchers have identified stigma as a factor negatively impacting patient satisfaction and the type of care received (Russell & Hawkey, 2017; Smith & Trimble, 2016). Allen et al. (2014) found that Medicaid patients reported poor health care services due to their health insurance status and had worse health outcomes due to stigma. A more recent study found that women with Medi-Cal insurance, and diagnosed with a severe mental illness were 3 times more likely to experience premature births (Baer et al.,2016).

Russell and Hawkey (2017) indicated that stigma might lead to adverse health consequences due to its influence on an individual's behaviors and response in various domains. Moreover, Hansen et al. (2014) reported that stigma might also impede access to services because of negative perceptions of self. As a result, some believe that stigma may directly contribute toward health disparities and poor treatment outcomes among vulnerable groups such as those with Medi-Cal insurance coverage (Phelan, et al., 2014; Wong et al., 2015)

In this study, I explored how stigma impacts treatment services for Medi-Cal patients receiving mental health services. The data were gathered from a single focus group consisting of social work service providers working or volunteering in Federally Qualified Health Centers (FQHCs) within Southern California, providing mental health services. The California Health Care Foundation (CHCF; 2013) reported that social workers are among the largest group of mental health professionals providing mental services for patients with publicly funded insurance coverage. Thus, I believed the information provided by these stakeholders was valuable in understanding the impact stigma poses for Medi-Cal patients, given the social workers' their interactions working with underserved populations.

Organization of Paper

This action research includes four sections. In the first section, I present the foundation of the study and the literature review. Within this section, I the problem statement, main research questions, the significance of the study, and the theoretical framework are discussed. In the second section, I will present the research design and describe data collection, including methodology, participant recruitment, instrumentation, data analysis, and ethical procedures incorporated for the study. The third section of the paper will include a description of how I analyzed the data and a presentation of the findings. The final section of this paper will conclude with applications to professional practice and implications for social change. To this end, I will review professional ethics in social work practice, as well as provide recommendations for social work practice and a concise summary.

Problem Statement

There is a growing demand for mental health services among Medi-Cal enrollees (DHCS, 2015). Heisler (2018) reported that social workers were the largest group of mental health professionals in the United States, offering treatment to those with mental health needs. Moreover, the Substance Abuse and Mental Health Services Administration (SAMHSA; 2012) reported higher concentrations of social workers providing mental health services for people residing in the United States. For example, for every 100,000 people living in the United States from 2006 to 2008, social workers outnumbered all other mental health professionals (SAMHSA, 2012). As a result, social workers appear to play a vital role in delivering mental health services to consumers, and more specifically, to those with Medi-Cal coverages.

In the discussion of mental health services, stigma continues to complicate treatment services for individuals (Russell & Hawkey, 2017). The surgeon general cited stigma as one of the most significant obstacles toward improving mental health in the United States (U.S. Department of Health and Human Services [DHHS], 1999). Since this report, the public has been more aware of complexities surrounding stigma, but non government organizations continue to acknowledge it as one of the most significant influencing factors complicating treatment services among the public (California Department of Mental Health [DMHC], 2009; National Alliance on Mental Illness, 2015; WHO, 2017). The federal government allotted nearly $44 million towards research and program development in 2018 to reduce health disparities associated with stigma (AHRQ, 2017). Thus, a significant amount of money was allocated to improve health care services and identify gaps in services for the public.

Purpose Statement and Research Question

The purpose of this action research was to explore the perception of social workers regarding how stigma impacts treatment services among Medi-Cal patients receiving mental health services. As it pertains to this study, the definition of stigma includes an individual's negative devaluation of themself due to others' negative perceptions (Goffman, 1963). As previously mentioned, stigma continues to impact health care services and complicate treatment for those seeking mental health services

(Russell & Hawkey, 2017; WHO, 2017). For instance, researchers have found that stigma may have the potential to disrupt mental health treatment services, contribute toward reduced service utilization, and act as a barrier toward addressing mental health needs (Guerrero et al., 2012; Hall et al., 2015; SAMHSA, 2015). Over the past 25 years, acknowledging stigma and its negative impact on health care services has taken place within government sectors (AHRQ, 2013a). For this reason, an increase in research and training has occurred in an attempt to improve health care services for those living in the United States (AHRQ, 2014).

Research indicates that stigma influences treatment and patient-provider relationships (Carrara et al., 2019; Paradies et al., 2013). Some of the literature suggests health care professionals who interact more frequently with those impacted by stigma tend to have a greater awareness or understanding regarding the challenges stigmatized patients may encounter (Farotimi et al., 2015; Sima et al., 2019; Stull et al., 2012). However, other researchers have also suggested that health care professionals may be influenced by stigma, which may complicate treatment services for those affected by stigma (Caplan et al., 2016; Lee et al., 2019; Stringer et al., 2016). In a cross-sectional study by Dong et al. (2018) explored HIV-related discrimination with 972 health care providers in China and found more than three quarters of participants reported engaging in discriminatory practices toward patients diagnosed with HIV. More than half of the participants admitted to providing differential treatment to patients with an HIV diagnosis and violated patient consent by administering HIV antibody tests. Caplan et al. (2016) examined attitudes of multidisciplinary health care providers toward mental illness in the

Dominican Republic and found that some health care providers engaged in overt and stigmatizing beliefs toward patients living with mental illness, limiting patient empowerment. Thus, research confirms that health care providers are not immune to stigma, and its influence may alter treatment and clinical practices.

Currently, extensive literature exists on stigma; however, there is limited research demonstrating how stigma impacts treatment services among Medi-Cal patients. A great deal of scholarly research on the topic of stigma has tended to focus on definitions or terminology associated with stigma theory (Link & Phelan, 2014; Richman & Lattaner, 2014). Other academic work has examined the interplay between stigma and various socio-demographic information (i.e., race, sexuality, socioeconomic status, or a patient's physical health; AHRQ, 2013a; Hall et al., 2015; Smith & Trimble, 2015). There also appears to be more research on stigma with service providers working in health care settings outside of the United States (Caplan et al., 2016; Dong et al., 2018; Lee et al., 2019). Therefore, gaps exist concerning knowledge and information related to how stigma impacts mental health services from service providers, such as social workers, who frequently work with vulnerable groups (CHCF, 2018; Heisler, 2018).

The main research questions guiding this study were:

RQ1: What is the perception of social workers regarding the impact of stigma on mental health services among Medi-Cal patients in Southern California?

RQ2: What do social workers perceive as barriers impacting the receipt of mental health services for Medi-Cal patients in Southern California?

Definitions

To help readers understand this research, I define key terms used in the study in this section.

FQHCs are federally funded nonprofit health clinics providing comprehensive health care services to medically underserved areas (Health Resources and Services Administration [HRSA], 2018a; HRSA, 2021; HealthCare.gov, n.d.). There are nearly 1,400 health centers across the United States, serving nearly 30 million people (HRSA, 2021). It is estimated that 1 out of 3 people living in poverty in the United States receive health care services from FQHCs (HRSA, 2018b). An FQHC may go by different terminologies in their respective communities (i.e., community health centers, migrant health centers, health care for the homeless health centers, public housing primary care centers, and facilities operated by a tribal organization or an urban Indian organization (Centers for Medicare & Medicaid Services (CMS), 2018). Regardless of their name, FQHCs all meet a specific set of criteria (HRSA, 2018a). For example, the CMS (2018) reported FQHCs must serve a designated medically underserved area; offer a sliding fee scale to persons with incomes below 200% of the federal poverty level; and be governed by a board of directors, whose majority receive care at their facilities. They are also required to provide health care services regardless of a patient's ability to pay (HRSA, 2018a). For this reason, FQHCs are termed patient-directed organizations (HRSA, 2018a).

FQHCs have an extensive and diverse workforce of health care professionals. For instance, there is approximately 252,867 employed staff across the country (HRSA, 2019). Medical providers make up nearly 35% of the total workforce, whereas mental health staff accounts for almost 5%. Among mental health professionals, social workers account for the largest mental health staff group, with 4,524 full-time employees (HRSA, 2019). As a result, they are more than double the size of all other mental health professionals, including psychiatrists (896) and psychologists (962; HRSA, 2019).

Integrated care: Health care services received from medical and mental health professionals collaboratively to address patients' needs (AHRQ, n.d.). In the medical community, there are many terms to describe integrated care practices such as collaborative care, behavioral health integration, integrated behavioral health, team-based health care, and primary care behavioral health (AHRQ, n.d.; Center for Integrated Health Solutions [CIHS], 2014; Hunter, et al., 2017). Regardless of their name or designation, the main principle of integrated care includes a team of medical professionals and other health care staff to provide whole-person care to patients in primary care settings (AHRQ, 2013b). With this in mind, the use of telemedicine, in which providers speak to patients virtually, also suffices for integrated care practices (CIHS, 2014).

Through an integrated care model, patients are encouraged to receive care from their primary care physician. However, in some cases, mental health services may also be accessed directly from FQHCs. For instance, in the state of California, mental health services are carved out under many insurance plans, meaning that consumers may access mental health services directly without going through their primary care physician or insurance plans (California Primary Care Association [CPCA], 2017). As a result, the ease of accessing mental health services directly through an FQHC may improve access and service utilization for patients (AHRQ, 2013a; CIHS, 2014; CMS, 2018).

Mental health services: Services providing support and treatment to improve an individual's emotional and psychological well-being (DMHC, 2018). Mental health service may occur through two forms of treatment, psychosocial services (i.e., talk therapy) or pharmacological services (i.e., medication management; Garfield, 2011). Under psychosocial services, mental health services are delivered through individual and group counseling, and supportive services are frequently referred to as case management services (SAMHSA, 2017). Moreover, services may be received through an outpatient or inpatient health care setting, such as specialty community behavioral health centers, substance use disorder rehabilitation programs, hospitals, support groups, community-based organizations, schools, jails, prisons, independent providers, and community health centers (SAMHSA, 2017).

Public stigma: Deriving from harmful messages, stereotypes, and labels in society (Bos et al., 2013). These negative messages that emerge from public opinion may lead to degrading labels (i.e., unfit, weak-willed, undeserving, and unworthy; H. Allen et al., 2014; AVERT, 2018, Goffman, 1963). In response to negative messages, individuals alter their responses, interactions, actions, and behaviors within their environment to avoid labels or hide them (AVERT, 2018, Wong et al., 2015). In one qualitative study, researchers examined the experiences of men having sex with men. They found that over half of participants declined to disclose sensitive health information when receiving health care services due to negative perceptions in their environment (Jeffries et al., 2015). Furthermore, information obtained from the 2014 California Well-Being Survey found that nearly 70% of people reported they would hide mental health problems from coworkers or classmates (Wong et al., 2015).

Self-stigma: Deriving from a individual's devaluation of themself due to the negative stereotypes, messages, and labels in their environment (Goffman, 1963). As such, the devaluation of self may lead to a decrease in goal attainment or self-efficacy. Corrigan et al. (2016) found individuals who applied negative stereotypes to themselves led to an increase in hopeless behavior and thought processes. The researchers suggested self-stigma may also to a lower sense of self-respect. These finding tend to support other empirical research in the field. For instance, Lannin et al. (2015) examined how self-stigma impacts individuals' self-concept and discovered that self-stigma was a predictor for decreased self-esteem among participants in their research.

Service provider: A mental health professional providing psychosocial services (i.e., talk therapy or psychotherapy) to consumers in a competent manner under the guidance of a state licensing board (Dulmus & Sowers, 2012; Heisler, 2018). Many mental health professionals designated to treat and diagnose mental health disorders (DMHC, 2018). Social workers are the largest group of identified mental health professionals in the United States (Heisler, 2018). In California, social workers are reported as the second-largest mental health professionals (CHCF, 2018). The California Board of Behavioral Sciences (2018) report there are approximately 43,342 registered associate clinical social workers (15,619) and licensed clinical social workers (27,723) in the state.

Stigma: Negative associations, labels, characteristics, and perceptions by others, leading to a change in response and behavior from an individual (Lannin et al., 2015). Goffman (1963) described stigma as a discrediting attribute, that results in a perceived shortcoming or failure. To this end, stigma may come in various forms and impact an individual on multiple levels (Mittal et al., 2012). Researchers have contended various stigmas may interact to affect an individual's response to their environment (Corrigan et al., 2016; Corrigan et al., 2017a; Luckstead & Drapalski, 2015). For instance, self-stigma, public stigma, and structural stigma are three different forms of stigma. These stigmas are also believed as pertinent to barriers associated with individuals seeking mental health services, influencing thoughts, behaviors, and actions associated with decisions to seek and remain in treatment (DMHC, 2009, Corrigan, 2004, Hatzenbuehler, 2016).

Structural stigma: Also referred to as institutional stigma, this type of stigma is defined as the policies, procedures, legislation, and regulations impacting stigmatized groups (AVERT, 2018). Furthermore, it may encompass negative attitudes and beliefs deriving from individuals associated with an agency in which stigmatized groups receive health care services (California Mental Health Services Authority [CMHSA], n. d.). Thus, structural stigma includes service providers and those entrusted with providing stigmatized groups' health care needs (Garthwaite et al., 2013; Rhodes et al., 2015). The WHO (2018) recognizes structural stigma as a hindrance toward mental health services, contributing to health disparities.

Nature of the Doctoral Project

In this study, I used a qualitative approach with an action research as design (see Alderfer & Sood, 2016; Gough & Deatrick, 2015; Kozleski, 2017; McNiff & Whitehead, 2010; Stringer, 2014). This project required input from stakeholders in the community with knowledge on the subject matter of mental health and stigma; therefore, I identified social worker service providers providing mental health services to Medi-Cal patients as the most ideal candidates. Their history in working with vulnerable, underserved, and stigmatized groups was vital toward knowledge and understanding the interplay between stigma and mental health services (National Association of Social Workers [NASW], 2015). I collected data using a focus group consisting of five social work service providers employed or volunteering in FQHCs in Southern California.

Significance of the Study

I conducted a qualitative study using action research to explore social workers' perceptions toward stigma and its impact on mental health services. The information gained from research may help identify successful policies and best practices to reduce stigma and improve health care services (Guerrero et al., 2013; Johnson et al., 2017). Additionally, the findings of this research may also provide insights to social work professionals in the region and competency standards within the NASW framework. For instance, there are cultural competency standards for social workers (NASW, 2015). These standards require social work professionals to understand how personal beliefs, attitudes, and feelings impact their clients; therefore, acknowledging stigma within counseling settings is vital in addressing possible health disparities, whereas, a lack of its existence may indicate a shortcoming of NASW competency standard measures among the workforce.

This action research study contributes to social change by addressing potential barriers impacting treatment services among Medi-Cal patients receiving mental health services. Stigma is a significant contributor to health disparities (Bridges et al., 2014; Guerrero, 2013; Williams, 2012; WHO, 2017). A sufficient amount of scholarly work on stigma and its impact on health outcomes is readily available in the field. For instance, several qualitative, peer-reviewed articles provide a platform for identifying and acknowledging the existence of stigma in health care settings from a consumer or patient perspective (Camacho et al., 2015; Miranda et al., 2015; Saechao et al., 2012). However, there is a lack of information from a social work provider perspective (Shavers et al., 2012). This is somewhat surprising because social workers are the largest group of mental health professionals in the United States (Heiser, 2018). Therefore, their peer-reviewed literature input is limited, and their feedback on this research subject may be valuable towards contributing to current knowledge on stigma and mental health. Social work service providers may help identify crucial organizational policy and procedural changes to reduce stigma and improve patient-centered care practices for stigmatized groups (NASW, 2017). Their knowledge and experience in the field may also improve access to care and utilization of mental health services among Medi-Cal patients.

Theoretical Framework

I used stigma theory as a theoretical framework to examine how stigma may impact mental health services between a Medi-Cal patient and a service provider. This theory holds that negative perceptions affect certain groups held in low esteem, helping to contribute toward inequalities (Link & Phelan, 2014). Within this theory, stigma may occur on three different levels (i.e., self-stigma, public stigma, and structural stigma). For instance, self-stigma includes an individual's harmful devaluations of themself due to critical public opinions or stigma (Goffman, 1963). On the other hand, public stigma includes messages in literature or media that negatively depict a group of individuals (Bos et al., 2013; Metzl & Hansen, 2014). Lastly, structural stigma describes the process in which societal policies or standards perpetuate inequalities through negative perceptions of particular groups (Hatzenbehler et al., 2014).

Stigma theory is useful in understanding the interaction that occurs between patients and service providers. Researchers have used this theoretical model to analyze health disparities in society (Link & Phelan, 2001). Furthermore, stigma theory provides a multi-faceted view of challenges patients may experience when accessing health care services. Traces of stigma theory are tied to some early social scientists such as W. E. B. Du Bois (1903) who described a process in which persons evaluate themselves through the perception of others called “double consciousness” (p. 2). Du Bois theorized that this phenomenon helped shape African Americans' identity and actions, thus impacting their ability to advance in society. Later on, Goffman (1963) provided a more detailed definition of stigma through the seminal writing, *Stigma: Notes on the Management of Spoiled Identity*. Goffman's first books on stigma provided the platform for stigma theory in the United States, which many researchers have adopted for their framework.

Stigma theory can be used to help understand patients' care and experiences while receiving mental health services. For instance, self-stigma, public stigma, and structural stigma are three types of stigma that may impact treatment for those seeking mental health services and tend to be the most popular when discussing stigma and mental health (Bos et al., 2013; Link & Phelan, 2001). These different types of stigma may influence help-seeking behaviors and the type of assistance a person receives (Wong et al., 2015). Researchers have also agreed that these stigmas may work independently of each other or interact with one another, thereby creating additional barriers for stigmatized groups who attempt to secure goods or services (Corrigan, 2004; Corrigan et al., 2014).

Values and Ethics

In this action research, I sought to gather information on a service provider's perceptions of stigma and its impact on mental health services. The data obtained in this study may provide insight into understanding how stigma may contribute toward health inequities among stigmatized groups. Social workers are vital in delivering direct services in health care facilities across the United States (CHCF, 2013; Calo et al., 2015). With this in mind, their knowledge and first-hand experiences in the field may help identify possible barriers among groups impacted by stigma.

The NASW Code of Ethics (COE; 2017) identified service as one of its core values, entrusting social workers with improving care. When discussing the sector of health care, there are apparent inequalities faced by specific groups (i.e., people of color, low socioeconomic status, and uninsured; AHRQ, 2013a). These groups experience many health disparities and tend to receive a lower quality of care (CHCF, 2013). As such, information derived from this action research may serve as a tool in understanding the complexity of specific health disparities caused by stigma. It may also support improving mental health services by identifying ways to improve service utilization and prevent pre-mature termination or dropouts among stigmatized groups.

Lastly, the NASW COE (2017) indicated dignity and worth of a person is another set of core value. To this end, I focused on a segment in the United States that is often overlooked and disregarded due to their social status. Stigmatized groups generally receive a lower quality of health care access and services than the general population (AHRQ, 2013a; CHCF 2013). Therefore, with the findings of this study, I hope to contribute to current knowledge of stigma in health care settings, working toward improving treatment strategies among social worker service providers to support treatment, interventions, and engagement among stigmatized groups (see NASW, 2015).

Review of the Professional and Academic Literature

The demand for mental health services is increasing in the state of California (DHCS, 2015). The projected budget for mental health expenditures for Medi-Cal subscriber in 2016-2017 stood at more than $1 billion (DHCS, 2015). As the demand for mental health services increases, there are continual challenges in meeting Medi-Cal consumers' needs. For example, a lack of culturally competent mental health providers, an inadequate supply of mental health providers, and limited options for access to care are some factors impacting mental health services (CHCF, 2018; Coffman et al., 2018). However, one of the most significant challenges in meeting the demand for individuals with publicly funded insurance concerns stigma, because it contributes to health disparities among Medi-Cal subscribers (Coffman et al., 2018; Lannin et al., 2016).

To understand how stigma impacts mental health services, I used EBSCO Host as the primary search engine to select scholarly articles for the literature review. Under EBSCO Host, various database were accessed to acquire information about the research topic, such as Psych Articles, Psych Info, Soc INDEX with full text, MEDLINE with full text, and CINAHL Plus with full text from 2012-2018. Key terms narrowed down the search of peer-reviewed articles published in the past 7 years. The specific keyword searchers carried out for this study included *social work, mental health, service providers, behavioral health, stigma, health, integrated care, disparities, health care, barriers, and stigma theory.* I also obtained government reports to gather information related to health care statistics. The central government reports included findings from AHRQ and SAMHSA. Moreover, state reports were used to gather specific information for patients insured under the Medi-Cal program. To this end, I used periodic and annual reports from DHCS to understand the present situation facing underserved populations impacted by stigma.

Stigma and Mental Health

In a review of stigma and health care in the literature, self-stigma, public stigma, and structural stigma were three specific types of stigma widely viewed as impacting mental health services (Bos et al., 2013; Goldberg, 2017). The literature also noted these identified stigmas tend to operate interactively with each other. Therefore, researchers acknowledged a consistent interplay among the specific forms of stigma that may negatively influence a patient's response, reaction, and receipt of mental health services (Lannin et al., 2016). Furthermore, research suggests identified stigmas may potentially impact health care workers' actions and attitudes or service providers working directly with stigmatized groups (Blair et al., 2013; Chapman et al., 2013; Gengler & Jarrell, 2015).

In discussing the interaction between self-stigma, public stigma, and structural stigma, researchers indicated these stigmas intersect in a sophisticated manner where information obtained from one has the potential to influence another (Bos et al., 2013). For instance, self-stigma, defined as an individual's devaluation of themself, arises mainly from negative stereotypes or labels from the society or environment which a person lives (Goffman, 1963). Moreover, society's negative messages may occur through various outlets such as written material, social media, or everyday casual conversations between people (Lannin et al., 2016; Morey, 2018). Thus, researchers have contended that self-stigma primarily relies on external influences, such as public stigma, to drive its development within an individual. Without the use of external factors, self-stigma loses its potential for influence over an individual, their cognitive processes, and actions or behaviors. Additionally, both self-stigma and public stigma may impact treatment services among stigmatized groups through another from of stigma referred to as structural stigma.

Structural stigma, defined as the creation of legislation, policies, and procedures that directly impact stigmatized groups, is another form of stigma that interacts fluidly with self-stigma and public stigma, and it may also impact health care services (Corrigan et al., 2004; Goldberg, 2017). For example, researchers contended that certain groups' negative perceptions and low status greatly influence policymakers and managed care companies in their payment systems to health care providers (Bailey et al., 2017; Corrigan, 2004; Robbins, 2017). Health insurance plans covering stigmatized patients often foster restrictive administrative barriers such as low reimbursement rates and delayed payments (Gordon et al., 2018; Roby et al., 2018; Sommers & Kronick, 2016; U.S. Government Accountability Office, 2011). Consequently, these barriers have contributed to health care professionals reporting a poor experience working with Medicaid plan and decreased the number of service providers willing to work with stigmatized groups (Common Fund & Kaiser Foundation, 2015; U.S. Government Accountability Office, 2011).

Another way stigma may affect health care services includes the interaction between a patient and health care provider. For example, evidence has shown stigma may influence an individual’s thought process and actions in health care settings (Reid, Dovidio et al., 2014; Sarkin et al., 2015). For instance, multiple studies have suggested stigma may contribute to nondisclosure from a patient to health care provider and impede treatment services (Bennett et al., 2016; Jeffries et al., 2015; Magnus et al., 2013). In one qualitative study, participants reported engaging in conscious nondisclosure with health care professions. In the study, patient avoided asking medical professionals’ help for their current health condition when they perceived negative labels by their health care provider (Jones, 2015). Closchesy et al. (2015) found that patients refused to adhere to recommended treatment plans when they felt a lack of respect from their health care providers. The participants in the study also reported a conscious effort to avoid prescribed medication by their health care providers for this reason. Unfortunately, a patient's decision to disengage in a clinical setting may have dire consequences and lead to worsening health conditions in the future (AHRQ, 2013a).

Stigma and Health Care Services

Academic literature has also shown that stigma may contribute to health disparities among disenfranchised populations (AHRQ, 2013a; Goodman et al., 2017). For example, researchers have found that stigma may impact a person's decision to seek help for a suspected mental health condition and their ability to access literature about a suspected mental health need (Crowe et al., 2018; Kawaii-Bogue et al., 2017; Sheri, 2015). Stigma also negatively impacts those in close contact with someone living with a mental health condition. For instance, Fernando et al. (2017) interviewed family members caring for a loved one with a mental health condition. They found 20% of caretakers made a conscientious decision to delay or avoid mental health services when stigma was present. Corrigan (2014) described that label avoidance often impacts stigmatized groups and occurs when a person makes a conscious attempt to avoid discrimination or negative labels by declining treatment to negative public perception.

Additional studies have supported that external factors such as negative public perception (i.e., public stigma), may directly impact access and utilization of health care services among stigmatized groups. Toomey et al. (2014) conducted a longitudinal study of utilization of health care services among adolescent Mexican American mothers living in Arizona. The researchers found that the passing of controversial legislation, targeting undocumented immigrants, known as SB 1070, led to a significant decrease in children accessing medical care and public assistance. The researchers believed a reduction in care access was directly related to the negative associations support by the surrounding community's immigration law. Thus, the literature identifies structural stigma and other forms of stigma as deterrent for health care and treatment services (Corrigan & Rao, 2012; Vogel et al., 2007; WHO, 2017).

Stigma and Health Care Providers

Access to good quality care and perceived devaluation by service providers are other barriers impacting health care services among stigmatized groups (Feagin & Bennefield, 2014; Goodman et al., 2017; Joseph, 2017). For example, Blair et al. (2013) interviewed 210 primary care physicians in Colorado's three health care organizations. They found a majority of doctors preferred a specific type of patient based on factors associated with race. The researchers also reported two thirds of physicians reported a negative evaluation or perception among patients of color before entering the exam room. Unfortunately, when negative perceptions invade clinical or health care settings, it may alter the interactions between patients and health care professionals (Bitan et al., 2018; Cooper et al., 2012). Moreover, skewed perceptions by health care professionals may also contribute to a clinical misdiagnosis or poor treatment outcomes among stigmatized groups (Corrigan et al., 2014; Tiruneh et al., 2016).

Social scientists have tended to look at the individual, environmental, and legislative factors impacting individuals or groups affected by stigma (Anakwenze & Zuberi, 2013; Corrigan, 2004; Mirabito et al., 2016; Raymond-Flesch et al., 2014).

Moreover, researchers have used a variety of methodological approaches examining stigma and its relationship to health care services or patient experiences (AHRQ, 2013a). For this reason, many quantitative and mixed-method studies on stigma have tended to be correlational studies looking at factors associated with stigma and patient health status (AHRQ, 2013a; NCLR, 2014). On the other hand, many of the qualitative studies have tended to examine patient experiences related to stigma and perceived barriers impacting services (G. Allen et al., 2016; Calo et al., 2015). There is extensive research on stigma and health care services to educate the public and improve services delivery to stigmatized groups (CMHSA, 2017; Corrigan, 2004, Hayes, 2016; DHHS, 2011).

Research on Stigma and Health Care Services

The literature I gathered from databases and government reports about stigma appeared to center on three main areas. First, a significant amount of research focused on statistical information between health disparities and outcomes among stigmatized groups (AHRQ, 2013a; Hatzenbuehler et al., 2014; Hatzenbuehler et al., 2013; Tudose et al., 2017). Moreover, the bulk of peer-reviewed material found tended to derive from the lived experiences of a consumer's or patient's perspective associated with stigma. Second, researchers made numerous attempts to build on past stigma theory with the creations of new definitions and phenomena in the field related to stigma (Bos et al., 2013; Cook et al., 2014; Corrigan & Fong, 2014; Richman & Lattanner, 2014). Lastly, there emerged literature seeking to provide practical interventions or strategies geared toward service providers working with people impacted by stigma with a goal to improve service utilization and care (Roe et al., 2014; Russell & Hawkey, 2017).

Summary

In examining the extant literature on stigma and health care, a considerable amount of research is provided directly from groups impacted by stigma (G. Allen et al., 2016; Cook et al., 2014; Corrigan et al., 2017b; Goodman et al., 2017). Researchers have often looked at the challenges faced by stigmatized groups through evaluating patient experiences and treatment outcomes (Ingram et al., 2014). However, this is a limited information in the academic literature describing how stigma impacts mental health services among Medi-Cal patients (Bridges et al., 2014; Garvey et al., 2016; Mittal et al., 2012). Research from a social work service provider perspective is even more scarce (Rasmussen & Garran, 2016). Therefore, gathering social work service providers' contributions perspectives in this study may help develop greater insight to understand inequalities or disparities in health care settings among Medi-Cal patients (see Spector, 2012). Social work professionals are committed to advocating for social justice, reducing health disparities, and improving service delivery among disenfranchised groups (NASW, 2017). With this study, I hoped to contribute to current literature on stigma, help identify ways to improve patient-centered care practices, and identify potential barriers impacting treatment services among stigmatized groups attempting to access mental health services.

Section 2: Research Design and Data Collection

Introduction

The demand for mental health services in California is steadily increasing among Medi-Cal patients (DHCS, 2015). There is an allotment of nearly of nearly $3 billion to address the current need for mental health services among Medi-Cal patients; however, stigma often complicates the care and receipt of mental health services for these patients (DHHS, 1999; WHO, 2018). Vulnerable populations, such as those with publicly funded insurances, are believed to be at higher risk of encountered barriers due to stigma and their devaluation in the general society (Calo et al., 2015; Goffman, 1963; McAuliff et al., 2014; Spencer & Grace, 2016). Increased attention on the expansion of mental health services in California aims to improve access and quality of care for those seeking mental health services impacted by stigma (DMHC, 2009; DHCS, 2015). In California alone, the state developed an extensive 10 year plan to reduce stigma through advocacy and supports in psychoeducation to service providers and employers across various sectors including education, hospitality, manufacturing, and health care (DMHC, 2009). In this study, I explored social workers' perceptions regarding how stigma affects treatment services among Medi-Cal patients receiving mental health services. A qualitative approach involving a single focus group with social work service providers treating Medi-Cal patients was used to gather information for this research. With the findings of this study, I hope to contribute to current literature on stigma and mental health, identify barriers impacting treatment services among stigmatized groups, and identify patient-centered policies to improve access and delivery of health care services for those affected by stigma.

In this section, I provide an overview of the research design, methodology, and participant recruitment as well as information about the construction of the instrumentation, data analysis, and ethical procedures incorporated for this study. Throughout this section, I also outline the steps used to uphold the integrity of the research design and trustworthiness. This section concludes with a summary and brief outline discussing the subsequent section.

Research Design

There is a need to expand mental health services among vulnerable groups in California (DHCS, 2015). Stigma continues to impact health care services among Medi-Cal patients and is a deterrent in accessing and utilizing mental health services in the United States (AHRQ, 2013a; DHHS, 1999). In this study, I sought to understand how stigma impacts Medi-Cal patients receiving mental health services from a social work service provider's perspective, focusing on improving access and quality of care for those affected by stigma.

I used a qualitative action research approach to explore stigma and its impact on treatment services. To better understand this, I used expert stakeholders to examine the social problem (see McNiff & Whitehead, 2010; Stringer, 2014). Employing an action research design is useful for evaluating policies, procedures, and health care services (Ungar et al., 2015). For instance, Mill et al. (2013) used action research to evaluate care standards for persons living with HIV in four different countries. Through interviews and focus groups with health care workers, the researchers successfully identified factors impacting care for persons living with HIV. Throughout their research, they were also able to identify social and cultural factors affecting patient privacy and confidentiality. Therefore, the inclusion of stakeholders' is an essential aspect of action research and may lead toward a better understanding of factors impacting social problems (Mill et al., 2013; Stringer, 2014; Unger et al., 2015).

Methodology

Prospective Data

The method for collecting data in this study included the use of a focus group (see Ingram et al., 2014). The focus group consisted of five social work professionals working with stigmatized groups in integrated health care facilities serving underserved populations (i.e., FQHCs). The focus group was 60 minutes in duration, followed by a structured questionnaire, and audio recorded to assist in accuracy for transcription (see Chiweshe & Macleod, 2017; Clochesy et al., 2015; Zakrajsek et al., 2013). As in any research dealing with human subjects, I enacted procedures to support the integrity of this study.

As such, throughout the study, reflexivity was incorporated to strengthen trustworthiness. Reflexivity, defined as the process of a person’s critical self-reflection through examining their own biases, preferences, and preconceptions, is highly suggested in the field of qualitative research and may help support measures toward establishing trustworthiness (Lincoln & Guba, 1985). I kept a journal to document my thoughts, feelings, and actions while carrying out this study from beginning to end. I also used reflexivity to examine the contextual relationships between myself and the participants as well as understand my values and pre-existing beliefs concerning the study and the social problem (see Berger, 2015; Dodgson, 2019). Researchers suggested reflexivity may help strengthen rigor and confirmability among qualitative studies (see Darawsheh, 2014; Houghton et al., 2013; Moser & Korstjens, 2018).

Participants

I used a non-probability purposive and snowball sampling techniques to identify participants for this research (see Cupertino et al., 2013; Valerio et al., 2016). FitzPatrick (2019) reported that selecting participants with sufficient job knowledge on a related topic and social problem helps strengthen validity within qualitative research. To this end, I decided to use social workers employed or volunteering in FQHCs, providing mental health services to Medi-Cal patients because of their exposure and knowledge in working with stigmatized groups (see Heisler, 2018).

For recruitment purposes, I disseminated informational flyers to invite potential candidates. The flyer was placed in strategic locations such as community health centers, hospitals, local health care agencies, churches, and outpatient mental health counseling agencies. The flyers were also posted electronically on social media outlets, such as LinkedIn. The posting of the flyer occurred for 2 weeks to get a sufficient response from eligible participants.

Upon receipt of information from potential candidates, I reached out to each one using a telephone script as a means of screening purposes (see Raymond-Flesch et al., 2014). After establishing that prospective candidates met the study's inclusion requirements, I worked to obtain their consent to participate in the study. I provided each participant with an electronic copy of the informed consent form for review and signature. Prospective participants were directed to send an electronic copy of their signed consent to me for participation in the study. In the end, five social work service providers agreed to participate and attended the focus group. Past researchers, using an action research design, have included similar sample sizes when interviewing service providers (Chiweshe & Macleod, 2017; Collier et al., 2012; Villalobos et al., 2016; Zakrajsek et al., 2013).

Instrumentation

I used a self-administered demographic questionnaire to obtain participant information related to their age, gender, ethnicity, licensure status, and the number of years employed in the FQHC setting (see Becerra et al., 2015). In looking for an instrument to study service providers' percpetions about how stigma impacts mental health services, I searched the scholarly literature and found multiple options (see Bunn et al., 2007; Destrebecq et al., 2018; Govindharaj et al., 2018). However, these instruments appeared narrow in their scope with the intent of measuring the level of stigma within an individual or group of people (Hanschimdt et al., 2018). De Vellis (2012) reported that it is not uncommon for social scientists to encounter challenges when identifying appropriate scales or questionnaires to study complex variables.

In response to the lack of particular instrumentation to understand how social workers perceive the impact of stigma on mental health services, I created a semi-structured open-ended questionnaire. Using information from Bradburn et al. (2004) to guide the development of the questionnaire, I constructed it to obtain meaningful information from the participants. For instance, I avoided using loaded words to reduce social desirability bias and created it to support dialogue by starting with fact-based questions and including less socially desirable topics, such as stigma, towards the end (see Bradburn et al., 2004). The semi-structured questionnaire went through various revisions under my department chair's direction to improve its quality and content.

Data Analysis

I conducted a focus group to gather data addressing the research questions of this study. The resulting data were analyzed using an approach known as thematic analysis (see Ayón, 2016; Saechao et al., 2012). This approach allows the researcher to identify themes associated with the research problem and provides a level of depth or insight not otherwise available using other techniques (Lee et al., 2016; Yull et al., 2014). After the focus group was held, I transcribed the dialogue and interactions from the audio-recording. A second transcription of the audio-recording was completed to confirm the accuracy and support the integrity of the data. Using a thematic analysis approach, I highlighted key terms and identified patterns or themes from the participants' responses associated with the specific research questions. To organize the data, I categorized it into clusters.

After organizing the data, I engaged in a process known as member checking to ensure the credibility of data received from each participant (see Stringer, 2014). I reached out to participants by phone, and asked them to review my initial codings and themes (see Stringer, 2014). The participants were asked to check my transcription of their responses regarding questions posed during the focus group to confirm the accuracy and strengthen validity (see Madill & Sullivan, 2018). I also used member checking to identify possible biases or discrepancies, and provide participants with the chance to revise or clarify their focus group statements (see Madill & Sullivan, 2018; Stringer, 2014). The use of member checking supports the credibility of data analysis and helps reduce misrepresentation from those involved in the study (see Verdinelli & Biever, 2013). Varpio et al. (2017) stated researchers often use member checking to enrich the data analysis process by asking participants to help inform the researcher's understanding of the data.

I incorporated a reflexivity journal to track my thoughts and feelings throughout the data retrieval and analysis process (see McNiff & Whitehead, 2010). The reflexivity journal provided additional insights into my judgments, thoughts, feelings, actions, and data analysis. Houghton et al. (2013) reported using a reflexivity journal might be useful in providing a rationale for decisions made during qualitative research by assisting a researcher in identifying potential challenges related to their study. Reflexivity within the frame of qualitative research may help support credibility and validity measures (Stringer, 2014).

Ethical Procedures

I obtained approval through the Institutional Review Board (IRB) of Walden University. The IRB approval number is 02-19-20-0594688 and will expire on February 18th, 2021. An informed consent form was used to help protect the confidentiality of social workers participating in the focus group. The informed consent form provided the purpose of the study, eligibility criteria for participation, an explanation of participant rights, and possible risks associated with the study. I allotted sufficient time for each participant to review the informed consent form and ask questions regarding the study. No deadline was given to return the informed consent form to reduce pressure on the participants. The informed consent form also clearly emphasized that participants could opt out of the research at any given time. I wrote the informed consent form in plain language and ensured it was easy to follow. Lastly, the informed consent form directed all participants to maintain the focus group's confidentiality and keep the contents of the discussion private.

Other measures to protect confidentiality included using identifiers to keep the participant's data anonymous. I did not ask participants for their names or any other identifying information beyond their signature on the informed consent form. I secured data in a locked filing cabinet. All transcriptions and other electronic materials were password protected and encrypted to ensure confidentiality (see Stringer, 2014). Data will be maintained for 5 years and destroyed after that. At that time, all electronic media and files will be deleted, and all paper sources will be shredded, ensuring the privacy and confidentiality of research participants.

Summary

I conducted a qualitative study with an action research design to understand social workers' perceptions of stigma and its impact on mental health services among Medi-Cal patients'. A focus group was the primary method collecting data. Non-probability and snowball sampling were used to identify participants. To ensure trustworthiness in the study, I used reflexivity and member checks. Proper procedures were enacted to protect the privacy of participants. Data were coded using thematic analysis to categorize data and identify potential themes. Lastly, I kept confidential through the use of a locked filing cabinet and securing all electronic data with password protection and encryption. After five years, all sources of data will be deleted or shredded. In the following section, I will provide additional information on collecting and analyzing the data from the social work participants.

Section 3: Presentation of the Findings

Introduction

The purpose of this research was to explore service providers' perceptions of stigma and its impact on mental health services. Using an action research design to explore this topic, I conducted a focus group to collect data from social work service providers. The social work professionals worked or volunteered in integrated health care facilities known as FQHCs in Southern California.

Two main research questions were used for this study:

RQ1: What is the perception of social workers regarding the impact of stigma on mental health services among Medi-Cal patients in Southern California?

RQ2: What do social workers perceive as barriers impacting the receipt of mental health services for Medi-Cal patients in Southern California?

In this section, I present a brief review of the purpose and research questions to address the identified problem. I also detail how I collected and organized the data. This section also includes a description of the data analysis techniques employed, the recruitment process, and the measures to support trustworthiness and limitations encountered. The key findings and emergent themes from the focus group are also reported. I end this chapter with a summary of the information obtained from this research.

Data Analysis Techniques

I collected the data for this study in the spring of 2020 after IRB approval (Approval No. 02-19-20-0594688) was granted. After receiving approval, I began the recruitment of participants. Recruitment lased for 5 weeks, with eight social workers expressing interest and meeting eligibility criteria. In the end, five social workers attended a focus group lasting 60 minutes. Each participant held a master's degree in social work. Of these, five individuals licensed clinical social workers, and two were pre-licensed as associates clinical social workers. All obtained and held licensure in California under the Board of Behavioral Sciences.

After the focus group concluded, I transcribed the audio-recorded group meeting verbatim. This process took 2 weeks. Once completed, I categorized the information by identifying texts, phrases, and topics associated with the research questions. I read and re-read the transcription to identify the themes and cluster the data with an approach known as mind mapping. This process includes categorizing the data in central themes and then branching out the subjects (Whiting & Sines, 2012). Whiting and Sines (2012) reported that mind maps provide social scientists with a visual representation of ideas, concepts, and sub-concepts to organize data representing the importance of categories and subcategories in a framework. As a result, during this phase, I highlighted repetitious key terms from participants and began to look for patterns associated with stigma and treatment services. During this stage, I also incorporated reflexivity to add insights to and transparency within the research process as well as provide a sense of understanding of emerging themes and concepts. The whole process of coding and analyzing the data took 3 weeks.

From the beginning of this study, I used reflexivity to support validity and rigor. Through journaling my experiences as a social work service provider to vulnerable populations, I was able to gain insight related to my motivation and interest about the research topic. I documented my professional experiences and challenges when providing mental health services to Medi-Cal recipients and I uncovered personal biases and stereotypes associated with the research topic of stigma and mental health. For instance, reflexivity revealed the challenges in my youth as a survivor of sexual abuse. It also supported the introspection on perceived barriers towards various stigmas I encountered as a heterosexual, male, Latino, veteran of the U.S. Army. Reflexivity allowed for greater understanding surrounding my experiences and guided my approach to this study. Darawsheh (2014) noted that reflexivity might help researchers understand their decision-making processes and identify potential hindrances.

Additionally, I strengthened the rigor of the study by incorporating member checking (see Lincoln & Guba, 1985). To accomplish this, I reached out to each participant and set up a time to meet telephonically. When talking with the participants, I asked them to review their transcripts. Upon reading their transcripts, participants provided feedback to ensure the accuracy of the transcription (see Stringer, 2014). Furthermore, I asked participants to verify their words matched intended meanings to avoid misrepresentation or misinterpretation (see Varpio et al., 2017). The process of getting clarification helped identify blind spots or missed information from our previous interaction (see Madill & Sullivan, 2018). It also provided the participants with an opportunity to make revisions to their initial transcriptions and modify statements related to the research question or subject matter (see Verdinelli & Biever, 2013). During the member checking process, the partcipants did not alter their transcriptions from the focus group meeting. Participants reported the transcriptions were accurate and reflected the essence and messaging of their personal perceptions on the matter of stigma and mental health services.

Limitations

The limitations of this study included the low number of research participants. For example, this study had five social work service providers, which is hardly representative of social workers in the region or nationally. Having a more diverse ethnic sample also limited the data and its findings. Although this research included three social work service providers identifying as Latino and one identifying as Middle Eastern, the results do not represent the broader scope of social work services providers in the field. To this end, the findings cannot be generalized beyond the information obtained from participants within this study. An additional limitation included no subsequent focus group sessions. Holding one focus group limited the amount of information disclosed by providers and limited additional insights. Future studies increase the number of social work service providers as participants, have a more diverse sample of social work providers, and hold multiple focus groups to gain information on stigma and its impact on mental health services.

Findings

The primary research questions focused on exploring how social workers perceived stigma and its impact on mental health services, as well as the perceived barriers impacting the receipt of mental health services among Medi-Cal patients. Exploring the perception of stigma included having participants provide a definition of stigma and discuss how they perceived its interaction with patient care and the utilization of mental health services. Moreover, it also included having social workers identify barriers impacting care and treatment services among Medi-Cal patients. In the focus group, the social work provider participants discussed their experiences working with patients in their respective integrated health care facilities. The findings were summarized through three major themes, (a) socio-cultural barriers to treatment services, (b) administrative barriers to treatment services, and (c) stigma reduction strategies.

Sample Characteristics

The focus group participants consisted of four women and one male who all possessed a master of social work degree. In the focus group, the participants provided their knowledge related to and experiences serving vulnerable groups in integrated health care settings. Their combined experience totaled more than 27 years of working in FQHCs, and providing mental health services to patients with Medi-Cal insurance plans. Furthermore, four of the social work service providers spoke a second language. There was some degree of diversity among the group with three service providers identifying as Latino, one identifying as Middle Eastern, and one as White. Additionally, three of the participants were registered as licensed clinical social workers, while two social work service providers identified as an associate clinical social workers with the California State Board of Behavioral Sciences. Participant names were excluded to maintain their confidentiality.

Theme 1: Socio-Cultural Barriers to Treatment Services

One resounding theme that resulted from the exploration of stigma and its impact on treatment services in this study centered around culture. When participants were asked about their perception of how stigma impacted treatment services, they agreed that culture had a significant influence on the utilization of mental health services. For instance, a majority perceived that patients from specific ethnic heritages experienced challenges accessing and utilizing mental health care services due to stigma. One social worker reported:

> In Afghan culture, it is stigmatizing to see a mental health professional. It's considered weak or crazy. In Middle East culture, it is very difficult to see a mental health professional. I think it is about their culture, family, or upbringing.

Other participants discussed additional perceived challenges among Latin American patients receiving mental health care through the following assertion:

> If they are Hispanic, they have no knowledge of therapy. They may be the first one to access mental health services…culturally they don't feel comfortable with the idea that therapy is going to be a source of help because they don't know anybody prior to them seeking that type of help…working with Hispanics, I feel that there is this negative view that if I go to therapy, "I'm crazy, there is something wrong me with me."

Some participants also acknowledged ongoing acculturation factors impacting treatment services due to a patient's ethnic heritage. One participant noted that when working with Latinos, she often got a sense of concern related to their privacy by saying:

> When working with Hispanics, they would sometimes say, "it is going to show up in the system when they look me up," and I would ask, "what do you mean when they look you up?" My patients believe there is a database where they track all those things. So that's why they didn't want to go to therapy in the first place. I definitely feel that it impacts them and keeps them from getting services.

Other participants also expressed perceived acculturation factors influencing treatment services among Asian-Americans seeking counseling services in her agency through the following statement:

> In regard to families, I think it is culturally sensitive. Asians have a high stigma and are less likely to engage in therapy. With Hispanics, I don't seek it quite as much, because Spanish people have been more involved in our society than older Vietnamese people. I don't know why that is… I know in Asian culture, they have some of the highest stigma, they might hear, you're crazy if you go to counseling or there must be something really wrong with you.

Another socio-cultural factor brought up in the focus group pertained to specific demographics of patients. For instance, one participant reported identified stigma related to the age of their patients by sharing,

> I see stigma with older generations and younger generations. With younger generations, like teenagers. A lot of them definitely have stigma on mental health. I hear some say, "there must be something wrong with me." With older generations they are less likely to receive counseling if they are less educated.

> From my experiences, educated older persons are much more likely to accept services in a clinical setting.

Socio-cultural factors associated with employment also appeared to emerge among providers in discussing stigma and mental health services. Some participants believed these factors also appeared to hinder access and utilization of mental health services, stating,

> I’ve heard that people who seek mental health services in the military are stigmatized. They are seen as "weak" or "crazy," and they are shunned in terms of people that could participate on the battlefield or even in terms of being a fellow brother.

On the topic of socio-cultural factors, another participant added,

> Once they decide to seek treatment, even during the process, oftentimes are no willing to open to talk about their experiences because of fear that other people are going to judge them based on that or that it is going to affect them in another area of their lives. For instance, I have had people say, "I don’t want my employer to know that I am coming to therapy; they might think I am craze or something is wrong with me."

Theme 2: Administrative Barriers to Treatment Services

Participants indicated an assortment of administrative barriers complicating the treatment process or attempts of a patient securing mental health services. Most of the obstacles described appeared to start before services. The following participant described how publicly funded insurances, such as Medi-Cal, sometimes influence treatment services for patients,

> When you hear the word Medi-Cal, what does that entail? What does that mean to social workers? I'm not judging, you know, I'm just identifying the source of where that patient is coming from. So, it is not someone financially stable. I do have patients with better insurance. Did you hear the word I used? When a patient is on Medi-Cal, they are limited to the type of help they can access. Patients feel when they come to a facility accepting Medi-Cal, they are going to receive sub par help, substandard care.

Another participant also pointed out how an agency's policy associated with follow up can negatively influence a patient's desire to remain in treatment

> I know that patients don't like that I have half-hour sessions. So, I lose some of them because of that. I have tried to get longer sessions in the past, but the agency will tell me that we want to help as many patients as possible. Also, some patients tell me that they have experienced a limited number of mental health sessions. Patients tell me that they ended their treatment services with another provider due to a cap on therapy sessions.

Others pointed out how socio-economics and poverty play a part among patients facing or dealing with stigma by stating the following:

> I think it goes back to income, or the idea that they are low-income, they come from poor backgrounds. Even if some of those things might be true, I feel that they are stigmatized. They feel they have more problems or that there is

> something wrong with them. I feel that patients are aware of this and don’t seek services in general.

One group member also identified the act of registering or screening for mental health service as a stressor for some patients, ultimately impacting their willingness to remain in treatment:

> Another stigma is paperwork. This morning someone came into, and they were so anxious they were not able to fill out the paperwork. There’s a ton of paperwork they have to fill out. No one communicated to them that they had to bring proof of address, proof of income, and all that stuff. Number two, they have to bring a bunch of documentation. Sometimes they are not told to bring in all the documentation, and when they get here, they're too anxious to fill out the paperwork. Patients are told they cannot have an appointment until they fill out all the forms, so there are patients who cancel their appointments because of all the paperwork. They almost feel judged.

Other participants noted additional administrative barriers associated with reimbursement rates and restrictive billing policy and methods complicating treatment services for stigmatized patients, leading to disruptions in care by reporting the following:

> I think one of the challenges is with the amount paid. You know, when you distinguish it from the amount that is paid to private insurances, Medi-Cal is always on the bottom…there are not enough providers. A lot of people we serve stop seeing their therapists because their provider stopped accepting Medi-Cal, so

> they come to us. It is very stigmatizing or marginalizing because someone they had seen for years and years all of a sudden cannot take them anymore.

Theme 3: Stigma Reduction Strategies

Participants reported an assortment of stigma reduction strategies when asked about strategies to reduce or address stigma in clinical settings. Interestingly, most of the methods mentioned occurred on an individual level as opposed to an organization level. Participants pointed out and emphasized their respective health care organizations did very little to address stigma and empower them in dealing with stigma occurring in the patient population.

> Concerning reducing stigma, I am sorry to say "no". I think people are trying to be more receptive to patients. As far as our medical staff, I don’t know a whole lot. I think there are some that are trying to reduce stigma.

Another participant pointed out the lack of congruency in their agency’s mission and level of service on the ground with patients with the following comment:

> You know that they talk about it in their mission statement, but I do not believe that they do something like that. I think we do have culturally sensitive providers, and I think a lot of our providers are culturally sensitive, but in all honesty, I don’t think they do enough.

During the focus group, participants were active in describing an assortment of strategies used with patients experiencing or impacted by stigma. The strategies discussed were grouped into five different categories: validation, psychoeducation, identification of stigma, empathy, and patient-empowerment.

Validation. Participants reported validation as a tool to address stigma in clinical settings with patients. Participants reported the following:

> I let them know I take their issue seriously. That is not something like you know that before their parents or family didn’t take it seriously, but I take it seriously. I ask patients how they feel about stigma. I will say, "how do you feel about it?" I would also ask about their support from their friends. Do their friends support them in what they are doing? If not, let’s discuss about it… I start with where the patient is, listening and telling me why they are here. I think that validating their fears and concerns are important and what their viewpoints or opinions about therapy are.

Psychoeducation. Psychoeducation was another tool providers mentioned throughout the focus group. The following statements summarized their efforts in reducing stigma by providing information provided to patients:

> When they come in with a stigma, you try to educate the patient. I fell it helps them to see that their beliefs are based on a stigma or a social construct around mental health…I educate them on the process that we are about to enter. Educating them on steps, they are going to take.

Identification. One participant noted identification was another means used to reduce stigma with the patients experiencing stigma by saying,

> I think the first thing in reducing stigma is to call it out. I will often say to a patient, "is your family supportive of you coming here today?" and if they’re not, we will talk about why. Identification is very important to bring it out to the light.

> Just like discrimination, stigma has a lot in common. A lot of times, people take them for granted until they are brought out into daylight, and we talk about them. So that would be number one, identification.

Empathy. At least several participants reported using empathy as a method in buffering against stigma in clinical settings. They remarked:

> I let them know that they can share what they need with me, and I'm open to hearing about it. I empathize with them. I meet them where they are at…So starting with the patient, I ask, "Why did you allow yourself to come to this session?" I think that if I listen to the patient, what she/he tells me in the first session, it heightens the possibility of that patient returning…I start where the patient is, listening and hearing them tell me why they are here.

Patient-empowerment. Another effective strategy in addressing stigma included patient-empowerment. Participants reported that supporting their patients through the identification of strengths and avoiding labels helped reduce stigma.

> I identify a specific skill set that I can teach them. Many times, patients already have skills, but they do not know that they are already doing them. So, a young man experiencing a lot of anxiety or insomnia might tell me he works out. I will follow up with, "Wow! That is a great coping skill, working out". It appears no one has ever told him that working out can be a great source of help physiologically to the brain. Just having that knowledge and tell them that they are already doing something to help themselves is huge.

> I try not to box them into any category, like the DSM. I try not to say, "all patients are this diagnosis" or should receive a specific treatment. Also, based on their religious preferences or their cultural preferences, I meet them with those things too. For example, if they are very spiritually based, then I will ask them about spirituality, but I won't ask about spirituality if they don't want to hear about God.

Unexpected Findings

There were several unexpected findings from this study. First, participants in this study were able to identify various stigmas and factors influencing stigmas. However, many of them failed to identify how their own beliefs may influence factors surrounding stigma. Only one of the participants in this study commented on how negative stereotypes regarding patients with publicly funded services may lead to substandard care. This is important as the literature suggests awareness within one's own beliefs or stereotypes is vital toward understanding, identifying, and combating the impact of stigma between health care professionals and patients (Goodman et al., 2017; NASW, 2015; Rao, 2015).

Another unexpected finding in this study included the disconnect between policy and practice concerning stigma. For example, there are many national, state, and local attempts in reducing stigma through psychoeducation and training for health care professionals (AHRQ, 2014; DMHC, 2009; CMHSA, n.d.). However, all the participants failed to report that their respective agencies attempted to integrate this knowledge into their clinical practice and interactions with patients. They emphasized little support from their administration to equip them with tools to address stigma. Many seemed to identify a sense of loss in conjunction with training or education related to stigma. This is significant, provided that policymakers in the United States have recognized stigma as one of the most significant barriers to utilization and access to mental health services (AHRQ 2013a; DHHS, 1999; NCLR, 2016; WHO, 2018).

Lastly, when describing stigma, participants appeared to associate or identify it with racial constructs. For example, when discussing stigma, participants described most of their experiences on stigma when working directly with patients from specific ethnic heritages such as Latin American, Asian, and Middle Eastern backgrounds. The literature suggests that no group is immune to stigma (Corrigan, 2004; Hatzenbeuehler et al., 2013). However, it appears that individual patients from historically oppressed backgrounds may find it harder to break stereotypes surrounding stigma as service providers may associate stigma with race or ethnicity (Becerra et al., 2015; Saechao et al., 2012; Spencer & Grace, 2016).

Summary

The research questions in this action research focused on exploring social work service provider's perceptions of stigma and its impact on mental health treatment services among Medi-Cal patients. Social work participants described their interactions and experiences, providing mental health services to patients in their respective integrated health care organizations. Participants indicated that patients experiencing stigma often face socio-cultural barriers to treatment. These barriers were mainly described in terms of culture, ethnic heritage, age, and employment. Participants also identified various administrative barriers impacting treatment services when discussing stigma. For example, most participants attributed the limited number of sessions, reduced face-to-face opportunities with patients, and patient registration processes due to institutional stigma forms. Additionally, providers perceived a lack of support from their health care agencies relating to stigma and stigma reduction strategies. All of the participants in this study were able to identify an assortment of stigma reduction strategies to buffer against stigma. These strategies were described as validation, psychoeducation, identification of stigma, empathy, and patient-empowerment.

In the next session, I discuss how the findings from this study may be applied to professional practices. Furthermore, I discuss how identifying stigma and increasing the understanding between the relationship between stigma and mental health services among stigmatized groups may contribute to social change.

Section 4: Application to Professional Practice and Implications for Social Change

Introduction

The purpose of the study was to explore perceptions of social work service providers regarding stigma and its impact on mental health services among Medi-Cal patients. In this qualitative action research study, I used a purposive sample of social workers employed or volunteering in integrated health settings in Southern California. Data were gathered through a single focus group meeting. This approach allowed participants to discuss their perceptions of stigma and the strategies employed to mitigate stigma in clinical environments. Exploring this topic also allowed participants to discuss perceived barriers impacting patients seeking mental health services affected by stigma.

A summary of the significant findings resulted in three major themes: perceived socio-cultural barriers impacting treatment services, administrative barriers affecting treatment services, and stigma reduction strategies to address stigma in clinical settings. The information gathered in this research may help inform social work practice by improving knowledge surrounding stigma and its interaction with utilization and access to mental health services among stigmatized groups. The findings of this study also has implications to inform social work practice by improving patient-centered care practices and policies. Enhancing the patient experience as well as interactions between social work providers and their patients may reduce health disparities through improved treatment outcomes and patient engagement.

One of the most significant findings of this research included an apparent disconnect between policy and procedural practices from the viewpoint of social worker service providers'. For example, some states have implemented guides or strategies to reduce stigma (DMHC, 2009). These plans are often well structured and outline a specific timeline to reduce stigma (Clark et al., 2013). In California, a 10 year plan was established in 2009 to address stigma and discrimination that provided a four step blueprint for addressing stigma within the state through a collaborative approach of advocacy and education between policymakers, employers, and the general public (DMHC, 2009). Yet, as indicated in this study, all the participants reported an absence of training, discussions, and/or meetings on helping patients who may be experiencing stigma in health care settings. These findings may be used to help to identify ways to support social work service providers in the future leading to greater competency and improved treatment outcomes among stigmatized populations. With this in mind, the this section I outline how these findings apply directly to the discipline of social work, used to develop recommendations for social work practice, and can be used to help create positive social change.

Application for Professional Ethics in Social Work Practice

The social work profession has adopted a core set of values known as the NASW (2017) COE. These values act as a guide for social workers to address social problems with consumers. Concerning this study regarding stigma and its impact on mental health services among patients with publicly funded insurances, several connections with values related to service, dignity, and worth of the person and competence appear.

The NASW (2017) COE guides social work practice through improving access and utilization of mental health services among vulnerable populations. The COE also supports healthy interactions among social work service providers and consumers seeking mental health services. Although the current study has specific implications among vulnerable groups affected by stigma, it also has implications for the general population.

The value of service regards helping people in need to address social problems (NASW, 2017). Stigma is one of the most significant social issues existing today, contributing to health disparities among vulnerable groups (WHO, 2017). One of the main questions addressed in this study centered around exploring the impact of stigma on mental health services and the perceived barriers to access and utilization of mental health services. Ultimately, I believe that the continued exploration of the relationship between stigma and mental health services may lead to improved patient-centered care practices and identification of possible barriers associated with organizational policies impacting treatment services.

The values of dignity and worth of the person involve treating individuals in a caring and respectful manner and include being mindful of differences associated with an individual's culture or ethnic heritage (NASW, 2017). When addressing stigma, it is integral social workers avoid compartmentalizing patients or providing services in a one size fits all approach. Respecting the uniqueness of each individual helps enhance the interaction and experiences for those affected by stigma. Additionally, within the NASW (2017) COE framework, competence includes enhancing professional expertise among social work professionals. Social workers desiring to help stigmatized groups are required to build on their knowledge and skills. Regardless of their background, life experiences, or training, each social work professional must continue to develop or grow. This may include competency training or self-inspection to understand how their actions or inactions may impact those served.

Recommendations for Social Work Practice

Based on the findings, I recommend two specific action steps that may help improve treatment outcomes among stigmatized groups seeking mental health services. The first action step is social worker practitioners helping local health care agencies increase their awareness of current literature or resources related to stigma. The second action step is social work practitioners helping to incorporate stigma-related pieces of training or discussions in their respective work environments with the hopes of building competency and knowledge surrounding stigma.

One important take away from this study was a perception of disconnect between social work practitioners and their respective agencies concerning specific training or discussions on stigma. All the participants indicated their health care agencies did not have formal meetings, conferences, or training related to stigma. As a result, there appear to be opportunities for social work practitioners to strengthen policy initiatives within their respective agencies to address and help reduce stigma. For example, there are many resources available on the international, federal, and state levels to empower and equip health care professionals in their work with stigmatized groups (AHRQ, 2014; DMHC, 2009; WHO, 2018). However, many agencies lack knowledge or awareness of these resources available to them at no cost. Social work practitioners may fill this gap by assisting their agencies to become more aware of resources through advocacy.

In California, one resource available to social work practitioners to support local health care agencies is the "California Strategic Plan on Reducing Mental Health Stigma and Discrimination" (DMHC, 2009). This comprehensive, well-detailed plan provides a framework for addressing stigma in various sectors such as business, education, housing, and health care. The plan includes definitions and terminologies related to stigma and how it impacts environmental settings. It also describes the three most common forms of stigma discussed in this research: self-stigma, public stigma, and institutional stigma. This manual may guide health care agencies to improve understanding of how stigma may impact patients and their staff. It may also be used as a psychoeducation source for health care staff to support the second action step regarding advocacy for specific staff training centered on stigma. Social work practitioners may support integrating knowledge and resources from academic-and research-based platforms in their respective health agencies to bridge the gap between policy and practice.

A second way social work practitioners may support positive social change is through assisting with training on stigma in their health care workplace environments. Because social workers are the largest group of mental health providers in the United States, they appear best suited for training on stigma in health care workplace environments (see Heisler, 2018). Their increased interactions with vulnerable populations and rich history of serving disenfranchised groups provide the foundation needed to support dialogue and credibility. To this end, social workers may help in assisting with training on stigma in their workplace to support more substantial treatment outcomes, best practices, and work to reduce disparities.

Conducting this study has helped improve my understanding and awareness of stigma in mental health services. For example, before this study, my knowledge surrounding stigma was limited. My direct experience was derived from lived experiences as a male, Latino (i.e., Mexican American and Puerto Rican ethnic heritages), military veteran, and survivor of complex trauma. These experiences allowed some insight into the challenges of obtaining treatment services due to stigma but limited my understanding of its impact beyond the initial engagement with health care professionals or entities. This study has granted me more insight into the complexities of stigma and how it manifests within a clinical context.

Stigma continues to be a difficult variable to grasp due to its influence on the individual and their environment. No person or entity can avoid being impacted by stigma, and awareness is key to addressing stigma in health care settings. With this in mind, I hope to increase the awareness of stigma in clinical environments through psychoeducation to help health care professionals identify how biases and stereotypes shape patient interaction and treatment. Honest dialogue and discourse are needed to address possible stigma with health care providers. Additionally, an examination of policy and procedures is required to improve access to care and services to improve treatment outcomes among stigmatized groups in mental health settings.

Transferability

The transferability of this qualitative study is limited due to the number of participants and data retrieval from a specific geographic locality. For example, this action research had five social work service providers employed within a specific region of Southern California. Although the participants came from integrated health care settings known as FQHCs, their views cannot be assumed to represent the vast majority of social worker service providers in this general area. Thus, the limited number of participants and specific geographic locations where data were gathered does not represent other social workers employed in integrated health care settings across the region, state, or nation. To this end, transferability is best determined by the reader after consideration of the depth of information provided about the research process, the participants, and their connection to the literature. Even with a small sample, the application of this data may be useful for other health care settings where mental health services are offered within the continuum of care.

Usefulness of the Findings

There were various findings from this study that help to better understand how stigma interacts with mental health services in integrated health facilities and their direct impact on patient care. First, this study provides evidence for the ongoing need to bridge policy and practice on the subject of stigma and mental health services. For instance, all participants noted an absence of training or discussions regarding stigma and reduction strategies to address stigma in their respective health care agencies. Furthermore, all participants reported their agencies failed to address stigma in appropriate ways to support treatment outcomes. As a result, the results of this study speak to the importance of integrating current stigma related resources in outpatient mental health or integrated health care settings to support competency, service delivery, and policy initiatives to reduce stigma.

This study also provided insight into barriers associated with institutional stigma among those attempting to secure mental health services. For example, several providers in this study perceived different ways their agencies contributed to stigma through layered administrative procedures associated with the initial registration paperwork for mental health services. Providers mentioned the completion of paperwork, at times, confused and burdened patients dealing with stigma. They indicated forms associated with financial records, housing, and other sensitive documentation related to patient identity contributed to stressful and unproductive encounters or interactions with patients. The findings of Becerra et al. (2015) were confirmed by the responses of social work service providers in the current study. Becerra et al. who examined the experiences of Latinos who lacked linguistic acculturation in health care settings, found patients reported challenges in securing health care services due to filling out health-related forms and experienced difficulty in understanding written information provided to them. Patients in their study reported feeling a sense of discrimination and rated their health care services as substandard. As a result, integrated health care facilities, serving populations impacted by stigma, may benefit from a process evaluation from the intake to discharge to understand how administrative procedures impact a patient's experience. It would also help if agencies incorporated surveys or questionnaires, with a specific question related to stigma, to inform administrators of ways to improve the access and utilization of services.

Another take away from this study includes the ongoing challenge of supporting patient-centered care standards with organizational sustainability. For example, several participants expressed concern about patient-centered care standards due to patient scheduling upon the initial encounter with patients. One participant reported their follow-up counseling appointment often led to delays in treatment services, which they felt negatively impacted stigmatized groups' health care services. Another provider noted that organizational and policy initiatives were counterproductive to providing quality health care service for patients affected by stigma. The participant noted pressure to meet all community members' needs through an open caseload format, which limited their ability to provide consistency of mental health follow-up appointments after the initial meeting with a patient. Several participants blamed delays in regular follow-up appointments due to the sustainability measures employed by their agencies. Participants indicated they perceived these practices as detrimental to patients' overall health and well-being. To this end, organizations may benefit from examining how sustainability measures impact care among stigmatized groups.

Limitation of the Findings

Several limitations were associated with this study. First, the sample size for this research was small and lacked diversity in gender and ethnic background of social work providers. A more diverse sample may have given the study additional insights on the issues of stigma and outcomes associated with mental health services. The small sample size limits the representativeness and generalizability of this study's findings. Additionally, this study received data from one type of health care setting. The receipt of information from a specific health care facility, as opposed to other mental health settings, prevented a full scope of how stigma impacts psychological health services. Lastly, social desirability bias may have affected this study. For example, participants may have offered responses perceived as relevant to the interviewer during the focus group or answered what they think would be a socially acceptable response to patients affected by stigma in a clinical setting.

Recommendations for Future Research

Future recommendations should include the inclusion of expanding the number of social work participants to increase transferability. Future studies should also include social workers from a larger geographical area or include multiple geographic regions. Furthermore, this study obtained all its findings from a single focus group. Future studies should consist of in-depth interviews or additional focus groups to explore factors associated with stigma and how it impacts treatment for those seeking mental health services. Also, the triangulation of findings from other resources would benefit future studies on this research topic. Additional research may consider the use of scales to measure stigma in social work service providers to understand better actions and behaviors associated with stigma in clinical treatment settings.

Dissemination of the Research

This study's findings may be used as a teaching tool to inform social work practitioners and other health care professionals regarding stigma and its impact in clinical settings. The need for ongoing training and discussions is also essential, as indicated by participants in this study. Therefore, I plan on extending knowledge from this research to include in-service training at local health care agencies in my region. By taking information derived from this research regarding stigma and its impact in clinical settings, I hope to bring awareness among health care providers regarding stigma and its interaction with the patient experience. Specifically, I plan on taking portions of this study and placing them in informative handouts or pamphlets. For instance, the stigma reduction strategies identified by social work practitioners provide an excellent platform to inform service providers of skills that may help address stigma in healthy ways leading to improved patient care. Another way to disseminate information produced in this study includes attempting to publish this research in a journal article. The extension of knowledge of this topic is vital to creating lasting social change and equipping social work professionals with information to reducing health disparities contributed by stigma.

Implications for Social Change

This research's findings provided useful information relevant to support practice, policy, and research among social workers and other health care professionals. A critical outcome from this research project included acknowledging inadequate or insufficient training on stigma in health care settings. All participants reported their respective agencies failed to equip or train them on stigma or stigma reduction strategies. It is apparent from the review of available research on stigma; there exists a considerable amount of material related to stigma. For example, in the state of California, a ten year initiative was created to reduce stigma. The manual, created by public health officials, is directly aimed at supporting business, education, and health care sectors and attempts to inform the public about stigma through informative research-based psychoeducation. Resources such as this manual exist to provide support to health care workers and other professionals. However, there is an apparent gap bridging current resources to social work providers in the field.

It is suggested that social workers assist in implementing training centered on stigma with their respective employers. From my viewpoint, social work professionals are competent to provide specialized training on topics surrounding stigma considering their long history of advocacy and action on social change for policies concerning vulnerable groups. One of the main goals for any organized training on stigma includes building awareness among health care professionals to improve service delivery and treatment outcomes. As indicated in this research, various types of stigmas in society influence or interact with each other. Unfortunately, there is a lack of awareness regarding stigma, and it is often the patient who ends up carrying the burden of stigma. Research supports increased awareness of an individual's values, prejudices, and stereotypes promote strengthening patient-centered care practices among providers and the health care experiences for stigmatized groups (Ackerman-Barger & Hummel, 2015; Bailey et al., 2017).

Another suggestion to support shortening the gap between policy and practice includes stigma reduction training for health care professionals. For instance, this research identified an array of stigma reduction strategies social work providers often use in working with patients affected by stigma. Some of these were validation, psychoeducation, identification, empathy, and patient-empowerment. With this in mind, creating handouts or pamphlets with these tools may support health care providers in the field and complement their current skill set. Furthermore, for agencies that find it challenging to organize training for their staff on stigma, this may help support their team toward supporting competency and best practices.

Additionally, it may be helpful to include or mandate training related to stigma. For instance, many state licensing boards require a certain number of continuing education units for license renewal on various subjects related to their field of study. There is no mandate in California within the Board of Behavioral Sciences for social workers to take continuing education courses on stigma. However, stigma is one of the most significant barriers to utilizing mental health services in the United States and the world. To this end, it may benefit legislators or policymakers to mandate continuing education courses centered on stigma to improve competency, service, utilization of services, access, and care.

In the area of research, it is vital to support ongoing research studying stigma and its impact on mental health services. It has been over 20 years since the U.S. surgeon general identified stigma as the most substantial barrier to access and utilization of mental health services. Research also supports that stigma is a crucial contributor to health disparities in the United States (AHRQ 2013a; DHHS, 1999; SAMHSA, 2015). There is a vast amount of information on stigma from the patient's perspective in the academic literature. It appears that additional research from health care providers also needs to take place in the future to identify how stigma impacts the delivery of services from beginning to end. Research suggests health care providers are influential in patient disclosure and coordination of care due to factors affected by stigma (Clochesy et al., 2015; Farotimi et al., 2015; Goodman et al., 2017; Malat et al., 2010). Thus, health care providers provide unique perspectives of knowledge related to uncovering how stigma interacts and impacts treatment services and improving treatment outcomes concerning stigma and mental health topics.

Summary

Stigma continues to act as a nuisance, deterrent, hindrance, and barrier towards access and utilization of mental health services in the United States. It is also one of the main contributors to health disparities among vulnerable groups (AHRQ, 2013a; Corrigan, 2004; Wong et al., 2015). This action research explored stigma and mental health treatment services from the perspective of social work service providers. The participants in this study discussed ways they address stigma in clinical settings and identified various barriers impacting treatment services among stigmatized patients.

Evidence from this action research indicates a growing need to bridge policy and practice to improve health care services among stigmatized groups seeking mental health services. Participants in this study reported more than 30 years of combined experience providing mental health services to underserved populations in integrated health care facilities. However, none of the participants reported active efforts by their respective health care agencies to incorporate training or discussions related to stigma. As a result, there exist opportunities to create systemic change in health care organizations by combining purposeful training associated with stigma. An intentional approach to dialogue and psychoeducation among service providers is vital for improving service delivery and treatment outcomes. Increasing service providers' awareness and insight regarding stigma are crucial to improving patient experiences and mental health services. Social workers, the largest mental health service provider in the United States (Heisler, 2018), appear best suited to address training for staff and health care workers based on their involvement and history of working with vulnerable populations due to their emphasis on social justice, valuing human relationships, and improving service and developing competency among their professional workforce (NASW, 2017).

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