6-1-2015

Mind the Gap: The Integration of Physical and Mental Healthcare in Federally Qualified Health Centers

Karen R. Monaghan
University of Massachusetts Boston

Recommended Citation

Monaghan, Karen R., "Mind the Gap: The Integration of Physical and Mental Healthcare in Federally Qualified Health Centers" (2015). *Graduate Doctoral Dissertations.* Paper 213.

MIND THE GAP: THE INTEGRATION OF PHYSICAL AND MENTAL HEALTHCARE IN FEDERALLY QUALIFIED HEALTH CENTERS.

A Dissertation Presented

by

KAREN R. MONAGHAN

Submitted to the Office of Graduate Studies,
University of Massachusetts Boston,
in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

June 2015

Public Policy Ph.D. Program

MIND THE GAP: THE INTEGRATION OF PHYSICAL AND MENTAL HEALTHCARE IN FEDERALLY QUALIFIED HEALTH CENTERS.

A Dissertation Presented

by

KAREN R. MONAGHAN

Approved as to style and content by:

Donna Haig Friedman, Ph.D., Senior Research Fellow, Center for Social Policy
Chairperson of Committee

Amy E. Smith, Assistant Professor
Member

Edward A. Miller, Associate Professor
Member

Christopher R. Larrison, Associate Professor, University of Illinois
Member

Christine Brenner, Program Director
Public Policy Ph.D. Program

Christine Brenner, Chairperson, Department of
Public Policy and Public Affairs

ABSTRACT

MIND THE GAP: THE INTEGRATION OF PHYSICAL AND MENTAL HEALTHCARE IN FEDERALLY QUALIFIED HEALTH CENTERS.

June 2015

Karen R. Monaghan, B.A., University of Stirling, Scotland
M.SW., University of Ulster, Northern Ireland
M.S., University of Massachusetts Boston
Ph.D., University of Massachusetts Boston

Directed by Donna Haig Friedman, Ph.D.

In the United States, approximately 50 percent of people experience mental illness during their lifetimes (Cunningham, 2009). However, previous studies estimate that up to 80 percent of people living with a mental illness do not access services (Mackenzie et al., 2007). While there are numerous explanations for such disparity, this study posited that stigma associated with mental illness is a significant contributory factor.

In an attempt to address the gap between prevalence of mental illness and access to services, the Patient Protection and Affordable Care Act (PPACA), 2010 (US Government Printing Office, (a) 2011) mandated that Federally Qualified Health Centers (FQHCs) integrate physical and mental healthcare. This research employed case study methods to examine the implementation of this federal policy in FQHCs, focusing on what role, if any, stigma plays in such implementation. Analyzing data obtained from in-depth interviews and direct observations at two case study sites, as well as key informant interviews, and background information, this research explores the following questions: Does stigma impact the implementation of mental health policy and affect access to treatment in FQHCs for people living with mental illness? And, if stigma does impact mental health policy implementation and access to mental healthcare in FQHCs, how does this occur?

Study findings include: multiple definitions of and approaches for integrating physical and mental healthcare; mental healthcare being subsumed into, rather than integrated with, the medical model; and institutional stigma persisting in the agencies studied, resulting in the reinforcement of exclusionary policies and practices and limited access to mental healthcare for FQHC patients.

Empirical findings inform a new theoretical framework that identifies the role of institutional stigma in mental health policy development and implementation in FQHCs. Policy recommendations include: the adoption of non-stigmatizing practices in FQHCs; the inclusion of a single clear definition of integration within enabling legislation; restructuring of mental healthcare funding streams to facilitate agencies’ access to resources; and federally mandated reporting of mental health outcomes to improve FQHC accountability. These recommendations aim to promote the equitable implementation of integration policy within FQHCs and increase access to mental healthcare for those persons in need.

ACKNOWLEDGMENTS

Attaining a Ph.D. has been a long held goal of mine, and there are many people to whom I owe a debt of gratitude in completing this dissertation. First, a huge thank you to my committee, I feel very grateful to have been surrounded by such a group and could not have hoped for a better committee. To Donna Haig Friedman, the chair of my committee: Donna, your tireless advice, mentorship, support, and encouragement through many versions of this dissertation are very much appreciated. I am very fortunate to have had you on this journey with me. Your guidance and expertise have greatly contributed to me being able to conduct the research that I have been interested in for many years, and for that I am beyond grateful. Many thanks are also due to Amy Smith, Eddie Miller, and Chris Larrison for serving on my committee. Your thoughtful insight, feedback, advice and your commitment to my success in this endeavor have been hugely beneficial and are very much appreciated.

I would like to thank Monica, my fellow student and study partner of the past year, for her support, encouragement, and friendship. I am very glad that we were able to travel this road together. To our fellow students from the cohort of 2009 -- Carolyn, Diana, Michael, and Rachel -- I am so appreciative of all that you brought to our classes and to our friendships outside of the classroom. Your support, encouragement, and alternative views of the world have been a large part of my successful completion of the program.

I am grateful to the faculty and staff of the Public Policy program, and I also extend many thanks to everyone at the Center for Social Policy at UMass Boston. It was

at CSP that I found my research home. Thank you for providing such a space and for being such inspiring role models and supportive colleagues.

Of course, I would not have been able to conduct the research that led to this dissertation without the individuals who participated in the study. Many thanks go to the respondents at both case study sites and to the key informants. Your candor, willingness to share your experiences, and trust in the research process and in me, made this project possible.

Thank you to my extended family and friends who whole-heartedly supported me in my endeavor to obtain my Ph.D. Furthermore, you understood when I disappeared into academia; thank you for still being here as I emerge on the other side. Thank you to my parents, and to my brother and his family who always believed that I would reach my goal, and who are always proud of me, whatever I do.

Finally, and most importantly, I cannot completely convey how grateful I am to my husband, Darrell Morrow. I could not have completed my Ph.D. without you. You have been my constant support, encouraging me when I've been overwhelmed and you have such a clear understanding of why this work is important. Thank you for all the sacrifices you have made for me, and for your commitment to my success. You are truly remarkable. I love you.

TABLE OF CONTENTS

CHAPTER

RESEARCH FINDINGS

DISCUSSION

CHAPTER

APPENDIX

LIST OF FIGURES

LIST OF TABLES

CHAPTER 1

INTRODUCTION

In the early 2000s, I worked as a practitioner in a community mental health team in a United Kingdom-based health center. The center provided many social services and had a policy of providing appropriate care to all clients. At the center, the community mental health team, comprised of psychiatric nurses and clinical social workers, provided mental healthcare and services to individuals living with mental illness who required support. However, one of the first directions my supervisor gave me was not to see any clients with a personality disorder because “they don’t want to get better and it’s a waste of time and money,” thus suggesting bias in determining who received mental health services. During my employment there, no one with a personality disorder asked for services so I did not have to directly address this directive. However, I did work with one client, referred to herein as Mary,[1] whose situation raised many concerns. Mary was an elderly woman who lived in poverty and squalor in a one-bedroom trailer with her elderly husband, adult son, and seven dogs.

Mary had been a long time client of the agency after receiving a diagnosis of schizophrenia approximately 40 years prior. However, she was not taking medication, had not been receiving therapy or many other services, and had never been reassessed.

---

[1] Name has been changed

Mary was often non-compliant with care plans and was considered to be difficult. After working with Mary, I determined that she did not have a psychotic illness; rather she had depression associated with numerous social problems and difficulty in attending to her own personal care. My impression was that she had been placed with the mental health team, rather than the elder services team, to get her out of the way, as little attention was paid to clients of the mental health team, compared to other teams in the health center. I believed that she would receive more appropriate care which would enable her to remain safely in her own home, if she were to be transferred to elder services, which was better funded and supported than mental health.

I discussed Mary's case with my supervisor but he was reluctant to transfer Mary to elder services for several reasons. First, he believed that she did have schizophrenia although he had not seen or assessed her, perhaps signaling the staying power of a diagnosis of mental illness, even if applied erroneously or no longer relevant. Second, he experienced pressure from his superiors, that is, agency leaders, to keep Mary with the mental health team. This strategy had greater financial benefit to the agency, as the mental health services Mary received were cheaper than those she could access through the elder services program. I was advised by my supervisor not to rock the boat, to ignore my concerns and to maintain Mary as a client.

I strongly advocated for Mary to be moved to elder services and my supervisor finally agreed to meet with agency leaders and me to discuss the case. In the meeting, the rationale agency leaders offered for Mary having schizophrenia did not meet psychiatric diagnostic criteria. Rather, it was apparent that she was an older woman, who was perceived as difficult, with needs for services that would be more expensive to provide in the elder services program. After a lot of resistance from both my supervisor and his superiors, Mary was finally transferred to the elder services program.

This case provides a clear example of how, even if programming and service delivery policy is designed with the best of intentions, outcomes are strongly influenced by the attitudes of implementers. The agency leaders did not want to transfer Mary to a more suitable program, that is, from mental health services to elder services, even though she did not meet the criteria of having a serious mental illness and rather had situational depression that could have been addressed by resources available within the elder services team. This opposition to transferring Mary was contrary to agency policy to provide appropriate care to all clients. In sum, agency leaders made assumptions about Mary's mental health and her capacity and competence. The reasons for not wanting to transfer Mary were numerous: care in the elder services program was more expensive for the agency; Mary's case was complex, and if her needs were not met this gap in service provision could be more easily hidden in the mental health department; finally, agency leaders did not want to admit that mistakes had been made in providing care to Mary over many years.

My supervisor was under pressure from both his superiors and from me as the clinician. He had made assumptions about Mary's mental health and, as aforementioned, had already shared with me his opinions about the curability and treatability of certain mental illnesses. He was implementing the health center's policy in a way that allocated resources to those areas he felt were most deserving and he was, in actuality, creating policy by limiting which clients could be seen by the mental health team. However, once I had made him aware of my concerns, he did accept that Mary should be moved to the elder services program, although the considerable pressure he felt from his supervisors and the complexity of Mary's living situation made him reluctant to get involved.

In my capacity as a practitioner, I subverted agency policy by determining that Mary was not mentally ill and by not providing mental health services to her as instructed. I also rejected my supervisor's practice of not questioning the appropriateness of service provision and his attitudes about who deserves to receive mental healthcare. Rather, I strongly advocated for Mary to be transferred to the elder services team, as I believed that this was the most appropriate venue for her to receive services.

Dissertation Overview

Mary's experience and this example of policy creation and interpretation are neither unique nor solely a UK problem. Rather, they highlight some of the components that impact policy implementation and outcomes in the broader mental health arena. Indeed, achieving successful implementation of mental health policy has long been a challenge in the US. The intent of policy is often different from actual practice because of decisions made during the implementation process. This reality is relevant at the federal, state, local and organizational levels of policymaking and implementation as the policy decisions and behaviors of all pertinent actors impact outcomes (Laumann & Knoke, 1987; Peters & Pierre, 2003). Policy is also influenced by public opinion (McSween, 2002), thus misperceptions and stereotyping of mental illness may have serious consequences for developing and implementing policies that meet the prevailing need for mental healthcare.

Problems exist in many policy arenas including in the development of effective and appropriate policy, in the implementation of policy, and in achieving desired outcomes. This study focused on the process of policy implementation and evolution. In particular, it focused on the Patient Protection and Affordable Care Act (PPACA, 2010) mandate for Federally Qualified Health Centers (FQHCs) to integrate physical and mental healthcare to improve patient access to mental healthcare in these centers.

I believe that access to mental health treatment is a significant area of concern, as a well-documented disparity persists between the numbers of people who are living with a mental illness and those who actually access and comply with treatment (Palpant et al., 2006; Corrigan & Shapiro, 2010). More than 26% of the US population is diagnosed with a mental illness or disorder every year, (Palpant et al., 2006), but only 33% of those individuals receive care (Cunningham, 2009). Indeed, in 2007, 24.3 million adults experienced serious psychological distress, and 16.5 million adults had a major depressive episode; 30.4 million adults will have at least one major depressive episode in their lifetime (Agency for Healthcare Research and Quality, 2013). Certainly, mental healthcare receives less government support and funding than physical healthcare. The prevalence rate of mental illness is not reflected in spending as, in 2010, per capita spending on mental healthcare by state ranged from $38.38 to $388.83; spending on mental healthcare as a percentage of total health (i.e., physical and mental healthcare) spending ranged from 0.61% to 5.52% (Kaiser Family Foundation, December 2011).

Access to mental healthcare is an increasingly relevant and important issue because there is consistent growth in the number of people diagnosed with a mental illness (Cunningham, 2009; Roy-Byrne et al., 2009), but service utilization remains low.

Such disparity matters for social justice reasons because limited access to mental healthcare has significant impact on overall health and life expectancy (Ingoglia and Roth, 2012). Indeed, it is well documented that people living with serious mental illnesses die, on average, 25 years younger than the general population (Manderscheid, 2006; Alexander & Wilson, 2010; Miller & Prewitt, 2012; Woltmann et al., 2012). Prior research indicates that a significant reason for the funding disparity between physical and mental health is stigma (Athos & Coffey, 1968; McSween, 2002; Frank & Glied, 2006; Hinshaw & Stier, 2008). Furthermore, extant research suggests that stigma is an underlying influence when decisions are made about the allocation of resources across treatment programs (Rack, 1982; McSween, 2002; Robichau & Lynn, 2009).

While acknowledging that there are numerous considerations that explain why so many people living with mental illness do not access treatment, this study posits that, as with decisions about funding and resource allocation, stigma is a major contributor to this problem. This role of stigma is of concern because its role in impeding treatment could mean "the difference between hope and despair, struggle and recovery and even life and death" (National Alliance for the Mentally Ill, Massachusetts, 2004, p. 2). However, little is known about the function of stigma as it interacts with the implementation process, its impact on practices of integrating physical and mental healthcare or its effect on mental health outcomes. Thus the central research questions that this study seeks to answer are: *Does stigma impact the implementation of mental health policy and affect access to treatment in community health settings for people living with mental illness? And, if stigma does impact the implementation of mental health policy and access and treatment, how does this occur?* In focusing on these two main questions, my study contributes to existing literature by developing an understanding of the interaction between stigma and the implementation of physical and mental healthcare integration policy (hereafter referred to as integration policy or practice) and contributes to practice by identifying agency practices that both facilitate and create barriers to the successful integration of physical and mental healthcare.

Influences on Policy Challenges

The development of US mental health policy demonstrates a shift over time from the asylums and isolation of the eighteenth century to the large inpatient psychiatric facilities of the nineteenth century to care in the community, first proposed in the mid-twentieth century (Corey et al., 2003; Corrigan, 2006). However, given that policies of deinstitutionalization in the 1960s did not adequately plan or provide for the provision of care in the community, a major unanticipated outcome has been an increase in homelessness and incarceration among the mentally ill population (Slate & Johnson, 2008). The problems of deinstitutionalization in the US were compounded by welfare cuts in the 1980s, which in turn led to a further rise in homelessness and neglect of the mentally ill (Mechanic & Rochefort, 1990). Many behaviors, such as homelessness, were criminalized under legislation such as the "zero-tolerance" policy in New York City introduced by Mayor Giuliani in the mid-1990s (Greene, 1999). This policy focused on quality of life issues and targeted "squeegee men…the petty drug dealers, the graffiti scribblers, and the prostitutes" (Greene, 1999, p.172). This zero-tolerance policy resulted in automatic punishment for behaviors, regardless of extenuating circumstances, and prosecution of individuals for even minor offences. The passing of such legislation and the provision of inadequate community supports suggested that the delivery of adequate mental healthcare was low on the policy agenda; as a consequence, access to mental healthcare became increasingly challenging for many people living with mental illness (Slate and Johnson, 2008: Cohen and Galea, 2011; Centers for Disease Control, 2012).

Policy Implementation Challenges

One explanation for the disconnect between prevalence and treatment in mental healthcare is that both policy and implementation may be influenced by public opinion (McSween, 2002), which is often negative about mental illness (Rack, 1982; Robichau & Lynn, 2009). While explicit biases have declined since the 1960s, implicit biases and stereotyping persist (Christensen et al., 2012). Corrigan and Shapiro, (2010) argue that the stereotyping of mental illness leads to prejudice which results in stigma and discrimination. As a result, the mentally ill can be seen by the public as somehow incompetent or not full persons, which is important as it can mean that inadequate and inappropriate services may be developed (Corrigan, 2007). Moreover, stigma, with adverse implications for access, has the potential to limit life expectancy and life opportunities and increase social isolation of people living with mental illness (Landsberg & Smiley, 2001; Corrigan, 2006; Colton & Manderscheid, 2006; Slate & Johnson, 2008; Smaldone & Cullen-Drill, 2010).

There are many complicating issues in implementing mental health policy and facilitating access to mental healthcare; attitudes of agency staff are important to consider in this regard. Mary's experience, as previously described, is certainly not an isolated one; agency workers at all levels implement mental health policy in ways that are influenced by their own attitudes, opinions, and biases about mental illness and about the clients they serve (Corrigan, 2007; Durant, 2010) as well as by organizational pressures and expectations. How attitudes impact staff behaviors is significant because mental health policy has many important implications, both in terms of promoting health and in influencing people's sense of belonging and ability to be contributing members of society (Link & Phelan, 2001).

Theories of organizational behavior and street level bureaucracy offer an explanation as to why practices often do not reflect the official intent of policy. Proponents of these theories note that context matters, that is, how a policy becomes practice is not consistent across agencies or groups (Lundin, 2007). Inconsistency in policy application may be evidenced in agency workers' decisions about service provision, which can have significant influence over the outcomes of people's lives. The decision-making process takes place within a context of constrained budgets and scarce resources (Lipsky, 1980), which may result in inadequate or inappropriate service provision. Furthermore, public opinion that is negative about mental illness may be reflected in the decisions of agency administrators, managers, and practitioners, or street level bureaucrats, who provide treatment (Lipsky, 1980; McSween, 2002). Decisions influenced by workers' own perceptions of mental illness, reflecting a range of public opinions on mental illness (Lipsky, 1980; McSween, 2002; Burris, 2006), may result in more positive or negative outcomes for people living with such illness, depending on the views of the implementer.

While practitioners implement policy that is developed at a higher agency level by managers and agency leaders, as well as by federal, state, and local officials, it is important to note that those who implement policy also influence its development. Street level decisions are referred to as policy because practitioners actualize policy by delivering services (Lipsky, 1980; Maynard-Moody & Musheno, 2003), although it remains differentiated from official policy as each individual practitioner has the capacity to develop policy in this unregulated way. Staff biases and stigmatizing beliefs, coupled with limited resources and time constraints can result in the delivery of inconsistent and subpar services (Meyers & Vorsanger, 2003).

While acknowledging the numerous mental health policy arenas and multiple influences that contribute to the disparity between prevalence of mental illness and access to treatment, this research focused on the role of stigma in the implementation of a specific federal policy (PPACA, 2010). In particular, as aforementioned, the aim of this study was to uncover what role, if any, stigma plays in the implementation of policy on the integration of physical and mental healthcare in FQHCs, and the subsequent impact such implementation has on access to mental healthcare and treatment outcomes.

Dissertation Structure

This dissertation is comprised as follows. Chapter 2 provides background on mental health policy in the US and definitions of mental illness and stigma. Chapter 2 also examines the evolution of mental health policy to present day, and discusses how policies have been translated into practice. It further discusses the development of CHCs and FQHCs in the US. Chapter 3 is a review of pertinent theoretical, practice-based and empirical research literature on public perceptions of mental health, mental illness, stigma, and organizational behavior. The conceptual framework is outlined in Chapter 4, the research questions and working assumptions are found in Chapter 5, and the methodology is discussed in 6. Chapters 7 and 8 contain the research findings, while an analysis of the findings and the development of a new model of implementation is found in Chapter 9. A discussion of policy recommendations, and the significance of the research and its contribution to the literature to address gaps in knowledge related to how stigma influences mental health policy implementation, are found in Chapter 10.

CHAPTER 2

BACKGROUND

This chapter describes the development of mental health policy in the US and provides important definitions of mental illness and stigma. This chapter examines how mental health policy has evolved from practices of institutionalization to the community-based practices of the present day. It provides a discussion of how mental health policies have been implemented and become practice in the US. A summary of pertinent elements of the development of Community Health Centers and Federally Qualified Health Centers in the US is also provided.

Definitions

As previously noted, there are numerous mental health policies at the federal, state, and local level. This research focused on what role, if any, stigma plays in the implementation of the PPACA-mandated integration policy by FQHCs. As a first step in understanding the dynamics relating to stigma and mental illness, one requires a clear understanding of how these concepts are defined. A broadly accepted definition of mental illness is that it is “an organic, mental or emotional disorder which substantially impairs the person’s thought perception or reality, emotional process, judgment, behavior or ability to cope with the ordinary demands of life” (Hermann, 1997, p.76). Comprehensive definitions of what constitutes a mental illness are found in the Diagnostic and Statistical Manual or DSM (American Psychiatric Association. 2000).

The term stigma derives from the ancient Greek word for tattoo or brand. Slaves and criminals were burned or cut to identify them as “less valued members of society” (Arboleda-Flórez & Sartorius, 2008, p. x). Goffman (1984) provides arguably the most definitive explanation of the modern notion of stigma as “the situation of the individual who is disqualified from full social acceptance” (Goffman, 1984, p. 9), of one who has one or more discrediting attributes that result in a spoiled identity whereby that person “is thus reduced in our minds from being a whole and usual person to a tainted discounted one” (Goffman, 1984, p. 12). This definition of stigma is not just a theoretical construct; it has meaning in everyday society, which works to exclude certain groups from the benefits of full social membership (Link & Phelan, 2001).

Stigma is operationalized in society in numerous ways but this study focused on the role of public stigma and institutional stigma in integration policy implementation. Public stigma refers to the stereotyping, prejudices, and discrimination that the public displays toward people living with mental illness (Corrigan & Shapiro, 2010). Such stigma arises from individual beliefs that then form public opinion. Institutional or structural stigma is the process whereby institutions, informed by individual and public opinion, discriminate against a particular group. Such discrimination may result in outcomes such as partiality in policy and resource allocation, which in turn may limit the life chances of people living with a mental illness, both intentionally and unintentionally (Sirey et al., 2001; Corrigan & Shapiro, 2010; Heflinger & Hinshaw, 2010).

Historical Perceptions of Mental Illness and Service Delivery Prior to 1946

From Roman times through the medieval ages to the eighteenth century, people with mental illnesses were varyingly seen as possessed, evil, bad or, in rare instances, just accepted as part of society. There was no differentiation between illnesses; rather the mentally ill were seen as a homogenous group (Grob, 1994; Arboleda-Flórez & Sartorius, 2008). Asylums were first established in Valencia in 1409 and became popular dumping grounds for all of society's undesirables, more resembling prisons that increased the social exclusion of the mentally ill than care institutions. The number of asylums quickly grew across Europe (Arboleda-Flórez & Sartorius, 2008) and European settlers brought the concept to the US, where this practice of providing for the mentally ill continued until the 1700s.

The opening of the first psychiatric hospitals in the US in the eighteenth century (Minnesota Psychiatric Society, 2011, shifted the focus from asylums to control and containment in a medical setting. At this time, the first differentiations were made between different types of mental illnesses. As a result, specialized treatments and programs were developed and these new differentiations or labels reinforced ideas about who was normal and who was not and thus who was included in and excluded from society (Grob, 1973; Goffman, 1984). The majority of people living with mental illness were generally either ignored or incarcerated and removed from society. Furthermore, if a person was institutionalized, it was generally for life, without rehabilitation or training; exclusion from society was permanent (Mechanic & Rochefort, 1990). In the US, separation and institutionalization remained the dominant means of providing care for people with mental illness for the first half of the twentieth century with emphasis on control and containment in large facilities, rather than cure (Grob, 1991). As the century progressed however, there was a shift from support for large inpatient psychiatric facilities to care in the community.

From 1947 to Present Day

The development of public policy, services, and community based care. From the end of the Second World War to the present day has been a period of great change and upheaval in mental health policy, treatment, and provision of services in the US. In 1930, the U.S. Public Health Service established the Division of Mental Hygiene to combine research and treatment of mental illness (Minnesota Psychiatric Society, 2011). In the late 1930s, Lawrence Kolb, a psychiatrist and the head of the Division of Mental Hygiene, began advocating with Congress for a National Neuropsychiatric Institute modeled on the National Cancer Institute, which had been established in 1937 (Grob, 1991). Other issues, such as knowledge gained about psychological trauma in World War II within the military and in the general population, severe shortages of professional mental health personnel, growing public unease with conditions in psychiatric hospitals, limited understanding of the causes, treatment, and prevention of mental illness and psychiatrists wishing to be seen more as healers than as jailors were also catalysts for change in how mental healthcare was provided (Magaletta et al., 2009; Grob, 2000).

The watershed National Mental Health Act of 1946 was the first piece of federal legislation on mental healthcare, indicating that mental health had finally been placed on the national policy agenda (Grob, 1991). The Act reconceptualized the mental health arena by legislating community-based treatment and services as an alternative to institutionalized care in the form of long-term hospitalization and containment (Grob, 1991; Minnesota Psychiatric Society, 2011). One of the most important developments in mental healthcare and deinstitutionalization was the innovation of psychoactive drugs which theoretically made care in the community achievable. Indeed, while 49% of psychiatric treatment was provided on an inpatient basis in 1955, by 1971 that figure had dropped to 19% (Mechanic & Rochefort, 1990).

The push for deinstitutionalization culminated in the 1963 Community Mental Health Centers Act, which aimed to halve the number of people who were long-term inpatients in psychiatric facilities within twenty years. Provision was made for the shrinkage or closure of many large psychiatric hospitals and for the development of Community Mental Health Centers (CMHCs), although scarce resources and a lack of foresight and planning meant that such provision was inadequate (Mechanic & Rochefort, 1990; Berndt, 2004). Furthermore, deinstitutionalization took place much more rapidly than had been anticipated and greatly outpaced the development of the necessary infrastructure within the community to provide those services. The 1965 Community Mental Health Center Act Amendments attempted to address such rapid change by increasing federal funding and grants to community based centers (Minnesota Psychiatric Society, 2011); resources, however, remained insufficient to meet need.

The growth of federal social welfare programs and budgetary constraints from 1966 to the 2000s. Federal social welfare programs saw considerable growth from 1966 to the late 1970s, including the establishment of Medicare and Medicaid, which reimbursed services for those living with mental illness, dementia or other related illness.

Medicaid paid for the care of people who were moved from psychiatric facilities to nursing homes thus creating an incentive for such moves to take place, since the federal government paid, at a minimum, half of state Medicaid costs (Mechanic & Rochefort, 1990). This shift in setting, however, disregarded where people would receive the most appropriate care. The federal Social Services Block Grant Act of 1975 provided financial aid to states for programs that addressed mental healthcare needs and substance misuse issues. It promoted independence and community based care for this population, and also institutionalized care as needed (Minnesota Psychiatric Society, 2011).

The Federal Health Systems Act of 1980 had the potential to radically change how mental healthcare was provided and paid for; it introduced parity in health insurance for mental health coverage and expanded grants for community care (Mechanic & Rochefort, 1990; Minnesota Psychiatric Society, 2011). The Act restructured the federal Community Mental Health Center program and strengthened relationships between federal, state, and local governments. Numerous grant programs were established including: expansion grants for services for the severely mentally ill; grants for the severely emotionally disturbed; and grants for education and outreach (Mechanic & Rochefort, 1990; Minnesota Psychiatric Society, 2011).

However, the 1981 Omnibus Budget Reconciliation Act repealed the 1980 Act, replacing it with the Alcohol, Drug Abuse and Mental Health (ADMS) Block Grant. As a result, federal funding of mental health services and treatment was cut by 30% (Cunningham, 2009) and lack of access to mental healthcare continued to be a problem. At the same time, states assumed greater control of and decision-making responsibility for the CMHCs (Frank & Gaynor, 1994). While block grants created by the Reagan administration cut federal monies to CMHCs, they gave states more authority over how to use the federal funds that were provided (Frank & Gaynor, 1994). Obviously then CMHCs became more dependent on funding decisions of the state, rather than the federal government. This dependence is significant given that, unlike the federal government, states (with the exception of Vermont) must have a balanced budget (National Conference of State Legislators, 2011) and must make decisions about allocating scarce resources across many underfunded programs.

The Balanced Budget Act of 1997 (US Government Printing Office, (b) 2011) cut provisions of the Social Services Block Grant Act of 1975 from over $2 billion to $1.7 billion by 2002 (Minnesota Psychiatric Society, 2011). This included cuts to spending on Medicaid and Medicare. Such a reduction is important because rates of mental illness have steadily increased over the course of the past 60 years while at the same time, the federal government was reducing spending on mental healthcare, thereby leaving fewer resources to care for more people (National Institute of Mental Health, 2012). For example, in 1987, 1 in 184 Americans received Social Security Disability Insurance because they had a mental illness; by 2007, this disability rate was 1 in 76 Americans (Whitaker, 2010). Current research indicates that approximately 50% of all Americans will experience some kind of mental illness in their lifetime, 27% will have two or more such illnesses and 17.3% will have three or more (Gold & Shuman, 2009), but rates of accessing treatment have remained largely unchanged, at around 33%, over the past 40 years (Smedley et al., 2003; National Alliance for the Mentally Ill Massachusetts, 2004; Cunningham, 2009).

The federal Mental Health Parity and Addictions Equity Act of 2008 attempted to address access issues by requiring insurance plans that had mental health benefits to offer coverage at the same rate as physical health for firms with 50 or more employees. It did not however mandate starting date requirements or that plans had to provide mental health coverage at all (Cunningham, 2009, Smaldone & Cullen-Drill, 2010). It also did not provide for supportive services, control costs of prescription medications, or integrate the two separate health insurance and administrative systems for physical and mental health (Frank et al., 2003; Smaldone & Cullen-Drill, 2010).

Despite the policy aims behind deinstitutionalization legislation and the aforementioned enactment of laws to provide treatment and services in CMHCs, the disparity between need and accessing mental healthcare remains a problem (Palpant et al., 2006; Cunningham, 2009; Corrigan & Shapiro, 2010). As a result, many people do not receive appropriate and effective mental healthcare. The most recent legislation that has sought to address problems of access to services for people with mental illness was the Patient Protection and Affordable Care Act (PPACA), 2010. The Act's stated intent is to "improve access to and the delivery of healthcare services for all individuals, particularly low income, underserved, uninsured, minority, health disparity, and rural populations" (US Government Printing Office, (a) 2011). One goal is to promote the integration of physical and mental healthcare in community-based centers. In order to understand the process of integration, some discussion of the Community Health Center Program and the development of FQHCs is required.

The Development of the Community Health Center Program

Community Health Centers (CHCs) were first developed in 1965 as part of the Office of Economic Opportunity's (OEO) War on Poverty (Smedley et al., 2003; Lefkowitz, 2007; Bodenheimer & Grumbach, 2009). At that time, legislators began to see a link between health and poverty, and civil rights workers also saw a need to promote community health to improve the living conditions of minority communities (Lefkowitz, 2007). Prior to the development of such centers, the only option for the poor, uninsured, and underinsured to receive care was at charity hospitals that were still relatively expensive and generally not in the neighborhoods of those who needed government-subsidized care (Lefkowitz, 2007). Funding for CHCs was legislated by the Comprehensive Health Planning and Public Health Service Amendments of 1966 and the 1967 Partnership for Health Amendments (Faiella, 1989). Initially, funding came from the Office of Economic Opportunity and, from 1968, the Department of Health, Education and Welfare and its successor, the Department of Health and Human Services (Faiella, 1989; Lefkowitz, 2007). The aim of CHCs was to "provide a wide range of high-quality ambulatory services in an accessible 'single-door' facility, involve community residents, coordinate closely with other community resources, and make use of all existing funds, including those of Medicaid and other health programs" (Lefkowitz, 2007, p. 11).

The notion of Community Health Centers was a radical shift from the existing model of for-profit healthcare provision (Faiella, 1989; Lefkowitz, 2007). Civil rights workers promoted these centers to provide care to the uninsured and underinsured and to improve the living conditions of minority communities (Lefkowitz, 2007). Establishment of such centers was opposed by governors of southern states, organized medicine, and some members of Congress who rejected the idea of community-based, publicly subsidized care (Faiella, 1989; Lefkowitz, 2007).

Despite considerable opposition, on June 11, 1965, the Office of Economic Opportunity provided a grant to enable Tufts University to open the first Community Health Center in the US at Columbia Point in the Dorchester neighborhood of Boston. The location of the center was significant; it was in the district represented by John W. McCormack and the state represented by Edward Kennedy, both of whom were strong supporters of the community healthcare movement. The legacy of their work can be seen in the fact that presently Boston has more CHCs than any other US city. The Columbia Point CHC opened in December 1965 and was funded by the Office of Economic Opportunity and the Department of Health, Education and Welfare. This center was immediately overwhelmed by demand, with as many as 200 people being seen per day (Lefkowitz, 2007). Political support, interest from local universities and their affiliated medical schools, and a strong grass roots movement led to 18 more centers being set up in Boston by 1971 (Faiella, 1989). Hospitals were involved in the development of community health centers and support was garnered from community groups, religious groups and academics (Lefkowitz, 2007).

More CHCs soon opened in other cities including Denver, Chicago, and Los Angeles. By 1967 the Office of Economic Opportunity had provided $51 million for the establishment and support of more centers; as a result, within a year, 33 additional centers were funded (Lefkowitz, 2007). By 1971, there were 150 community health centers nationally, 100 funded by Office of Economic Opportunity and 50 by the Department of

Health, Education and Welfare. The ensuing development of CHCs reflected the prevailing political environment (Faiella, 1989). During the Nixon administration, some centers shifted to Department of Health, Education and Welfare funding, where the bureaucracy was larger and more decentralized. However, during Richard M. Nixon's second term, the administration increased pressure on community health centers regarding funding streams. In 1972, the Department of Health, Education and Welfare stated that since Medicaid, Medicare and private insurance could fund centers, they should and would become self-sufficient. In 1973, the Nixon administration petitioned Congress to phase out legislation providing funding for community health centers, but these plans were successfully opposed by Congressman Paul Rogers (D-Fla.), House Health Subcommittee chair, and Senator Edward Kennedy (D-Mass.), who was responsible for health in the Senate Labor and Public Welfare Committee. President Nixon's successor, Gerald R. Ford, held similar views about limiting federal funding for CHCs but President Jimmy Carter promoted funding increases and, in 1977, Congress passed the Rural Health Clinic Services Act that increased the level of reimbursement CHCs received from Medicare and Medicaid (Frank & Gaynor, 1994; Lefkowitz, 2007).

As previously noted, the first Reagan administration consolidated many social programs in block grants and all community health fell under the umbrella of the Department of Health and Human Services, which had been established in 1978 after education moved to its own department (Armour, 1981; Mechanic & Rochefort, 1990; Mowbray & Holter, 2002; Lefkowitz, 2007). In real terms, funding was reduced from $368 million in 1981 to $321 million in 1982. Funding remained stable under the G. H. W. Bush and W. J. Clinton administrations and, in 2001, G. W. Bush proposed significant expansion of CHCs, which was seen by some as a way to sidestep the push for universal health insurance coverage (Lefkowitz, 2007). Congress supported Bush's requests for expansion until 2005, when it cut the proposed increase from $219 to $116 million. However, Bush continued to push for increased funding until the end of his presidency and from 2002 to 2007, federal funding of CHCs increased from $1 billion to $2 billion and $7.2 million was provided to expand mental healthcare in 50 CHCs nationwide (Wells et al., 2010). Currently, CHCs provide "medical, dental, substance abuse, and mental health services; outreach, transportation to care, and social support services; health education; and nutrition, parenting, and child development services" (Lefkowitz, 2007, p. 25). However, only 71% of CHCs provide specialist mental healthcare services (National Association of Community Health Centers, 2012), although primary care providers do offer some element of mental healthcare if requested.

The Development of Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) are a subset of CHCs that also provide community-based, patient-centered healthcare to underserved populations. FQHCs must provide comprehensive care for all age groups, including, but not limited to mental health, dental care, and other specialty services. Nationally, the number of FQHCs increased from 545 in 1990 to 1124 in 2010, and patient numbers have increased by 103% over the same period. Patient visits for mental healthcare increased by 406% from 2000 to 2010 (the actual number of patients increased by 433%) (National Association of Community Health Centers, 2012). Nationally, between 1998 and 2003, the number of people receiving mental healthcare in CHCs increased from 210,000 to 800,000 (Mauer

& Druss, 2010).

FQHCs receive grants and higher rates of Medicare and Medicaid reimbursement than other clinics because they provide services for low income, disadvantaged groups who experience social, economic, and medical barriers to care (Knight, 2011). The FQHC benefit began in 1991 under the Omnibus Budget Reconciliation Act of 1990 (Department of Health and Human Services, 2013). Primary funding comes from the Health Resources and Services Administration (HRSA) Bureau of Primary Health Care. FQHCs also qualify for additional reimbursement from Medicare and Medicaid (Health Resources and Services Administration, 2013). There are numerous incentives for CHCs to become FQHCs. These include:

1. Section 330 grants (from the Public Health Service Act, 2010)
2. Capital improvements – grant support and loan guarantees from HRSA
3. Drug pricing – the Public Health Service Act provides for favorable pricing for FQHCs
4. Support from the Bureau of Primary Health Care (BPHC) within (HRSA including technical assistance
5. Enhancement of Medicaid reimbursement
6. Elimination of deductibles under Medicare (Brolin et al., 2012).

FQHCs are governed by boards whose members fall into one of three categories: non-consumers; non-representative consumers (not reflective of typical FQHC clients); and representative consumers (reflective of typical FQHC clients). The board is intended to reflect the population served and to have significant input on direction and policy (Wright, 2012). To that end, FQHC boards are federally required to be comprised of at least 51% active clients who are representative of the community the FQHC is based in (Brolin et al., 2012). However, most boards do not meet this requirement (Wright, 2013).

One study found that a minority of board members were representative clients and “a stratified random sample of thirty FQHC board members confirmed the existence of significant socioeconomic gaps between consumer board members and FQHC members” (Wright, 2013, p. 27). Whether or not the board makeup actually reflects the patient population is important as it “may influence the board’s ability to represent the community” (Wright, 2013, p. 27) and thus impact access to appropriate treatment.

Patient Protection and Affordable Care Act (PPACA) legislation on FQHC and integrating care. As previously discussed, the PPACA promotes integrating physical and mental healthcare. The PPACA legislates that, beginning in 2014, mental healthcare will be included in the essential benefits package of all insurance plans (US Government Printing Office (a) 2011). The PPACA has also allocated specific funds for mental health (also known as behavioral health) programs and for the “co-location of primary health care and mental health services” (Cunningham, 2009; Redhead et al., 2010) in Community Health Centers rather than in Community Mental Health Centers. While FQHCs were already established, the PPACA permanently authorized the program and provided $11 billion in new FQHC funds (Wright, 2013). Under the terms of the PPACA, Federally Qualified Health Centers (FQHCs) have access to extra funding from Medicare and Medicaid and are eligible for grants from HRSA to help pay for treatment of the uninsured and for the integration of mental health into primary care settings (Brolin et al., 2012).

At the federal level, the Center for Integrated Health Solutions (CIHS) promotes the integration of primary and mental healthcare. The Center is funded by the Substance

Abuse and Mental Health Services Administration (SAMHSA) and HRSA and is run by the National Council for Community Behavioral Health (SAMHSA-HSRA, 2013). SAMHSA also offers Primary and Behavioral Health Care Integration grants. At the state level, FQHCs work with both HRSA and SAMHSA to implement PPACA (2010) legislation relating to the integration of physical and mental healthcare (National Association of Community Health Centers 2013).

FQHCs and the integration of physical and mental healthcare. Primary care physicians are often the first provider a patient sees when seeking help for a mental health issue (Upshur, 2005; Lang, 2003; Alexander & Wilson, 2010). However, research has consistently indicated that many people with serious mental health issues do not receive either physical or mental healthcare; only half of the mentally ill population has a primary care provider (Lang, 2003). This is significant as approximately 68% of people living with mental illness also have serious physical health problems such as cardio-vascular disease, hypertension and diabetes (SAMHSA-HSRA Center for Integrated Health Solutions, 2012). People living with mental illness are less likely to receive physical healthcare than those without such illnesses (SAMHSA-HSRA Center for Integrated Health Solutions, 2012), which has significant impact on overall health and life expectancy (Ingoglia & Roth, 2012). As aforementioned, people living with serious mental illnesses die, on average, 25 years younger than those without such illnesses (Manderscheid, 2006; Allen et al., 2009; Alexander & Wilson, 2010; Miller & Prewitt, 2012; Woltmann et al, 2012).

Even when people do approach a primary care physician about mental health concerns, often such providers do not feel knowledgeable enough to provide appropriate psychiatric care, instead referring their patients to community-based mental health specialist services. However, between 50 and 60% of patients do not complete a referral to a mental health service agency or provider (Primary Care Behavioral Health, 2008). One explanation for this low uptake of referrals is that patients may prefer to receive mental and physical healthcare in the same setting (Mauksch et al., 2001). Providing mental health in primary care, while maintaining good relationships with administrators and providers at CMHCs, is one strategy for addressing the problem of low referral uptake that also facilitates good communication between the two types of centers. According to Brolin et al. (2012, p. 25), components requisite to the success of the integration of physical and mental healthcare are "coordination, collaboration, and communication between FQHCs and behavioral health providers, including community mental health centers (CMHCs)." Utilizing such strategies means that Community Health Centers (CHCs) meet most (80-90%) mental health needs, allowing specialty mental health services provided by Community Mental Health Centers (CMHCs) to focus on the most severely mentally ill, thereby limiting the number of patients who get lost in the system (Primary Care Behavioral Health, 2008; Blount & Olmedo, 2011; Possemato, 2011).

With a growing emphasis on evidence-based practice, research indicating patient preference for one-stop healthcare and increasing popularity of the patient-centered medical home model (Possemato, 2011), health providers and policymakers have begun to focus on integrating physical and mental healthcare to improve outcomes and reduce disparities in treatment (Institute of Medicine, 2006; Health Connector, 2010). Research indicates that the most effective way to integrate physical and mental healthcare is a collaborative multidisciplinary approach, which is also cost-effective, indicating value for society (Druss & Walker, 2011). Coordinating mental and physical healthcare in CHCs also helps to address the disparity between the number of people living with mental illness and those who seek treatment (Miller & Prewitt, 2012).

CHCs currently provide healthcare to more than 20 million people in the US. In doing so, CHC administrators must make decisions about the provision of a range of health services (physical and mental) in an environment characterized by scarce resources (National Association of Community Health Centers, 2012). Because CHCs are the primary source of care in some communities, resource scarcity and budget cuts -- routine conditions since the inception of the program -- can severely compromise access to care for those who depend on them, including the mentally ill (Smedley et al., 2003). Adequate funding that is earmarked specifically for mental or behavioral healthcare is therefore fundamental to providing a true continuum of healthcare.

Federally Qualified Health Centers (FQHCs) are among those organizations that are best placed to provide such comprehensive care. As they are based within the same location, primary care providers within FQHCs have opportunities to introduce patients to the mental healthcare providers who work within their facilities, thus increasing the chances of patient trust and engagement (Possemato, 2011). Moreover, integrating physical and mental healthcare in a single location “avoids the potential stigma of a referral to a mental health specialty clinic” (Lang, 2003, p. 142), normalizes the idea of attending to mental health (Brunelle & Porter, 2013), and is more patient-centered than specialized mental healthcare facilities, which tend to focus solely on the psychiatric needs of the most seriously mentally ill (Mauer & Druss, 2010; Little et al., 2012) and accept referrals for such patients from FQHCs.

The provision for the range of physical and mental healthcare within a single location signals that all types of health are important and should be adequately resourced. Being in the same location allows for a multidisciplinary problem-solving approach to care (Massachusetts Department of Public Health, 2012) and makes mental health services more accessible to the public. Furthermore, this integrated approach has the potential to reduce the stigma associated with mental illness by offering all services under one roof and making mental healthcare as routine as physical healthcare.

Integration of care may be achieved by primary care and mental healthcare providers if treatment and services are provided within one center (Upshur, 2005). Such integration is not a one-way process; primary care can be incorporated into mental health settings and mental healthcare can be incorporated into primary care organizations (SAMHSA-HSRA Center for Integrated Health Solutions, 2012). While integration of care and collaboration between professionals is most effective if physical and mental healthcare are provided in the same center (Collins et al., 2010), research indicates that patients are more likely to engage in mental healthcare if integration occurs in a primary care rather than a mental health setting. Therefore, this research took place in FQHCs that have integrated comprehensive mental healthcare and primary care in one agency.

Summary

This chapter examined the development of mental health policy and the growth of CHCs and FQHCs in the US. How mental healthcare is provided has shifted over time from long-term hospitalization and institutionalization to care in the community. The period immediately following the Second World War proved to be a turning point for how mental healthcare was provided. The move for deinstitutionalization grew in popularity and was enshrined in legislation in the 1963 Community Mental Health Centers Act. However, the rate at which deinstitutionalization occurred was much faster than policy makers had anticipated. Many people were discharged from facilities with no supports in place in the community, rates of homelessness and incarceration increased and barriers were created to people living with mental illness accessing mental healthcare or services.

Numerous policies have been developed to attempt to address the gap between prevalence of mental illness and access to services. Community Health Centers (CHCs) were established in the 1960s to provide healthcare to low-income individuals with limited or no health insurance. Following the establishment of these centers came Federally Qualified Health Centers (FQHC) that provide comprehensive healthcare, including, but not limited to, physical healthcare, mental healthcare and dental care to low-income individuals in their community. FQHC patients contend with social, financial and medical barriers to accessing healthcare and the centers receive higher rates of Medicare and Medicaid reimbursement to provide appropriate care.

The Patient Protection and Affordable Care Act (PPACA, 2010) underlined the importance of providing comprehensive care as a way to close the gap between prevalence of mental illness and access to care by mandating that FQHCs integrate physical and mental healthcare. Existing research has found that individuals are more likely to follow up on referrals to mental healthcare if such care is provided in the same location as their physical healthcare and if their providers work in a multidisciplinary team (Lang, 2003; Massachusetts Department of Public Health, 2012). Furthermore, by providing physical and mental healthcare in one setting, the idea of accessing mental health services is normalized and stigma is reduced (Brunelle & Porter, 2013).

CHAPTER 3

LITERATURE REVIEW

This chapter provides a review of literature that is pertinent to this dissertation. It examines theoretical, practice-based and empirical research literature on the stigma associated with mental illness. It also examines the intersection of stigma and policy and how stigma is operationalized in society, thus creating or reinforcing barriers to mental healthcare. A stigma model that explains this operationalization of stigma in society is reviewed. This chapter also examines literature on the social construction of mental illness, and on the reinforcement of power dynamics and the reproduction of stigma and social exclusion. Furthermore, this chapter includes a discussion of the literature relating to bureaucratic behavior and the function of organizations. This includes an overview of the role of an organization's culture and mission and relationships between different levels of agency workers. Policy implementation literature provides an understanding of the varying constraints on policy implementers within agencies. This literature also discusses models of policy implementation and provides explanations for why policy is often not implemented as the policy makers intended.

Stigma

Stigma remains arguably the greatest obstacle to progress in the arena of mental health (Meyer, 1992; Link & Phelan, 2001; Sirey et al., 2001; Kobau et al., 2010; Markowitz et al., 2011; Brunelle & Porter, 2013). Policy changes and increased resources may result in the availability of more treatment and services, but these do not eliminate the impact that stigma has in limiting access to care. Stigma has the potential to decrease life opportunities, such as employment and housing (Corrigan, 2006), increase the likelihood of interaction with the criminal justice system (Meyer, 1992; Slate & Johnson, 2008), and limit access to both physical and mental healthcare (Corrigan, 2006). Because stigma can have pervasive and persistent damaging effects that can last a lifetime (Kogut, 2008), an explanation of its function and importance in society is required.

Mental illness has been stigmatized to such an extent that the position of the mentally ill as excluded often goes unquestioned (Burke & Parker, 2007); power differences are so ingrained in society, they are not considered a problem by the dominant group, that is, those not living with a mental illness (Link & Phelan, 2001). For example, between 1907 and 1960, up to 60,000 people in the US living with a mental illness or intellectual disability were involuntarily sterilized (Bryan, 2002). Moreover, as recently as 2011, a Massachusetts court ordered that a woman living with schizophrenia undergo an abortion and mandatory sterilization; this ruling was later reversed on appeal (American Bar Association, 2012). While people living with mental illness may experience stigma and isolation in all aspects of their lives, being denied full access to the mental healthcare system is particularly troubling to the extent that their health outcomes and life expectancy are compromised (Colton & Manderscheid, 2006; Smaldone & Cullen-Drill, 2010).

The intersection of stigma and policy. Providing effective services and supports to stigmatized groups is a significant policy challenge. Separateness is a natural characteristic of the human condition, but exclusion is a problem when people do not have equitable access to opportunities and when it reinforces negative stereotypes and prejudices about certain groups (Allport, 1954; Link & Phelan, 2001; Sirey et al., 2001).

Stigma is a significant contributor to the creation and perpetuation of barriers to mental healthcare (Goffman, 1984; Corrigan, 2006). The role of stigma in policy implementation must be acknowledged and understood in order for it to be addressed. “Conceptions of mental illness in our society” observe Stuber and Schlesinger (2006, p. 943), “include a disparate array of negative attributes including unpredictability and dangerousness, weakness and incompetence and a generalized attribution of badness” which historically have resulted in discrimination. If, as the assumptions of this research suggest, stigma is a driving force for problems in implementation and in access to treatment, then, for research purposes, the puzzle becomes operationalizing the concept of stigma.

A stigma model. The process of stigma operationalization is demonstrated in an adaptation of Corrigan and Shapiro’s (2010) stigma model (Appendix A), which explains how stigma impacts people who have discrediting attributes such as mental illness. The cognitive and behavioral constructs within this model indicate how the stereotyping of mental illness leads to prejudice, which results in discrimination. In other words, the model suggests that thoughts about and perceptions of mental illness lead to actions and negative outcomes for those living with the illness (Corrigan, 2007). The model identifies two kinds of stigma, public stigma held by individuals, and institutional stigma, found and reproduced within the structures of organizations or institutions. The model offers a process for understanding how stigmatizing thoughts and stereotypes create prejudice and thus discrimination and social exclusion. As stigmatizing beliefs about mental illness are held by mass publics, or dominant groups, stigma becomes institutionalized, which facilitates the reproduction of such attitudes and outcomes in society (Fraser & Gordon, 1994; Corrigan & Shapiro, 2010). Because stigma has considerable power in the functions of organizations, it can become a significant source of social control (Burris, 2006). In order to effect change and develop some parity of treatment and service provision, mass publics (Jacobs, 1992), of which policy makers are a part, must understand and address the social constructions of mental illness as well as develop an understanding of how stigma and discrimination are institutionalized and replicated in organizations, thus allowing inequality to persist (Goffman, 1984).

This stigma model aids our understanding of the facets and impacts of stigma and offers an explanation for the creation and reinforcement of barriers to treatment (Corrigan, 2006). Firstly, public stigma refers to the stereotyping, prejudices, and discrimination, shaped by individual experience that the public displays towards people living with mental illness. In FQHCs, for example, this may be reflected in the attitudes and beliefs of administrators and practitioners; these individuals may hold assumptions about treatability and curability of mental illness that affects decision-making about service provision. Secondly, institutional stigma refers to policies and social structures within agencies that, both intentionally and unintentionally, limit opportunities for people living with a mental illness (Corrigan & Shapiro, 2010). Such stigma may be evidenced in policy decisions made at the local level, say, in FQHCs, that impact service delivery and the provision of treatment. Such stigma may also be reflected in decisions that are made about accessing optional funding sources made available by the PPACA (US Government Printing Office (a) 2011).

Institutional stigma might be seen in decisions made about allocating FQHC resources more to physical rather than mental healthcare, or within mental healthcare programs to focus more on neuroses such as depression and anxiety rather than psychoses such as schizophrenia and bipolar disorder. A rationale for such a decision might be that neuroses, as well as being easier and less expensive to treat than psychoses, are much less stigmatizing than serious mental health disorders and that this use of public funds for the "worried well" might be more acceptable to practitioners, managers, agencies, and mass publics in general (Smith et al., 1978; Fine & Asch, 1988; Jacobs, 1992; Caplan & Cosgrove, 2004).

Social Construction

Social construction plays a major role in determining not just characteristics of groups but also which groups have influence in reproducing social structures, power relationships, stigma, and social exclusion (Jacobs, 1992). While all citizens are legally equal, such equality is often not evidenced in public policy (Joniak, 2005). Benefits are directed to those who are socially constructed as more deserving or worthy than others, and these social constructions are very difficult to change. “Such treatment by policymakers sends citizens powerful messages about the capacities of such people,” conclude Ingram, Schneider, and deLeon (in Sabatier, 2007, p. 99), thus reinforcing negative stereotypes of those deemed to be “other” (Goffman, 1984).

Theories of social construction posit that the world is defined by meanings that dominant groups impose (Berger & Luckmann, 1967; Sabatier, 2007). Individuals absorb messages about themselves from society and can adopt beliefs created by dominant groups that do not necessarily reflect their reality (Schutt & Goldfinger, 2011). This is important as, if mental illness is a social construction, then it begins to be seen as an individual rather than a societal problem, which reinforces social exclusion (Burke & Parker, 2007). The social construction of stigma and of mental illness may play a significant part in creating barriers to care (Steinmo & Watts, 1995) and in influencing the policy agenda (Schneider & Ingram, 1993). As the dominant group is able to construct deserving and undeserving populations, disparities in provision can be justified and access to certain services, including mental healthcare, may be denied to certain groups (Fraser & Gordon, 1994).

Target populations, that is, those who are impacted by policy decisions, have been classified into four groups: the advantaged, contenders, dependents, and deviants, each with positive or negative power and construction (Schneider & Ingram, 1993). The dominant group can use prevailing constructions to “provide benefits to powerful, positively constructed groups and burdens to less powerful, negatively constructed ones” (Schneider & Ingram, 1993, p. 337); people living with mental illness fall into the latter category. As social constructionism influences the policy agenda, policy tools and the rationale for implementation, how target populations are constructed is crucial (Schneider and Ingram, 1993).

Different target populations get different messages from mental health policy and some are deterred while others are encouraged to participate in treatment. Extant research suggests that certain people living with mental illness, whose point of service is a CHC, receive negative messages from the administrators and practitioners of these centers (Colton & Manderscheid, 2006; Barnes, 2008; Agency for Healthcare Research and Quality. 2013). This notion is supported by other research, suggesting that many doctors, psychiatrists, psychologists and other mental health providers hold stigmatizing views about mental illness (Goldberg & Huxley, 1980; Lauber et al., 2006).

Stigmatization can shape social interaction, and whether or not an attribute is seen as stigmatizing depends on its social context. What is stigmatizing in one culture may not be in another, hence rendering mental illness a social construct and stigma socially relative (Goffman, 1984; Corrigan, 2006). Therefore social phenomena including mental illness and stigma can only be understood by uncovering the meaning that others, that is, the dominant groups within society, assign to them (O'Brien, 2008; Myers, 2009).

The social construction of stigma and mental illness. People with mental illness are assumed to hold negative characteristics and labels such as sick, unpredictable, dangerous, and incompetent are applied to them. This occurs even when the person with the illness does not exhibit any unusual behavior (Heatherton, 2000). The effect of stigma is reflected in the 1996 General Social Survey; 61% of respondents thought that people living with schizophrenia were likely (more than 50% probability) to be violent and 63%

of respondents were likely to remove themselves from people living with schizophrenia (McSween, 2002). The general public feels uncomfortable in interactions with people living with mental illness partly because of perceptions of unpredictability and dangerousness (Abrams et al., 2005). Therefore, while the reality is that less than 1 % of people living with a major mental illness exhibit violent behavior, (Slate & Johnson, 2008), the public perceives otherwise.

This commonly held view of the dangerous mentally ill person is a social construction (Schutt & Goldfinger, 2011) which can help explain a possible disconnect between policy and practice in mental health (Steinmo & Watts, 1995). Once social constructions are established, they are very difficult to challenge or change (Ingram et al., 2007), in part, because public policies can and do reinforce these constructions. If mental illness is perceived to be the problem of the individual rather than of society, social exclusion is reinforced (Burke & Parker, 2007). Social exclusion almost always leads to negative outcomes for the excluded individual or group and is a core element of stigmatization. Such exclusion is often socially consensual, that is, there is "general agreement within a culture that certain types of people should be excluded" (Abrams et al., 2005, p. 66).

There are a number of social constructions of mental illness:

I. All people with schizophrenia are violent and dangerous (Landsberg & Smiley, 2001). Fear and stigma remain common responses to mental illness, despite the fact that 95% of people living with mental illness do not exhibit violent tendencies (Rack, 1982). The public has a distorted view of people with mental health problems and this fear is heightened and encouraged by media representation of mental health issues (Jacobs, 1992; Community Care, 1999; Corey et al., 2003; Palpant et al., 2006). Observed Jamison, (2006, p. 533), “newspapers and television stations can print or broadcast statements about those with mental illness that simply would not be tolerated if they were said about any other minority group.”

II. People living with mental illness are unable to be productive, employed members of society; the life and work of mathematician and Nobel Prize winner, John Nash, among others, refutes this (Segal, 2009).

III. There is no recovery from mental illness; rather it is a lifelong condition. However, most people either recover or improve considerably over time (Markowitz et al., 2001; O’Day & Killeen, 2002; Corrigan & Shapiro, 2010).

If stigma associated with mental illness becomes institutionalized (Corrigan & Shapiro, 2010), negative perceptions of such illness may be witnessed even in organizations that provide mental healthcare and related services. Thus the aforementioned stereotypes may be effective in excluding significant numbers of people not only from society but also from needed treatment and services. An understanding of the nature of bureaucratic behavior is therefore required in order to address stigma in mental healthcare.

Bureaucratic Behavior

This research sought to explore what agencies do and how their aims impact implementation, goal attainment and outcomes. In order to understand the implementation process, an examination of how bureaucracies function, and how organizations, agency leaders, managers, and workers interact with each other is warranted. Bureaucracy is not one large homogenous organization; rather it consists of complex and varied internal and external systems of organizations or agencies. Executives are responsible for sustaining and growing agencies and providing resources to benefit distinct constituencies that include political support as well as capital and labor (Wilson, 1989). The examination of behavior of frontline workers, managers, and agency leaders is essential to this study as they both implement and create policy (Peters & Pierre, 2003). Because bureaucratic behavior is influenced, in part, by agency culture and mission, and by messages received from leadership about important goals, an examination of these concepts is required.

Organizational culture and mission. Organizations participate in society, both inhibiting and promoting social change, and an agency's culture and influence is shaped by its values and beliefs (Kreitner et al., 2001). The culture of an organization reflects its inherent beliefs and behaviors (Rousseau, 1989). It is one contributor to policy outcomes and is often passed from one generation of workers to the next. Agency leaders have enormous influence over an organization's character; it is they who develop the underlying philosophy or culture. In this context, leadership refers not only to the Executive Director (ED) and leadership team but also to the board of directors and its chair (Harrison & Murray 2012; Jaskyte, 2012). Indeed, the "board of directors and the ED form the leadership core and are critical components of governance" (Jaskyte, 2012; p. 440).

In order to succeed, an organization's values must be acceptable to the society in which it exists. When there is a disparity between the two, problems arise. Particularly in publicly funded organizations, how resources are utilized must be acceptable to the society within which they exist (Dowling & Pfeffer, 1975). Following from this, in order to continue their existence, organizations must justify their legitimacy to funders and to the general public. While facing these pressures, leaders create, manage, and change culture, sometimes consciously, sometimes not (Schein, 1980).

The culture of the organization has a role in shaping its mission or purpose as well as affecting outcomes. A sense of mission arises when practitioners and managers share and embrace the same sense of culture. Such unity is challenging in government agencies where goals are vague and practitioners may not have a clear understanding of their roles (Lipsky, 1980; Wilson, 1989). Also, any one agency can have competing cultures with more than one goal in mind though one culture may be more prominent than others. This can give rise to problems when tasks that fall outside the purview of the dominant culture do not get the same attention or resource allocation. Additionally, if there is more than one culture, there can be conflict among the representatives of each; for example, "organizations will resist taking on new tasks that seem incompatible with its dominant culture" (Wilson, 1989, p. 101).

Such resistance may be evidenced in FQHCs that are charged with integrating the two different cultures of physical and mental healthcare (Brolin, et al., 2012). FQHCs have been compromised in their ability to carry out integration in recent years due to growing demand for increasingly limited resources, and the rise in the numbers of chronically ill clients (National Association of Community Health Centers, 2012). Agencies that previously had been primarily focused on, and had a dominant culture of, physical health may not consider mental health as fitting into the main mission of the FQHCs and therefore mental health may receive less attention and resources in light of prevailing constraints. Thus decision-making about which services receive resources is indicative of the agency's perception of the value of mental healthcare relative to other priorities, and its commitment to truly integrate care (Joniak, 2005).

Organizational goals. In order to achieve desired policy outcomes, organizations must have clearly identified goals and missions (Meyers et al., 2001). As Wilson (1989, p. 36) notes, "when goals are vague, circumstances become important," particularly in the everyday experience of street level workers, as will be discussed further in this chapter. For example, in psychiatric hospitals and clinics, the goals may be to promote mental health, but institutions often lack the means to achieve those goals or even have a clear definition of what mental health means (Wilson, 1989). It may be argued that in CHCs, reimbursement is greater for primary care, therefore it receives more overall attention than mental healthcare (Barry et al., 2006). Furthermore, serious mental illness such as schizophrenia may be viewed as treatable but not curable (or perhaps even untreatable) and this might affect implementation of policy and treatment outcomes (Wilson, 1989) if more consideration is given to illnesses that are perceived to have "better" outcomes (i.e., cure rather than remission of symptoms) or are easier to treat (Kobau et al., 2010).

Street level bureaucracy. Much discussion exists in the literature about policy implementation and about stigma as a barrier to people's inclusion in society. This is relevant if perceptions of mental illness affect how practitioners implement policy. Empirical research indicates that street level bureaucrats or practitioners have significant influence over policy implementation and development (Riccucci, 2005). These frontline practitioners are the gatekeepers to public resources and they have substantial power over policy delivery (Lipsky, 1980; Prottas, 1981).

Practitioners are constrained by agency policy and procedures, but often these are so numerous, ambiguous, and complicated that, even within these constraints, practitioners have significant discretion over the type, quality, and amount of services that a client receives (Lipsky, 1980). Thus, there is significant room for discretion in translating and applying policy, and practitioners use their discretion both to implement and create policy (Vinzant & Crothers, 1998; Jewell & Glaser, 2007). This discretion in decision making results in some people benefitting from additional help and services, while others are excluded from such benefits (Maynard-Moody & Musheno, 2003) depending on the biases of the practitioners. These biases may reflect those held by the general public, specifically negative perceptions held by society about the mentally ill (Mechanic & Rochefort, 1990; Covey, 1998; Bryan, 2002; Newhill & Harris, 2007; Corrigan & Shapiro, 2010). In this way stigma may result in disparity between intent, implementation, and outcomes in mental health policy.

Another issue in policy implementation is that workers may be constrained by resource shortages, affecting client to worker ratios and time. Practitioners may have caseloads so large that they often cannot meet their mandated responsibilities, which can impede the development of effective relationships with clients, despite workers' best intentions. This set of cascading constraints may, in turn, cause workers to rely on stereotypes when making decisions about resource allocation and deserving groups (McSween, 2002; Corrigan, 2007). The high stress associated with the job, combined with a significant level of discretion and autonomy, contributes to practitioners making judgments based on their own values and assumptions about deserving and undeserving groups (Lipsky, 1980; Maynard-Moody & Musheno, 2003; Isett et al., 2007). Furthermore, practitioners may feel under threat from certain clients and be more reluctant to provide services to them. This complex mix of circumstances is particularly pertinent if the client is a person who is living with a serious mental illness such as schizophrenia, a condition that has been constructed in the public's mind as dangerous (Landsberg & Smiley, 2001; Stuber & Schlesinger, 2006).

Those who implement policy also influence its development. Consequently, street level decisions can, in fact, be referred to as policy because practitioners actualize policy by delivering services (Lipsky, 1980; Maynard-Moody & Musheno, 2003). Practitioners make policy in two ways; they individually make decisions about their clients and their collective actions result in agency behavior. Thus, explains Lipsky (1980, p.13), the "position of street level bureaucrats regularly permits them to make policy with respect to significant aspects of their interactions with citizens." This ability to make policy comes from the amount of discretion street level bureaucrats have in dealing with clients and their significant autonomy within the agency in which they work (Lipsky, 1980).

The dynamic between agency leaders, management, and practitioners and the effect on outcomes. The relationship between agency leadership, management, and practitioners is important to the delivery of services to clients. Because the division of power is an important element of organizational structure (Hall, 2002), one must consider the issue of power in organizational decision-making and who holds it (Handel, 2003). Practitioners often work under supervisors who have their own ideas about how the work should be done and who may have little interaction with clients: this can create conflict (Prottas, 1981). According to Evans (2010):

> The key tactics which street level bureaucrats can use to circumvent interference from supervisors are: control of information upwards; playing on the essentially private nature of their work; and exploitation of management's reliance on their good will and initiative, on which continuing service provision depends (Evans, 2010, p. 17).

There are certain expectations of any job and an important consideration is that, while high-level bureaucrats, or agency leaders may be constrained by their political superiors, practitioners are less constrained by their managers (Wilson, 1989). Lipsky (1980) argues that practitioners' goals differ from those of their managers and agencies. Because workers and managers have different priorities and values, workers are less concerned than managers with correctly implementing policy (Lipsky, 1980). Furthermore, managers have limited sanctions to deal with workers who are perceived as not carrying out their jobs appropriately, which may allow practitioners the freedom to interpret policy differently than the agency would expect (Wilson, 1989; Lewis & Lewis, 2001).

Organizational relationships that result in desired goals and outcomes may be improved by the fostering of good relationships between employees and peers/supervisors. Worker perceptions are influenced by these relationships and by expectations that workers have for each other which then reinforce both positive and negative behaviors (Harter et al., 2010). The argument is that employees are more likely to engage in behaviors that will help organizations achieve stated outcomes if they witness others doing so. Additionally, if employees have a positive regard for their workplace, it is argued that this is likely to be reflected in how they treat clients. Employees are likely to have a good perception of an organization that provides good salaries, benefits and job security, and provides good programs and services (Harter et al., 2010). Worker motivation is important as it influences the decisions practitioners make about how to implement agency policy (Lane & Scott, 2007).

Policy Implementation

As previously noted, more than 26% of the US population is diagnosed with a mental illness or disorder every year but only 8.6% of the same population receives treatment (Palpant et al., 2006). Therefore an examination of mental health policy implementation is pertinent to uncover elements that may, in part, explain why many people living with mental illness do not access treatment, care or community-based resources (Cook et al., 2007).

Wilson (1989) argues that government organizations or agencies are driven by constraints and, as such, often fail to implement policy as intended. Additionally, these organizations have several agendas to promote simultaneously, including working in the public's best interest. According to Wilson (1989) these constraints and competing objectives create substantial inefficiencies and failures in organizational outcomes, including service provision. There are many circumstances that impact how policy is implemented and treatment provided, including the role of the medical community, health insurance carriers, and client participation (Linhorst et al., 2005). This study focuses on the role of agency leaders, managers, and practitioners and their relationships with their agencies, in these processes of implementation. In particular, it seeks to examine how each level of agency worker implements and modifies policy and how the dynamics and interaction between these groups affect outcomes for FQHC clients.

Empirical research on policy implementation indicates a gap between intent and outcomes (deLeon & deLeon, 2002). Various issues can impede or promote successful implementation, and practices often do not reflect the official intent of policy. Moreover, context matters, and how a policy becomes practice is not necessarily consistent across agencies or groups (Lundin, 2007). Two main views on policy implementation are discussed in the literature. One is the top-down approach, which gained popularity in the 1970s and posits that political overseers successfully constrain the practice of local bureaucrats, that implementation is controlled at the national or state level, and attempts are made to regulate practice. The second is the bottom-up approach, which focuses first on the actors at the local or operational level and the features that influence how they respond to a particular issue, policy or directive (Sabatier, 1986). Thus the top-down approach focuses on goal achievement whereas the bottom-up approach focuses on problem solving (Peters & Pierre, 2003).

The top-down approach. The top-down approach examines a government decision and the extent to which a policy was implemented in line with the objectives of those promulgating the policy, the extent to which the objectives of the policy were attained over time, and what components of the policy affect its outputs and impacts. The top down approach also examines whether a policy was modified or adapted in response to outcomes and lessons learned (Sabatier & Mazmanian, 1980; Pressman & Wildavsky, 1984; Sabatier, 1986). Two underlying assumptions about top-down implementation are pertinent to this research. One is that there is one main actor whose role it is to provide oversight and ensure accountability of the organization. It is necessary to improve communication between this actor and all others for successful implementation to occur. The second is that programs generally fail, despite the best intentions of the actors involved (deLeon & deLeon, 2002). One argument that pushes back on the second assumption is that policies fail not because of the policies themselves but because of problems with implementation and because of how power is diffused at the local level (Pressman & Wildavsky, 1984). Moreover, human involvement is necessary for implementation to occur, and this can lead to bias and goal shifting in implementation and finally policy failure (Myrtle, 1983).

The bottom-up approach. In the later 1970s and early 1980s, the bottom-up approach gained traction in the implementation arena (Lipsky, 1980). The national perspective looks at data in the aggregate, from the top down, at the agency level and over time and considers quantity of provision, whereas the local perspective looks at data from the bottom up, “the proximate, the conditional, the case and the choice of bureaucrats" (Whitford, 2007, p. 19) and determines which, if any, services should be provided. The bottom-up approach identifies the network of actors who provide services and from this, is able to identify the local, regional, and national actors important to how policy implementation unfolds. This network is a mechanism for moving from the bottom, i.e. practitioners, to the top, i.e. agency leaders and policymakers (Sabatier, 1986).

The bottom-up theory of implementation that helps explain the role of stigma in program administration/implementation is a compelling one. Here, the focus is on frontline employees, or street level bureaucrats, who have case-level discretion over how policy is implemented at the local level (Whitford, 2007). The street level model focuses on the actions and decisions of local actors and "emphasizes mission, organizational cultures, personnel changes, technical expertise and professional norms" (Whitford, 2007, p. 19). In this model, practitioners are those who interact with the public to administer programs and provide services (Lipsky, 1980). They have significant influence over the outcomes of people's lives and they also have to contend with the pressure to provide services with constrained budgets and scarce resources (Lipsky, 1980).

Critiques of top-down and bottom-up policy-making approaches. A main critique that bottom-up proponents have of top-down policy making is that the latter focuses on policymakers, ignoring other actors and initiatives bubbling up from policy subsystems. They also argue that top down models are hard to use when there is no dominant policy to focus on, as is often the case in social services. Another criticism is that top-down policymaking ignores or underestimates “the strategies used by street level bureaucrats and target groups to get around central policy and/or to divert it to their own purposes” (Sabatier, 1986, p. 30).

It has been argued that the bottom-up approach may overstate the power that street level workers have over policy and may underestimate the indirect impact that policymakers have on implementation (Sabatier, 1986). One criticism of the bottom-up approach is that upper level management may take worker discretion too much into account when making administrative decisions, leading to negative outcomes for clients (Werner, 2004). Another major criticism of bottom-up theory is that it does not have a strong theoretical underpinning but rather relies on the “perceptions and activities of participants” (Sabatier, 1986, p. 35) and does not consider that other elements may have an indirect role in their behavior.

Rationale for applying an integrated model of both top-down and bottom up approaches. There are benefits to both the top-down and bottom-up approaches. This study examined practices of agency workers at the leadership, management, and frontline practitioner levels to understand how actors, reflecting multiple perspectives, affect policy implementation. Therefore, the most useful framework to underpin this research is an integrated model where “implementation is seen as occurring in a circular policy process” (Vinzant & Crothers, 1998, p. 57) incorporating elements of both the top-down and bottom-up approaches. Policy is developed and implemented at every level in an agency, both formally and informally, whether it is by agency leaders or by practitioners using their autonomy to engage in policy-making practices. Furthermore, there is a dynamic between the different levels of agency staff with agency leaders, managers, and practitioners all impacting each other. In this way, policymaking becomes a bi-directional rather than a one-way linear process.

In a professional organization, such as a FQHC, “the professional staff is often granted autonomy to organize and to exercise considerable control over the conduct of professional work” (Flood et al., 1982, p. 344), which may result in a bottom-up approach to policymaking. The quality of the work is determined by the organizational characteristics, the characteristics by which professionals organize themselves and the characteristics of the individuals including agency leaders, managers, and practitioners. Simultaneously, leadership and management’s focus on implementing national and state integration policy is reflective of the top-down model. Therefore this research examines how agency leaders, managers, and practitioners in FQHCs implement integration practices by utilizing both top-down and bottom-up elements.

Summary

This chapter reviewed the literature that is relevant to this study and that supports the conceptual framework (see Chapter 4) of this dissertation. The focus of the study is on the role of stigma in policy implementation; much literature exists on stigma and its function in limiting progress in the area of mental health. Stigma not only limits access to healthcare, it also limits opportunities for employment and housing (Corrigan, 2006; Kogut, 2008). This stigma can have lifelong negative impacts on individuals living with mental illness, who can then be excluded from society and seen as “other” (Goffman, 1984). Mental illness had become so stigmatized and has created such a power differential between the “normals” and the “others” (Goffman, 1984) that this exclusion is often invisible to the dominant group and can be ignored.

This study examined two facets of stigma, public and institutional stigma. Public stigma is evidenced in individuals, and reflects personal stigmatizing perceptions and attitudes about mental illness (Corrigan & Shapiro, 2010). Institutional stigma is seen in an agency’s policies, practice and structures and serves to limit opportunities for people living with a mental illness. Institutional stigma is often unrecognized and unchallenged, thus it is easily reproduced society (Fraser & Gordon, 1994; Corrigan & Shapiro, 2010). A stigma model (Corrigan & Shapiro, 2010) describes how these two types of stigma are operationalized, resulting in stereotypes, prejudice and discrimination against people living with mental illness.

Social construction is an important element of the perception of mental illness. Such construction determines which societal group is dominant and which is ‘other’, and it also specifies the defining characteristics of each group (Goffman, 1984; Jacobs, 1992). By constructing deserving and undeserving populations, inequities in service provision can be rationalized (Fraser & Gordon, 1994). Furthermore, the social construction of mental illness as an individual rather than a societal problem is important as this reinforces exclusion (Burke & Parker, 2007). Social construction is important as it has the potential to affect the policy agenda and policy implementation; thus it has significant impact on those in need of mental health services. There are several important erroneous social constructions of mental illness that create shape how people living with mental illness are perceived by the dominant group. These constructions are: people living with serious mental illness are violent and dangerous; people living with mental illness are unproductive and unemployable; and there is no recovery from mental illness (Rack, 1982; Jacobs, 1992; O'Day & Killeen, 2002; Jamison, 2006; Segal, 2009; Corrigan & Shapiro, 2010).

The literature on bureaucratic behavior aids our understanding of what agencies do and how they function. It also explains organizational relationships and behaviors, and describes how the beliefs and values of an agency are reflected in its culture and it its policies and practices. An organization's culture, goals and practices are influenced by leadership (including the board of directors), management and by frontline workers and also by the communities in which they are situate (Kreitner et al., 2001; Harrison & Murray 2012; Jaskyte, 2012). Challenges can arise when different cultures exist within a single agency when the dominant culture is prioritized in terms of allocation of resources and power hierarchies (Wilson, 1989).

Relationships and communication between workers at different levels within an agency have importance in how care is provided. Literature on policy implementation offers several explanations for how policy becomes practice and for why agencies often do not implement policy as intended (Wilson, 1989; deLeon & deLeon, 2002). The two main theories of policy implementation discussed in the literature are the top-down and the bottom-up approaches. The top-down approach focuses on the role of leadership in policymaking and implementation (Sabatier & Mazmanian, 1980; Pressman & Wildavsky, 1984; Sabatier, 1986). Leadership (the top) establishes agency goals, policies and practices, and frontline workers (the bottom) carry out their directives and it is how leadership perceives mental illness that shapes service delivery.

However, the bottom-up approach suggests that it is frontline workers or street level bureaucrats who have influence and discretion in implementing and creating policy (Lipsky, 1980), thus their perceptions of mental illness can impact how policies are put into practice. Literature also exists on a third, integrated model that incorporates both approaches in a circular process (Vinzant & Crothers, 1998). In this model, policy is created and implemented formally and informally, at every level. Furthermore, the dynamics of the relationships between leaders, management and frontline practitioners is such that workers at every level have influence over each other and both policy making and communication take place in a two-way, rather than a linear process.

CHAPTER 4

CONCEPTUAL FRAMEWORK

A conceptual framework develops the principles, assumptions, and ideas that frame research; it is a broad set of ideas and theories that identify a problem and its correlates from the researcher's perspective (Trochim & Donnelly, 2008). In doing so, it describes the key variables and explains the relationship between them (Miles & Huberman, 1994). The conceptual framework that underpinned this research sought to build on the literature to explain how stigma impacts the implementation of mental health policy and how this then creates or reinforces barriers to treatment. This chapter describes the elements of the conceptual framework upon which this dissertation is based. It first discusses the relevant literature about integration policy implementation and about the influences on agency workers that can impact such implementation. A concept map posits that stigma interferes with effective policy implementation, resulting in sub-par outcomes and increased barrier to accessing mental healthcare. This chapter then discusses the dynamics of influences on agency staff's decisions and actions in the course of their jobs. Following this are discussions of the dynamics of decision-making and policy implementation and the dynamics of interactions between agency staff members. Finally, this chapter examines the function of stigma as a barrier to integration policy implementation in FQHCs.

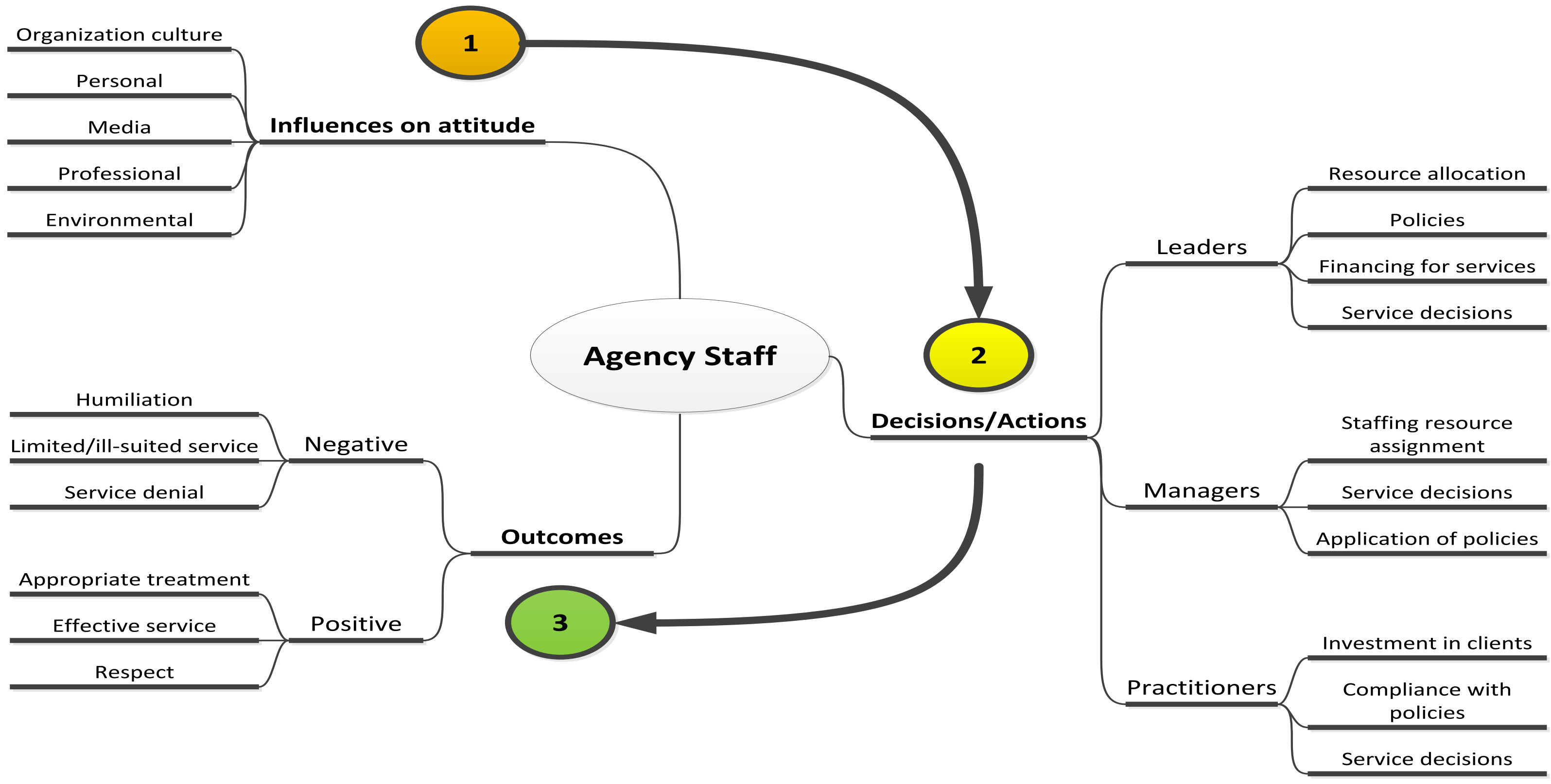
Theoretical, Practice, and Empirical Research Literature

The conceptual framework for this research, focusing on integration of physical and mental healthcare and service provision in Federally Qualified Health Centers (FQHCs), posited that mental health policy is both implemented and created at three levels: agency leadership, middle management, and frontline clinical workers providing services to people living with mental illness. The framework stated that integration policy is implemented and adapted at each worker level. Policy is shaped in part by agency workers' attitudes, opinions, and perceptions of mental illness. Societal assumptions about people living with mental illness can create public stigma whereby people with such illnesses are excluded from social acceptance and from engaging in regular social activities. If agency staff members hold these assumptions and attitudes, and bring them to their work, a culture of institutional or organizational stigma may result. These individuals' personal and professional experiences, the culture of the organization within which they work, messages received by the media and the community within which the FQHC is situated all affect assumptions, stereotypes, and beliefs about mental illness. People make assumptions about curability and treatability of mental illness; they also make assumptions about the capacity and competence of people living with mental illness.

The premise of the framework (see Figure 1, below) is that policy is legislated by the federal government and then enters the process of implementation, which, in being translated into day-to-day practice in FQHCs, impacts client outcomes (Sabatier & Mazmanian, 1980). It is posited that stigma interferes with the effective implementation of federal integration policy, resulting in outcomes that do not necessarily reflect the intent of policymakers; rather than making improvements, stigma creates or reinforces barriers to mental healthcare. The intent of the PPACA in mandating integration of care is to provide appropriate and adequate mental healthcare and to improve rates of access to mental healthcare in FQHCs.

In the context of the research, the power of stigma impacts how integration policy is implemented, contributing to the continuing gap between the numbers of people living with mental illness and the numbers who access treatment. The point at which stigma affects the implementation of mental health policy in terms of provision of treatment is at the local level, or the street level (Lipsky, 1980). In the FQHCs, this focal point refers to the administrators and managers who decide which polices and programs will be implemented and practitioners who decide which groups can access which services and for how long. The theories that informed this framework are those of stigma, the social construction of the mentally ill, organizational relationships and street-level bureaucracy.

Figure 1: Concept Map



Dynamics of Influences on Agency Staff

This framework (Figure 1) describes how the dynamics of the influences on agency workers attitudes affects their decisions and actions in their particular area of influence, and this in turn impacts people living with mental illness. Agency leaders may not have any direct contact with people living with mental illness in a clinical capacity and thus their assumptions about such illness and appropriateness of service provision may be shaped more by considerations of scarce resources and pressure coming from without and within the organization. Supervisors or managers may have had prior experience of direct clinical work but are generally removed from it. Their attitudes can be shaped by the impact of prior experience tempered with having to fulfill the challenges of a managerial role (Prottas, 1981; Harter et al., 2010). For clinicians, working directly with individuals who are living with a mental illness may challenge or reinforce previously accepted societal norms, personal experience, and lessons learned during training (Brief & Weiss, 2002).

Elements that inform agency worker attitudes about mental illness. Attitudes about mental illness are informed by a variety of considerations. A major influence that is on the whole negative is that of public messaging. Media messages about people living with mental illness reinforce negative and incorrect stereotypes, in particular linking mental illness and violence. There is little public rebuttal of these messages and none that has influence over the majority of mass publics.

Other issues, with both positive and negative elements, that inform attitudes are:

1. Personal experience -- their own, a family member or friends' mental illness; influence of their peer group.
2. Professional experience – training and professional education; exposure to a professional code of ethics; influence of a peer group; experience of working with people living with mental illness.
3. Organizational culture.
4. Environment -- political; economic; community values.

These latter elements may reinforce or in some part negate negative messages from the media and can influence how an individual thinks about ideas such as curability, treatability, competence and capacity in mental health, which can affect policy implementation and development and service provision within the agency. Agency leaders, supervisors and clinicians are all directly impacted by the first three influences. Agency leaders are also directly impacted by environmental pressures, and the impact of these is also indirectly felt by supervisors and clinicians, as agency leaders bring pressure to bear on them to apply policy in certain ways.

Dynamics of Decision-Making and Policy Implementation

Agency leaders make decisions about implementing federal, state, and local policy and creating agency policy. Elements that influence these decisions include financing the provision of mental health services and resource allocation. Policy and service provision decisions are also based on perceptions of the curability and treatability of mental illness and of the capacity and competence of people living with mental illness to be valued members of society. Middle managers implement and create policy in their interactions with staff. Attitudes about mental illness may affect how these managers comply with policy and make decisions about staffing resources and service delivery. Frontline workers or clinicians provide treatment and services to people living with mental illness. The attitudes they hold about mental illness can impact their level of investment in their clients and also their level of compliance with policy.

Dynamics of Interactions Between Agency Staff Members.

There is an interactive dynamic between the three levels of agency workers with varying degrees of compliance and resistance, and each group can impact the attitudes and decisions of the others. A strong message from leadership about providing ethical and appropriate service to clients living with mental illness can shape the actions and decisions of managers and clinicians and can create perplexing dilemmas if there is disagreement about such messages. Similarly, if agency policy is shaped more by negative and erroneous stereotypes about mental illness, clinicians can use their discretion to subvert policy and provide services they deem appropriate. According to Isett et al., (2007), bureaucrats or frontline practitioners can, and do, interpret policy in a way that reflects their own biases and perceptions of clients, thereby legitimizing rules and policies they apply to their work. Thus, outcomes for clients can vary depending on the attitudes and actions of these three levels of workers. There can be negative outcomes such as clients being denied services or provided with limited and inappropriate treatment and services, which can cause feelings of humiliation and shame in the clients. Alternatively, outcomes may be positive and result in the provision of respectful, appropriate, and effective service.

Stigma as a Barrier to Policy Implementation in FQHCs.

This study posited that the function of stigma in the implementation process of mental health policy in FQHCs is a major contributor to policy failure. The conceptual framework (Figure 1) operationalized stigma in policy implementation and provided an explanation of the theories and assumptions that became a guide for the research. The framework indicates that the policy implementation process can occur at the agency, management, and practitioner level in FQHCs. Theories of stigma, social construction, organizational relationships, and street level bureaucracy explain how stigma may interact with policy implementation processes and adversely affect outcomes for people living with mental illness, in this case by limiting access to mental healthcare. This interaction occurs because agency worker's attitudes and perceptions of mental illness may be affected by stigma, which could shape their opinions of clients and their worth in society. This shaping of perceptions is significant when resources are limited and decisions are made about which group will receive services.

Summary

By using theories of organizational relationships and street level bureaucracy along with those of stigma and social construction, a theoretical argument is provided to explain why implementation of federal policy to integrate physical and mental healthcare does not often reflect intent, due to the role of stigma in creating barriers to mental healthcare (Lipsky, 1980; deLeon & deLeon, 2002). The conceptual framework is informed by literature on theories of stigma (Goffman, 1984; Falk, 2001), social construction (Schneider & Ingram, 1993; Steinmo & Watts, 1995; Stuber & Schlesinger, 2006); organizational relationships (Hall, 2002; Handel, 2003; Harter et al., 2010); and street level bureaucracy (Lipsky, 1980; Maynard-Moody & Musheno, 2003; Whitford, 2007).

This framework explains how stigma can affect access to treatment for people living with mental illness. This can result from stigma impacting the level of integration between physical and mental healthcare, which, in turn, affects access to services and patient outcomes. Negative messaging not only informs public opinion about mental illness, it also constructs the mentally ill as dangerous, incurable, and otherwise undeserving of the full benefits of social membership. Furthermore, negative messaging in the public sphere contributes to stigma becoming so ingrained in policies, practices, and institutions that it becomes invisible to most and is therefore not addressed (Falk, 2001; Corrigan & Shapiro, 2010; Kobau, 2010). If these processes are at work, agency workers may be influenced by these negative stereotypes and thereby make decisions about what groups people are assigned to and which services they will receive in ways that limit access to treatment for those with mental illness. Thus stigma might affect the policy process at the point of implementation of integration policy, which creates barriers to treatment and, in turn, adversely affects outcomes for those in need of mental healthcare (Link and Phelan, 2001; Corrigan, 2006; Corrigan & Shapiro, 2010).

CHAPTER 5

RESEARCH QUESTIONS AND WORKING ASSUMPTIONS

The focus of this research is the exploration of the role of stigma in policy implementation. The central research question is: **Does stigma impact the implementation of mental health policy and affect access to treatment in FQHCs for people living with mental illness?** An equally important follow up question is: **If stigma does impact mental health policy implementation and access to mental healthcare in FQHCs, how does this occur?**

This research project examined how policy becomes practice and how stigma may or may not be a feature in the process of implementation; it did not examine how policies are created. While there are numerous mental health policy areas, the context for this dissertation is the integration of physical and mental healthcare in FQHCs in a large urban center in New England. This research is pertinent because the PPACA has designated funds specifically for the treatment of mental illness in FQHCs and for the integration of care. This topic is important because there is consistent growth in the number of people being diagnosed with a mental illness and because stigma has the potential to limit life expectancy and life opportunities and increase social isolation.

This research studied integration practices in two FQHCs. It examines the programs and services these FQHCs offer and determines how decisions are made about allocating scarce resources (National Alliance on Mental Illness, 2011). The research also examines inter-agency relationships and considers how agency leadership, managers, and practitioners interact in the processes of implementing and creating policy. While it may be the case that stigma associated with mental illness has a negative impact on mental healthcare and service provision, it may also hold true that there is no link between stigma and policy implementation or that indeed, there is a positive link between stigma and policy implementation in that practitioners in FQHCs may actively resist stigmatizing attitudes and behaviors.

The sub-research questions are as follows:

Sub-question 1:	**Do FQHC practices allocate resources and service provision in accordance with prevalence of illness?**
Working Assumption	Resource allocation and service provision does not reflect prevalence of mental illness within the population.
Alternative Explanation	Resource allocation and service provision does reflect prevalence of illness within the population.
Data Needed	Evidence of the level of mental healthcare services provided within the FQHCs – the percentage of resources allocated to mental healthcare compared to prevalence of mental illness in the general community.
Data Sources	FQHCs individual websites. * Government agencies websites. * Non-Governmental Organization websites. *[2] Brochures etc. available on-site. Informational posters in the CHCs. Interviews with agency leaders.
Data Collection Strategy	Descriptive statistical analysis from primary database of services- data gathered from above noted websites sources. Document analysis of literature obtained from FQHCs. Analysis of interviews with agency leaders for confirming or disconfirming evidence of patterns of resource allocation.
Analytical Approach	Theories of organizational behavior and decision making argue that decisions about resource allocation are not made according to need. Literature indicates a persistent disparity between prevalence of mental illness and access to treatment. Elements influencing decision-making include agency goals, mission and relationships. These decisions, in turn, affect the allocation of resources to mental healthcare.

---

[2] * - Publicly available information.

Sub-question 2:	**Are resources allocated and service provided in accordance with PPACA policy on the integration of physical and mental healthcare?**
Working Assumption	Resource allocation and service provision reflects federal policy.
Alternative Explanation	Resource allocation and service provision does not reflect federal policy.
Data Needed	Data on how integration of physical and mental healthcare occurs. Details of FQHC policy on the provision of mental healthcare. Evidence that mental healthcare services are provided and utilized within the FQHC. Data on percentage of people accessing mental health services compared to the total patient population at each FQHC.
Data Sources	Agency workers: leaders, managers, practitioners. Annual reports. Press releases.
Data Collection Strategy	In-depth interviews. Document analysis.
Analytical Approach	Using theories of organizational behavior and decision-making, which note that street level bureaucrats, i.e. frontline practitioners have considerable autonomy and discretion in deciding which policy to implement and how any such implementation takes place. Stigma and social construction of deserving groups and the mentally ill results in unequal allocation of resources. However, FQHCs are committed to federal policy relating to the integration of physical and mental healthcare and may allocate resources accordingly.

Sub-question 3:	**Do agency workers hold specific opinions about people living with mental illness? If so, how do agency workers form those opinions?**
Working Assumption	Agency workers form opinions based on media reports, personal and professional experience and organizational culture and create hierarchies of deserving patient populations.
Alternative Explanation	Agency workers have no preconceived opinions of people living with mental illness.
Data Needed	Where agency workers get information about mental illness. Does information come from prior professional experience, personal experience, media reports? Data on which sources are most likely to form opinions and whether these are positive or negative messages.
Data Sources	Agency workers: leaders, managers, practitioners.
Data Collection Strategy	In-depth interviews that provide information on how agency workers' attitudes about mental illness are informed.
Analytical Approach	Theories of constructions of mental illness and stigma argue that public perceptions of mental illness are erroneous and based on

	negative stereotypes of the mentally ill as being violent, dangerous, incompetent and undeserving. However, professional knowledge and experience, having an equity focused value base and having experience of mental illness (wither personally or a member of one's social circle) can lead to the rejection of negative constructs.

Sub-question 4:	**How do agency workers' opinions about mental illness impact their work and, as such, the extent to which service provision reflects PPACA policy on integration and the prevalence of mental illness within their catchment areas?**
Working Assumption	Workers have positive and/or negative perceptions of people living with mental illness and their attitudes and assumptions about mental illness impact their work.
Alternative Explanation	Workers have positive and/or negative perceptions of people living with mental illness and their attitudes and assumptions about mental illness do not affect their work.
Data Needed	How attitudes affect the development and implementation of policy and provision of services.
Data Sources	Agency workers: leaders, managers, practitioners.
Data Collection Strategy	In-depth interviews to uncover opinions about people living with mental illness. It is expected that such opinion will be reflected in the language used by workers. An example would be whether or not staff members use "people first" language, that is, describing patients as living with schizophrenia, rather than as schizophrenic, for instance. Additionally, interviews will gather data on how decisions are made about allocating resources and providing services.
Analytical Approach	Informed by theories of organizational relationships, street level bureaucracy, social constructions and stigma. Agency workers may reject stigma and not allow it to become institutionalized in the agency. Practitioners have considerable autonomy and discretion to subvert agency policy and engage in non-stigmatizing practice even if they have no managerial power. Alternatively, public stigma may become institutionalized in organization when agency workers use stereotypes and negative perceptions to inform their decisions.

Sub-question 5:	**Do agency workers believe that some mental illnesses are incurable/not treatable?**
Working Assumption	Beliefs about treatability and curability affect decision-making regarding treatment, leading to inappropriate allocation of resources across mental illnesses.
Alternative Explanation	Beliefs about treatability and curability have no influence on decision-making and allocation of resources across mental illnesses and in relation to medical care.
Data Needed	What beliefs are held about curability and treatability of mental illnesses and how this affects service provision?

Data Sources	Agency workers: leaders, managers, practitioners.
Data Collection Strategy	In-depth interviews to elicit opinions about the curability and treatability of different types of mental illness.
Analytical Approach	Using the lenses of organizational behavior, social construction and stigma. These theories posit that negative social constructions of mental illness and stigma have created perception that certain mental illnesses are more curable/treatable than others and certain groups within the mentally ill are more deserving than others. This may explain in part the disparity between prevalence of mental illness and uptake of treatment. Workers with positive/negative perceptions on the treatability and curability of mental illness may be more/less likely to provide adequate and appropriate services and work with clients to achieve positive/negative outcomes. Organizations with more than one service focus may prioritize one service over the other, based on attitudes about deserving groups and responding to public pressures regarding the allocation of scarce resources. Thus more resources may be directed to physical than mental healthcare and to people living with depression and anxiety rather than more serious mental illnesses.

These working assumptions, noted above, were explored in the course of the research. It is acknowledged that other circumstances exist to offer alternative explanations for levels of mental health service utilization. It may be the case that a person living with a mental illness has internalized the stigma associated with such illness and that it is this, rather than institutional stigma, or some combination of both, that impedes service utilization; however, there is no way to determine the impact of this dynamic in the context of the current research.

However, other, previously unidentified, explanations arose during the study. These previously unidentified explanations for low levels of mental health service utilization include but are not limited to: multiple definitions of and approaches for integrating physical and mental healthcare; mental healthcare has been subsumed into, rather than integrated with, the medical model; cultural barriers to developing a multidisciplinary team; and public stigma and particularly institutional stigma persist in these agencies, which reinforces exclusionary policies and practices and limits access to mental healthcare for FQHC patients. A full discussion of the factors affecting access to mental healthcare is found in the findings chapters (Chapters 7 and 8).

CHAPTER 6

METHODOLOGY

This chapter will describe the methodology used to answer the research questions outlined in the previous chapter. Included in this section is an explanation of: the rationale for utilizing the chosen methodology; the site selection procedure; the data collection strategy; and the data analysis process.

Rationale for Methodology Choice

This study sought to understand the role of stigma in the policy implementation process and answer the following research questions. Does stigma impact the implementation of mental health policy and affect access to treatment in FQHCs for people living with mental illness? And, if stigma does impact mental health policy implementation and access to mental healthcare in FQHCs, how does this occur?

These research questions were examined utilizing qualitative case study methods. This case study involved collection and qualitative analysis of data obtained from: in-depth interviews with agency staff at two FQHCs; interviews with key informants not associated with the case study sites but who have expertise in various aspects of the mental health field; background information on the FQHCs; and direct observations of agency systems (Yin, 2003). The rationale for using this approach is that the case study methodology permits deep analysis of FQHCs' mental health policies and practices. Moreover, the case study approach is an appropriate methodology as the research questions relate to how and why the phenomena occur and the research is based in the present (Yin, 2003). In particular, Schramm noted that the case study approach is useful because it highlights "a decision, or set of decisions: why they were taken, how they were implemented, and with what result" (as cited in Yin, 2003, p. 17). Moreover, it is a method suited to inductive rather than deductive research (Foldy & Buckley, 2010). While qualitative research samples are generally small and purposive (Miles & Huberman, 1994), by having multiple case study sites, research data are strengthened with respect to reliability and validity and the findings may be analytically generalizable to other FQHCs (Yin, 2003).

Site Selection

FQHCs were selected as the unit of analysis as they are often the healthcare setting of last resort, providing affordable healthcare to millions of Americans who are either underinsured or uninsured (National Association of Community Health Centers, 2012). Furthermore, they are mandated by the PPACA to promote the integration of physical and mental healthcare and they have access to additional resources to facilitate the provision of a comprehensive range of treatment and services. Moreover, as Medicaid is the largest payer of mental healthcare in the US, many people living with mental illness, a large proportion of whom are in receipt of Medicaid benefits, will first interact with the mental healthcare system in FQHCs, if they have any contact at all (Frank et al., 2003).

As noted, the research took place at FQHCs situated in a large urban center in New England. The rationale for choosing this setting is that, while there is more income disparity in mental healthcare and perhaps greater stigma attached to mental illness in rural areas (Agency for Healthcare Research and Quality, 2013), urban centers are primary target areas for FQHCs (Smedley et al., 2003). Moreover, if FQHCs are the optimal places for underserved populations to receive integrated care (Knight, 2011), then a study of such centers provides a good opportunity to uncover the processes for healthcare delivery and the ways that public perceptions of mental illness may affect mental health policy implementation in such settings.

An initial set of 15 potential sites was identified from an analysis of characteristics of FQHCs; such information is available in a database compiled during the initial stages of this project, and is summarized in Table 1, below. Selection was informed by consideration of a number of criteria. These include the range of health services offered by a FQHC, including specialized mental health services, with clinical providers (including psychiatrists and clinical social workers) being present at each site. Selection was also informed by the composition of the board of directors, and the location of each FQHC. Given the sensitive nature of the research and potential threats to confidentially, the names and locations of the participating FQHCs are not disclosed.

Exploration of background data and the historical context are a requirement for any qualitative study (Marshall & Rossman, 2006). The historical context of this research, which is discussed in the background section, informed which background data on 15 potential FQHCs in a large New England urban area were important to consider when selecting participating sites. Data was derived from government and public websites that provide information on each of the 15 FQHCs and from a document analysis of relevant annual reports, press releases, letters, newspaper reports and other documentation. This information, gathered from publicly available sources, was compiled into a database, which was supplemented with further information gathered from the FQHCs during the site selection and recruitment stage of the process.

Table 1: Characteristics of Potential Case Study Sites

Health Centers	# Clients 2011	# Clients using Mental Health Services	Clients using Mental Health Services as % of Total Client Population	Board At least 51% Patient Representatives	Operating Revenue	Mental Health Services Expenses	Mental Health Expenses as % of Operating Revenue
Independent							
Center #1	14534	2700	18.58	No	31,603,134	1,296,582	4.1
Center #2	21037	1762	8.38	Yes	22,356,949	1,546,119	6.92
Center #3	14281	459	3.21	No	29,538,000	8,000,000	27.08
Center #4	20758	1783	8.59	Yes	23,494,745	2,466,120	10.5
Center #5	19199	2492	12.98	No	43,349,951	3,713,857	8.57
Center #6	11633	433	3.72	Yes	8,956,000	687,000	7.67
Center #7	15000	N/A	N/A	Yes	13,795,703	4,214,404	30.55
Center #8	12773	1778	13.92	N/A	20,888,966	N/A	N/A
Not Independent							
Center #9	N/A	N/A	N/A	Yes	N/A	N/A	N/A
Center #10	12000	N/A	N/A	N/A	N/A	N/A	N/A
Center #11	7393	0	0	Yes	N/A	N/A	N/A
Center #12	N/A	N/A	N/A	Yes	N/A	N/A	N/A
Center #13	9348	483	5.17	Yes	N/A	N/A	N/A
Center #14	26511	1137	4.29	N/A	N/A	N/A	N/A
Center #15	N/A	N/A	N/A	Yes	N/A	N/A	N/A

Source: Data gathered from publicly available FQHC websites.

Table 1 (above) outlines the particular FQHC characteristics that informed site selection. Background information that was considered included the number of clients served, budget, range of services, and geographic location. Other information that was pertinent to the research related to the administration of the FQHCs. Initial analysis demonstrated that eight of the FQHCs are independently administered while the remaining seven fall under the administration of parent organizations. This criterion is important as it is anticipated that independent agencies would have more flexibility in policy decision making and implementation and that these would be more appropriate for case study. Furthermore, initial review of the data indicated that the independent FQHCs make much more information publicly available than those that are not independent. Only the eight independent sites were considered as potential case study sites.

A closer analysis of the eight independent sites indicated that Center #1 would not be a suitable research site. Unlike the other FQHCs considered Center # 1 provides care to a predominately homeless population; service provision takes place on the street, in shelters, and in outpatient clinics. Center #1 is unique in this subset of FQHCs, providing care to a scattered, fluctuating and inconsistent patient population that is difficult to track and assess; care continuity is frequently problematic. Because Center #1 differs in so many regards from the other seven FQHCs, it was excluded from the selection sample.

Beyond serving a consistent client population in the communities within which they reside, the most significant criterion in identifying the two case study sites from among the remaining seven independent FQHCs was the provision of specialized mental health services, i.e., having professional mental healthcare providers on site, rather than having primary care doctors treat patients for mental health related concerns. Provision of such specialized services may signify the level of importance placed on mental healthcare in resource allocation and on addressing the problem of disparity between prevalence of mental illness in society and the numbers of individuals accessing mental healthcare.

Board membership was another variable that was considered in determining site selection as it is expected that agencies with board membership meeting the federally required 51% client representative criteria would be more likely to adopt and implement policies that reflect the needs of their patient population. This criterion was applied to examine how different leadership characteristics affect intra-agency dynamics and the creation and implementation of mental health policies. Consideration of board membership also permits examination of who holds the power to define agency goals, culture and mission and why ownership of such power matters.

The availability of publicly accessible reports on FQHC websites was also considered. This criterion was included because it suggests transparency in practice. This is important to the extent that agencies that already make a considerable amount of information publicly available may be more likely to share information and participate as a case study in this research. FQHCs such as these may also make greater use of information technology and, as such, be more willing and able to share other pertinent data instructive to the study.

In summary, criteria for selection of the case study sites included: independent FQHCs; FQHCs that offer specialized mental healthcare; FQHCs with publicly accessible reports; and of course, FQHCs with leadership supportive of this project.

Taking the above-mentioned criteria into account, seven independent FQHCs were approached to participate in this study. All had similar characteristics in terms of criteria including but not limited to populations served, services offered, and geographic location. From these seven FQHCs, two that met all inclusion criteria agreed to be participant sites. These were Site A and Site B; Table 2[3] (below) outlines qualifying criteria and characteristics for each site. While both FQHCs meet criteria for inclusion, they differ in ways that were of interest to this research. Initial publically available information indicated that Site A did not have 51% patient representation on the board while Site B did have sufficient representation. Also of interest is that both have similar percentages of patients accessing mental healthcare; however, the mental health related expenditure as a percentage of operating revenue is approximately four times greater at Site A than Site B. This research sought to uncover whether differences across sites in patient representation and mental health spending impact how integration takes place and what role, if any, stigma has in the process. It is acknowledged that these sites may have characteristics that render them quite different from other FQHCs.

---

[3] 2012 HRSA Data. Available: http://hrsa.gov/uds/datacenter.aspx?q=d&year=2013

Table 2: Characteristics of Participating Sites

Criteria/Characteristics	Site A	Site B
Large urban location	Yes	Yes
Independent	Yes	Yes
Provision of specialized mental health services	Yes	Yes
Integrating physical and mental healthcare	Yes	Yes
Publicly accessible reports	Yes	Yes
Board At least 51% patient representatives	No	Yes
Leadership supportive of this project	Yes	Yes
Total # patients enrolled	14,687	11,772
Patients utilizing MHS	726	494
Clients using MHS as % of total client population	4.94%	4.2%
% Increase of patients accessing MHS 2010-2012	70.4%	40.7%
MH expenses as % of operating revenue	31.98%	8%
% Patients at or below 100% of poverty line	64.1%	63.4%
% Patients at or below 200% of poverty line	91.6%	94.4%
Racial and/or ethnic minority	95.7%	81.7%

Characteristics of the Sites Included in the Case Study.

While Table 2 reports key characteristics of the two participating case study sites, Table 3 (below) outlines the main similarities and differences between the two sites.

Table 3: Similarities and Differences Between Case Study Sites

Similarities Between Site A & Site B	**Differences Between Site A & Site B**
Independent	Reasons for integration
Integrated care prior to PPACA mandate	Level of financial resources for mental healthcare
Specialized mental health services	Size of FQHC campus
Publicly available reports	Level of patient representation on Boards
Patients largely from minority populations	Organization of service provision
Patients economically disadvantaged	Referral processes
Patient ethnicity not reflected in providers	
Use of electronic medical records	

Both participating sites are independently operating FQHCs located in the same large urban setting. Both sites have sought to integrate physical and behavioral healthcare. In publicly provided healthcare, the integration of physical and mental healthcare is impeded by high comorbidity levels, regulatory compliance demands and limited resources (Mauer & Druss, 2010). A study by the National Association of Community Health Centers (2012) found that FQHCs integrating physical and mental healthcare operated in 35 states. A survey from this 2011 study also found that only around 54% of FQHCs across the country were integrating such care.

Thus, in terms of this case study, these two sites are exceptional in that they have been providing some type of integrated physical and mental healthcare to their patients for some considerable time. This history makes these two FQHCs important sites for study precisely because both began the process of integrating physical and mental healthcare well before the PPACA mandate. Early experience integrating care permitted interviewees from the two case study sites to reflect on the process to date. This reflective knowledge was important in identifying influences that both facilitated and created barriers to integration, insights that might have been unavailable in sites with less experience of integrating care.

At initial introductory meetings with this researcher, representatives from leadership at both sites reported feeling proud that their sites were already integrating care to some extent, and indicated that they were very keen to participate in this research. Both sites provide a wide range of physical, mental, and substance use services that offer a continuum of care to the center's patients. Although both sites have long been committed to integrating physical and mental healthcare, they have done so for different reasons. At Site A, leadership stated that the decision to integrate was solely a financial one. However, Site B was set up with the intent of providing integrated care, as leadership believed that this was the best way to meet patient needs and to improve outcomes for the community.

The two case study sites are also similar to each other in that both are located in communities with a large proportion of minority individuals. At Site A, 95.7% of patients report being from a racial or ethnic minority and at Site B, this figure is 81.7%. These communities are economically disadvantaged, with a high level of need for public services. At Site A, in 2012, 64.1% of patients were at or below 100% of the poverty line and 91.6% at or below 200% of the poverty line. At Site B, these numbers were 63.4% and 94.4% respectively (HRSA, 2013).

Analysis of direct observations made at each case study site indicates that both sites were similar in that patient ethnic makeup is not reflected in healthcare providers and particularly in mental healthcare providers. While medical doctors and non-clinical staff at both sites were from racial minority groups, the only mental health provider from an ethnic minority was a psychiatrist. All of the other mental healthcare providers, such as clinical social workers and licensed mental health counselors, were white. One leadership representative noted that this lack of diversity is a challenge to promoting patient access to mental health services: “You really need to think in terms of diversity when you’re having a team that’s gonna be seeing people from different ethnic backgrounds and we don’t have that in mental health.” This lack of diversity in mental healthcare is not unique to these centers. Previous research indicates that around 90% of mental health professionals are non-Hispanic white, with just 8.7% of social workers, 15.4% of mental health counselors and 24.2% of psychiatrists coming from racial or ethnic minority groups (American Psychological Association, 2015).

Both sites also utilize health information technology and have a shared Electronic Medical Record (EMR) that is protected by HIPAA regulations (U.S. Department of Health and Human Services, December 2014). Patients are provided with information detailing their privacy rights and responsibilities. Personal information cannot be shared with individuals and entities not covered by HIPAA. These individuals and entities with whom such information can be shared include but are not limited to doctors and hospitals, family and friends as indicated by the patient, and government agencies in cases of illnesses that pose a threat to public health, for example, Ebola (Healthit.gov, 2015). While each site's EMR allows certain providers to read clinical notes about shared patients, there are restrictions placed on accessibility to mental health records. The issue of restricted access to patient mental health information will be discussed in greater length in the next chapter.

The two FQHC study sites differ in a number of important ways. Perhaps the most significant difference is the level of financial resources allocated to mental healthcare (see Table 2). The most recently available statistics, from 2012, indicate that, at Site A, the proportion of operating revenue allocated to the provision of mental healthcare was 31.98%, whereas at Site B, this figure was 8.00%. Another difference is that Site A is bigger in scale than Site B. In 2012, Site A served 14,687 patients, while at Site B, 11,772 patients were served. In the same year, at Site A, the proportion of total patients who accessed mental health services was 4.94%, whereas at Site B, 4.2% of total patients utilized mental health services (HRSA, 2014). Site A has a very large campus with numerous buildings providing a range of health and social services, while Site B has two small locations that the center has outgrown as services have been added, resulting in crowded waiting rooms and waiting lists for services.

A third difference between these two sites that was initially considered important was patient representation on the board of directors. At least 51% patient representation is a federal requirement for FQHCs. Preliminary analysis of background data indicated that the board at Site A did not meet the 51% patient representative standard, whereas the board at Site B did. However, during the course of this case study research, it became apparent that each site inaccurately reported these board characteristics in publically available information. The issue of levels of patient representation on the boards at each case study site is complicated and will be discussed in greater detail further in Chapter 8.

The case study sites also differed in their organization of service provision. Site A has separate services for adult and pediatric healthcare, whereas Site B is a family practice where providers offer care to patients across the full age continuum. Below, I discuss the impact of this difference on how integration took place. At Site A, which was established over a century ago, integration of adult and pediatric care occurred at different times. The integration of pediatric care began in the 2000s and was completed by 2011, while the integration of adult healthcare is currently in process. However, Site B established integrated, comprehensive care for all patients when it was established in the 1970s.

There are similarities and differences in mental health referral processes. These are noted briefly here and discussed in-depth in the following chapter. Both sites require individuals wishing to access mental health services to have a primary care provider at the FQHC. Such providers at each site generally make the referrals; differences arise in how this occurs. At Site A, medical providers are most likely to utilize the warm hand-off method. The warm hand-off refers to a physician introducing a patient to a mental health provider in-person, and explaining to the patient that the two providers work together as part of a multidisciplinary team. At Site B, the warm hand-off is the preferred referral method of mental health providers but, after a change in executive leadership, and a subsequent turnover of medical staff, this type of person-to-person referral process does not often occur. Rather, medical providers typically communicate directly with mental health providers when making the referral, often without the patient's consent or knowledge. Despite repeated requests, I was unable to meet with Site B's Executive Director to ask about staffing and referral issues.

Data Collection Methodology

Case studies were carried out at the identified FQHCs with the aim of understanding how implementation of integration policy takes place. The aforementioned conceptual framework underpinning the case studies is informed by theories of stigma (Goffman, 1984; Falk, 2001; Corrigan, 2010), social construction (Schneider & Ingram, 1993; Steinmo & Watts, 1995; Stuber & Schlesinger, 2006); organizational relationships (Hall, 2002; Handel, 2003; Harter et al., 2010) and street level bureaucracy (Lipsky, 1980; Maynard-Moody & Musheno, 2003; Whitford, 2007).

Interviews. A total of 40 in-depth, in-person interviews were carried out with representatives from leadership, management and frontline practitioners across the two sites and with key informants unaffiliated with the two case study sites. Leadership representatives were from the Executive Officer/Medical Director/Chief Behavioral Health Officer level, while managers were Program Directors, or similar. Frontline workers are those providing direct care and/or services to patients and include social workers, mental health counselors, and outreach workers. Each individual who participated in an interview was assigned a code to maintain confidentiality. Codes were developed so that the location and role of the individual would be apparent without breaking confidentiality. The letter of the code corresponded to the relevant site; i.e., A and B for the two case study sites, while key informant interviews were coded KI. These letters were then followed by a number indicating the order in which each member of a particular level at each case study site -- leadership, management, frontline workers -- was interviewed; this number has no other significance. Thus, for example, the first leadership representative interviewed at Site A was coded LeaderA01, while the second management representative at Site B was coded M/mentB02. For key informants interviews, the respondents were simply coded KI_01 to KI_19.

Twelve interviews took place at Site A, nine at Site B; 19 key informants were also interviewed. The key informants represent a range of professional groups and included eight mental healthcare providers (of whom seven work in a FQHC and one in an in-patient psychiatric facility), two physicians working in large hospitals, two legislators, three academics, three representatives of advocacy organizations for people living with mental illness and one journalist).

Interviewing staff members from different levels in the hierarchy at the two case study agencies provided an understanding of the phenomena studied from varied perspectives. Indeed, “to get to the construct, we need to see different instances of it, at different moments, in different places, with different people" (Miles & Huberman, 1994, p. 29). This researcher sought to interview any member of staff at either site who had a perspective on how physical and mental healthcare integration took place in the FQHC and who provided informed consent to be interviewed.

A point person at each site worked with this researcher to identify potential interviewees and emailed them to introduce the research and to ask them to participate. This researcher then followed up by email with each individual and asked him or her to participate, stressing the confidential nature of the interviews. There was a small level of snowball sampling, whereby interviewees suggested other potential participants for the research, including individuals unaffiliated with the two case study sites (i.e., the key informants) (Miles & Huberman, 1994; Weiss, 1994; Marshall & Rossman, 2006; Trochim & Donnelly, 2008). At Site A, nine participants were recruited by purposive sampling, while three participants were recruited by snowball sampling. At Site B, purposive sampling identified all respondents and purposive sampling identified thirteen key informants, while the remaining six were identified by snowball sampling. In total 31 participants were identified by purposive sampling and nine by snowball sampling.

At Site A, three representatives from leadership, three from management and six frontline practitioners participated in interviews, for a total of 12 interviews. At Site B, nine interviews were conducted with one leadership representative, four managers and four frontline practitioners participating in interviews. All but one participant at each site consented to be recorded and only one person at each site did not respond to numerous requests for interview. Where possible, consent forms were provided in advance to allow participants time to review the document.

Tables 4.1, 4.2 and 4.3, below, provide information on the respondent's self-reported influences on their perceptions and attitudes about mental illness.

Table 4.1: Reported Influences on Site A Respondent's Perceptions of Mental Illness

	Personal Experience	Professional Experience	Community	Political/Economic Environment	Media	
LeaderA01	x	x			x	
LeaderA02		x	x			
LeaderA03	x	x	x	x		
M/ment A01	x	x	x	x	x	
M/ment A02	x	x	x	x	x	
M/ment A03		x		x		
FLWA01	x	x			x	
FLWA02	x	x	x		x	
FLWA03	x	x		x		
FLWA04		x				
FLWA05	x	x				
FLWA06	x	x	x			37
Leader -Representative from Leadership						
M/ment - Representative from Management						
FLW - Frontline Worker						

The total sum of the columns (37) is greater than the total number of respondents (12) as respondents reported more than one influence on their perceptions of mental illness. The same is true for the tables relating to respondents at Site B and for the key informants.

Table 4.2: Reported Influences on Site B Respondent's Perceptions of Mental Illness

	Personal Experience	Professional Experience	Community	Political/Economic Environment	Media	
LeaderB01		x	x		x	
M/ment B01	x	x	x	x		
M/ment B02		x				
M/ment B03	x	x				
M/ment B04		x	x			
FLWB01	x					
FLWB02		x	x	x	x	
FLWB03	x	x	x		x	
FLWB04	x	x				23
Leader -Representative from Leadership						

M/ment - Representative from Management
FLW - Frontline Worker

Table 4.3: Reported Influences on Key Informant's Perceptions of Mental Illness

	Personal Experience	Professional Experience	Community	Political/Economic Environment	Media	
Mental Health Providers	4	8	5	4	4	
Physical Health Providers	2	3	1	2	1	
Politicians	2	2	2	2	2	
Academics	3	3	1	3	2	
Advocates	1	3	2	2		
Journalists	1	1	1	1	1	
Total	13	20	12	14	10	= 69

Key informants. Additional information was gathered from 19 key informant interviews who were not case study site employees but who have knowledge of the phenomena being studied (Weiss, 1994) and come from a wide range of professional backgrounds. Key informants provide a different perspective from other interviewees (Lofland & Lofland, 1995), including important background and contextual information and information that contributes to a broader understanding of the implementation process. Key informants are also useful in that they facilitate access to evidence that may confirm or contradict interview findings (Yin, 2003), although this researcher is mindful of potential biases held by these informants. In this study, the researcher contacted individuals who had some expertise in or detailed knowledge of federal, state, and local mental health policy, practice and/or integration. Snowball sampling was very useful in locating other key informants to interview during the course of the research (Miles & Huberman, 1994; Lee, 1999; Trochim & Donnelly, 2008).

Interview Protocol. Interviews relied on protocols that were informed by the conceptual framework and analysis of background information. There were four interview protocols, one for each group of interviewees: agency leaders, managers, practitioners and key informants (see Appendix B for the interview protocols, Appendix C for consent form). Each protocol was designed to uncover processes and attitudes about PPACA integration policy development and implementation, service provision, client groups, and mental illness in general. The interview protocols included questions about allocation of resources, integration of physical and mental healthcare, attitudes about mental illness, and willingness to implement mental health services. Questions were also asked about possible challenges or barriers to integration and provision of treatment (Hinshaw & Stier, 2008). The open-ended nature of the questions allowed for new information to arise and for the interviewees' perspectives on their experience within the agency and attitudes about mental illness to emerge.

Survey instrument. As part of the interview process, interviewees were asked to complete a stigma instrument or survey (Appendix D). This instrument uses questions utilizing a Likert scale, whereby answers reflect attitudes and beliefs (Clarke & Crewe, 2001; Arboleda-Flórez & Sartorius, 2008). The instrument was adapted from a survey developed by Johnsen et al., (1997) to gather information on attitudes of people holding leadership positions in the mental health field. The internal reliability of the original instrument, Cronbach's Alpha = 0.671, was adequate (Johnsen et al., 1997, p. 63); for the adapted version, administered in this study, Cronbach's Alpha = 0.692. According to Zaiontz, a "commonly-accepted rule of thumb is that an alpha of 0.7 (some say 0.6) indicates acceptable reliability and 0.8 or higher indicates good reliability” (Zaiontz, 2014, p. 1). The Likert scale is useful as it provides a means to “quantify constructs which are not directly measurable” (Gliem & Gliem, 2003; p. 82) whereby the researcher uses “multiple-item scales and summated ratings to quantify the construct(s) of interest” (Gliem & Gliem, 2003; p. 82). Additionally, benefits to using this instrument are that people taking the survey are not aware that it is measuring prejudice, and it is easy to administer.

Of course, the use of a Likert scale can be subject to several forms of bias, including: central tendency bias, where respondents avoid extremes on either side of the scale; acquiescence bias, whereby respondents agree with the written statement; and social desirability bias, where respondents give the answer they believe is expected of them, or that shows them most favorably (Fink, 2009).

The instrument was presented as a survey of societal perceptions about mental illness; the word stigma was not used in introducing the instrument. At each site, one participant did not complete the survey, one individual was called away and the other declined to complete it – this same individual also did not consent to being recorded. The survey completion rate for the study sites was 19 out of 21, or 90.5%.

This research only examines survey data (from the stigma instrument) from respondents at the two case study sites, and not from key informants, as the main purpose of this instrument was to attempt to determine if staff members at each of the two FQHCs studied held stigmatizing attitudes about people living with mental illness. In the stigma instrument, seven statements were positively associated with stigma, while seven had a negative association; i.e. statements positively associated with stigma are those that indicate a stigmatizing attitude towards mental illness, while negatively associated statements indicate a non-stigmatizing attitude. Statements with a positive association with stigma are about people living with mental illness being excluded from society in some way, while negatively associated statements are more inclusionary. For example, one statement that was positively associated with stigma was “The best way to handle the mentally ill is to keep them behind locked doors.” It was expected that a person who held stigmatizing beliefs about people living with mental illness would score this statement quite highly, towards the “strongly agree” end of the scale, while interviewees without such beliefs would score towards the middle or closer to “strongly disagree.” One negatively associated statement was “Most people with serious mental illness can, with treatment, get well and return to productive lives.” It was expected that respondents who did not hold stigmatizing beliefs about mental illness would score this statement towards strongly agree, while a person holding stigmatizing beliefs would score it more in the middle or closer towards “strongly disagree”. Respondents scored each statement on a five-point range from strongly disagree (1) to strongly agree (5). T-tests for differences in means were used to examine differences between the two sites, between levels of workers and between professional disciplines.

After the statements were divided into the positive and negative typologies, the negative responses were reverse coded (Hartley, 2014), so that for each answer, the scores range from 1 (little/no stigma) to 5 (significant stigma). Each interviewee’s total score for all 14 statements each section was calculated and from this, a mean score was calculated. All total mean, mode and median scores for each respondent can be found in Table 6 (in Chapter 8), while scores by site and by mental health related and non mental health related respondents, and physicians and non-physicians are found in Tables 7.1, 7.2 and 7.3 respectively (also, in Chapter 8).

For example, respondent Aa001 scored a total of 23 and had a mean score of 1.64. The mean scores for each individual were then compared to their statements made during the interview process. Further detail on scoring, as well as any differences between statements and scores are highlighted and discussed in the findings chapters.

Direct observation. Direct observations within case study sites also provide data pertinent to this research. Data was gathered from 13 direct observations at each site. These included observations made by this researcher of interpersonal interactions between staff members and of agency systems and processes; there were no observations of client interactions. Direct observations took place at staff meetings and during interview visits. It was expected that the norms of the agency would be reflected in interactions, communications, and environment. Furthermore, it was anticipated that the workings of intra-agency relationships would be reflected in interactions between staff at different levels within the agency. These ideas will be discussed further in the findings chapter.

Direct observation is a useful method for discovering “recurring patterns of behavior and relationships” (Marshall & Rossman, 2006, p. 99). Furthermore it “is used to discover complex interactions in natural settings” (Marshall & Rossman, 2006, p. 99) and can reveal attitudes and behaviors that may not be displayed in a more controlled setting. Thus it is expected that biases and prejudices can be detected if witnessed in informal interactions and in non-verbal communications between different staff levels.

Data from direct observations were recorded in field notes that provide “detailed, nonjudgmental, concrete descriptions of what has been observed” (Marshall & Rossman, 2006, p. 98).

Language that is used in interviews or observed in interactions among staff is an indicator of attitudes and perceptions of mental illness. It was anticipated that the use of “people first” language (talking about a person living with mental illness rather than a mentally ill person) would indicate more respectful, inclusive attitudes and environments. Given the sensitive nature of the research, the fact that people living with mental illness may be considered a vulnerable population, and concerns regarding confidentiality, no observations of or interaction with clients took place. Any identifying information that was unintentionally revealed to this researcher was not documented, and was disregarded.

Document review of background information. As part of the case study, data were also obtained from content analysis of printed material (such as brochures and posters) on mental health services and resources that are available at each FQHC, as well as other pertinent information available from each FQHCs website. Content analysis allows for “describing and interpreting the artifacts of a society of group” (Marshall & Rossman, 2006, p.108). It involves identifying patterns in the documents by counting how often themes appear (Trochim & Donnelly, 2008). Content analysis is useful because it is non-invasive and its accuracy can be easily verified (Marshall & Rossman, 2006), although the researcher must be mindful of bias in the analysis process. It is especially “rich in portraying the values and beliefs of participants in the setting” (Marshall & Rossman, 2006, p. 107).

A thorough review of documents relating to policies, procedures, and publicly available reports and other documents, including but not limited to, meeting minutes, announcements and press releases from each agency was carried out (Yin, 2003). Data gathered included information on physical and mental healthcare and services that are offered, numbers of clients who participate in such services, and agency commitment to integrating physical and mental healthcare. Documents were analyzed to look for pertinent components contributing to policy development and implementation.

Data Analysis

Prior to beginning the research, a full Institutional Review Board (IRB) application, addressing all ethical considerations, was submitted and approved. The rigorous IRB application process aided in anticipating potential problems or ethical concerns and in identifying means to address them prior to beginning the research. Given the nature of the research project, all data was anonymized and confidentiality was maintained to the greatest degree possible. Data was stored on a non-networked hard drive and paperwork kept in a locked cabinet.

Data for this study were gathered from multiple sources: 40 in-depth interviews, the stigma instrument, reflection memos, direct observations, background information, and document analysis. It was anticipated that certain themes would be found during the course of the analysis, but it was also expected that other, unanticipated themes would emerge from the data. In order to produce high quality analysis, all collected evidence, both confirming and disconfirming, was examined and all possible interpretations considered (Yin, 2003).

A professional transcriptionist transcribed the interviews verbatim, and ensuing data from all sources was coded by this researcher and analyzed using HyperResearch software. Data were first sorted using analysis matrices (Appendix E) created by this researcher, and informed by the conceptual framework. From the matrices, codes and a codebook were developed for use with HyperResearch (Appendix F). Data were then analyzed to search for confirming and disconfirming evidence of the working assumptions. The main analytic technique employed is pattern matching, whereby patterns found in the data analysis are compared with those predicted in the conceptual framework and literature review (Yin, 2003). These are described in the analytic approach of the research sub-questions, found in Chapter 5. The patterns or themes that the researcher anticipated finding in the analysis reflect the theories that underpin the conceptual framework. The following provides two examples.

(1) Theories of organizational relationships and decision-making argue that decisions about resource allocation are not made according to need. Indeed, the literature indicates a persistent disparity between prevalence of mental illness and access to treatment. Therefore one may expect to find that elements influencing decision-making include agency goals, mission, and relationships, which then impact the allocation of resources to mental healthcare. Further discussion of patterns and themes is found in the chapters on findings.

(2) Theories of stigma and the social construction of deserving groups and the mentally ill suggest that such constructions result in unequal allocation of

resources. However, FQHCs are committed to integrating physical and mental healthcare and may allocate resources accordingly. Public stigma becomes institutionalized in organizations when agency workers use stereotypes and negative perceptions to inform their decision of policymaking and implementation. However, agency workers may reject stigma and not allow it to become institutionalized in the agency. Workers with positive perceptions on the treatability and curability of mental illness may be more likely to provide adequate and appropriate services and work with clients to achieve positive outcomes. In cases where workers have negative perceptions, the expectation is that the opposite will be true. Again, these themes are discussed in detail in the findings chapters.

Soundness: internal and external validity. The numerous data sources used in this study allow for triangulation (Yin, 2003), thus improving the internal validity of this research, as credibility comes from multiple forms of corroborating data. Having two case study sites adds to the robustness of the findings. Analysis of the data was carried out until theoretical saturation "when new data no longer adds new meaning" (Trochim & Donnelly, 2008, p. G-9) was reached. Data obtained from interviews with each research participant was compared to that of other interviewees, with background data, documents analysis, and direct observations thus allowing for triangulation (Miles & Huberman, 1994, Marshall & Rossman, 2006). Ensuring that the research took place within the boundaries of the case study sites and the limitations of the theoretical framework also strengthened internal validity.

The external validity of this research is evidenced not by its statistical generalizability but in its analytic transferability, that is, theories of stigma in policy implementation help to identify other cases in which the results may be transferable. Moreover, case studies "provide for a more complete understanding of a situation's complexity by examining behavior in context," which assist in determining the transferability of the findings as well (Majchrzak, 1984, p. 63).

The reliability or dependability of the research is indicated by how the research is carried out. The intent of qualitative research is to start from the particular, to operationalize all the steps taken in conducting research, and to learn from particulars specific to the case under examination (Marshall & Rossman, 2006, Trochim & Donnelly, 2008). Using interview protocols based on the conceptual framework also reinforces reliability, as such instruments help to ensure uniformity in questioning of interviewees; additionally, such protocols are IRB approved, thus have met certain standards for quality. By analyzing data obtained from these interviews, as well as the other aforementioned data sources, it is possible to develop a revised framework for integration policy implementation that pertains to this case and, possibly, to others like it. This concluding framework, therefore, helps to promote replicability and transferability by providing future researchers with a tool to engage in additional study of policy implementation in other contexts; the model developed from this study is found in the Conclusions chapter. Additionally, by making explicit the development of the database, outlining the multiple sources of evidence, maintaining a chain of evidence used and data sources accessed (while maintaining confidentiality), the dependability of the study is reinforced. Furthermore, a repeat of this research with more investigators could look for inter-coder reliability, in order to further bolster findings.

Study Limitations

There are several potential limitations to this case study. The stigma instrument uses Cronbach's alpha as an estimate of reliability, to test that it is measuring stigma consistently -- the instrument applied in this study has an estimate of 0.692 which indicates adequate but not good reliability. Other limitations of the research are that it was not possible to interview any board members, that these two case study sites are exceptional, as will be discussed in the findings chapters, and that the results are not transferable to all other FQHCs, although they may be to some extent at FQHCs with similarities to the sites studied. Additionally, while this research does not address the financial aspect of care, it does acknowledge the continuing role that allocation of such resources play in creating barriers to integration.

CHAPTER 7

AN ANALYSIS OF THE COMPLEXITIES OF INTEGRATING PHYSICAL AND MENTAL HEALTHCARE IN FQHCS

The intent of this study was to further understanding of the process of policy implementation, with a particular focus on stigma in integration policy implementation in FQHCs. The main findings from this study are discussed in this and the following chapter. This chapter specifically addresses the implementation of federal integration policy by local agencies, i.e. FQHCs. Such implementation is a complicated and involved process. This chapter discusses the central themes that emerged in case study sites' implementation of integration policy. In-depth analysis of the data uncovered core themes about the integration of physical and mental healthcare, as well as elements that both facilitate and create barriers to successful integration.

A main finding was that there are multiple definitions of and approaches to the integration of physical and mental healthcare in FQHCs, and a continuum of integration exists. Moreover, different providers within the same agency had differing views on what integration actually means. Key elements that both facilitate and create barriers to the integration of physical and mental healthcare in FQHCs are then explored. Close analysis of the data finds that these elements are complex, and often nuanced and inter-related. Facilitators include, among others, the co-location of providers, a warm hand-off referral process and collaborative professional relationships. Some barriers that were found were interdisciplinary conflict, communication difficulties and the subsumation of mental healthcare into the medical model.

Multiple Definitions of Integration

The extent and nature of integration policy, as it is implemented in FQHCs, is central to this dissertation. The PPACA has mandated that FQHCs integrate physical and mental healthcare in order to improve health service provision. The notion of integration is an attractive one, as it has the potential to improve patient access to mental healthcare and challenge some stigmatizing attitudes and beliefs about mental illness. The federal mandate to integrate care at FQHCs was enacted in 2010; however, the two sites participating in this research had already integrated at least some of their physical and mental healthcare prior to this date. This study asked questions about what integration means, how it occurs (i.e., how integration policy is implemented), if patient access to mental healthcare and outcomes has improved as a result of such integration, and what factors facilitate or pose barriers to integration and to patients accessing mental healthcare.

While the PPACA (2010) has mandated that FQHCs integrate physical and mental healthcare, the concept of such integration is not a new one. Key informant interviews with legislators indicated that integration has been discussed in the public realm for many years. These key informants had considerable previous experience in developing state level mental health policy and had good insight into the challenges of addressing the gap between prevalence of mental illness and the number of people accessing mental healthcare services. For example, one former legislator noted that, while integration is not a new issue, it is crucial to improving access to care and that “the community health centers can and should play a much bigger role” in promoting the integration of physical and mental healthcare. Such an opinion was supported by a physician who worked in a medical setting where physical and mental healthcare is not yet integrated: “It would be nice to see in a community setting how they can do it [integration] and teach us how to do it well.” This statement supports one assertion of this dissertation that, given that many FQHCs are in the early stages of integration, there are valuable lessons to be learned from study of other centers where integration policy has already been implemented.

Another key informant, a legislator, added support for the integration of physical and mental healthcare. This individual argued:

> As long as we have a system in which the primary care physician is central to first, diagnosis, and second, referring you to specialists for treatment, which is the way things were basically in the system, then you want it integrated.

This same respondent noted that a main focus of his work was mental health policy reform that included some integration of healthcare.

> I put together a Mental Health Action Project…we filed legislation to fundamentally reform the mental health system. We had everything in there from soup to nuts. We had family supports. We had respite care for families. We quadrupled the number of housing units for chronically mentally ill people around the state…We had state of the art inpatient state operated hospitals on the grounds of the old hospitals, there was no reason why we couldn’t use the facilities [for

> comprehensive healthcare provision]…It was transformative. It would have been transformative…Then [a change of administration] came in…They basically dismantled the mental health system in the state.

This statement indicates prior attempts to overhaul at least some elements of mental healthcare provision. While this and many other policies that certain key informants developed were not in fact implemented, in some cases due to a change of administration, some of their ideas for improving access to mental healthcare are encapsulated in the PPACA and its integration mandate.

Key informants offered a very clear definition of what integration meant to them. In their descriptions of various policy development strategies, key informants perceived integration to mean providing physical and mental healthcare to patients in the same health center, where mental health needs and physical health concerns are afforded the same importance and status. All key informant interviewees stated that mental health is part of overall health, but noted that this idea may not be widely socially accepted due to a general lack of public awareness about what mental health means and the ongoing stigma associated with mental illness that persists in society. There was agreement among key informants, which was also supported by respondents at case study sites, that integrating care would go some way to reducing or eliminating such stigma, because people could see their primary care and mental healthcare providers in the same department, in the same agency. The argument that these respondents made was that the full integration of services into one multidisciplinary team normalized mental healthcare provision, both for patients and for organizational staff.

Statements from interviewees at the case study sites support this argument. As one leadership representative at Site A noted:

> You're getting called by the same front desk person. You're going into the same space and you're going into the same exam rooms. Nobody outside knows who's gonna see you within that exam room and very often, it's both the medical person and the behavioral health person…we make this very normative [for everyone].

This quote highlights some concrete practices that the respondent believes have been successful in minimizing stigma at Site A.

Interviewees at Site B made similar statements, with one frontline practitioner noting:

> I think certainly one way we address it [stigma] is just having us on site like in the same space as the medical providers. Sometimes people don't even necessarily realize like what you are. I think it just becomes like a more comfortable thing. They don't have to walk into a mental health center, for example. So I think we've cut down on the stigma that way.

This normalization of accessing mental healthcare, in turn, is believed to improve both access to care and patient outcomes. Another respondent from Site B, a frontline practitioner, stated that, as a result of integration practices, more patients are accessing mental health services, and, importantly, "sticking with them." Furthermore, one manager at Site B stated:

> when people see mental health as being connected to overall health, it becomes less about what's wrong with me or I'm the problem or crazy or whatever people think to oh it's a health issue. So that's another way of trying to lessen or take

> away the stigma. You wouldn’t be criticizing someone for diabetes. Why for depression?

This statement indicated that the manager agrees that mental health is part of overall health and supports practices to minimize stigma in the FQHC.

The definition of integration favored by interviewees is comprehensive. However, results from this case study, which are supported by findings from a review of relevant literature, indicate that, in practice, there is not one clear, widely adopted definition of integration or related terms. Peek et al. (2013), for example, identified three main models on a continuum of integrated care: care coordination, co-location, and integration (an example of such a continuum is seen in Table 5, below).

Table 5: A Continuum of Physical and Mental Healthcare Provision

Term	Meaning
Care Co-ordination	Behavioral health and primary care practitioners practice separately within their respective systems. Information regarding mutual patients may be exchanged as needed, and collaboration is limited outside of the initial referral.
Co-location	Behavioral health providers and primary care providers (e.g., physicians, nurse practitioners) deliver care in the same practice. Co-location is more of a description of where services are provided rather than a specific service; however, co-location maintains a referral process, which may begin as medical cases and are transferred to behavioral health.
Integration	Tightly integrated, on-site teamwork with unified care plan. Often connotes close organizational integration as well, perhaps involving social and other services.

Source: Miller et al. (2009).

In coordinated care systems, medical and mental healthcare providers work separately in their own agencies. Communication or information about the patient, beyond the initial referral, is shared as needed, generally on a limited basis (Miller et al., 2009; Blount, 2003). Co-located care means that the medical and mental healthcare providers work for the same agency, but the two disciplines are separate, may not even be in the same geographic location and have little communication (Peek et al., 2013). Integrated care refers to the use of the multidisciplinary team, consisting of medical and mental healthcare providers working together to develop care plans and to provide holistic care to patients (Miller et al., 2009). This definition involves housing multidisciplinary teams within one department, where primary care providers physically introduce patients to mental health providers -- the warm hand-off. It is this latter definition of integration that was espoused by interviewees.

The two case study sites offer slightly different models of integration, although both follow some version of the full integration model. Site A is integrating care in two stages. It had integrated pediatric care by 2011 and is in the process of preparing to integrate adult care. This is in contrast to Site B, which has offered integrated pediatric and adult care in a family practice setting since its inception in the 1970s. Moreover, although interviewees from both sites state that they have implemented full integration, the particular model of integration adopted by each site is not the same. This difference highlights the challenge of understanding integration when there is no one clear definition of what integration means. Furthermore, interviews with key informants from other FQHCs revealed that other agencies also interpret the terminology differently. The presence of varying definitions of integration is important because it can result in differences in program planning, staffing decisions, and service delivery across sites.

For Site A, integration means having medical and mental health providers and services working together as a multidisciplinary team in a single department; this model currently exists in pediatric care and will soon be implemented in adult care. This team provides a wide spectrum of care and services to patients. Due to an ongoing construction project, the mental healthcare providers have temporarily been moved out of the department and will be moved back once the building work is completed. In Site B, the physical and mental healthcare providers are on separate floors, while working as a team; a new building that is currently being constructed will allow them to share the same space, as in Site A. While it may seem insignificant to patient care that the providers at Site B are a floor apart, providers at Site A noted that, since the mental healthcare providers had been moved approximately 40 feet across the hall, referral to mental healthcare by primary care providers has dropped by around 50%.

As aforementioned, integration occurred at each site for different reasons and in different ways. Site A began by integrating its pediatric services in the 2000s, with the process being completed in 2011, and is now in the process of integrating adult medicine and adult mental healthcare. The decision to integrate pediatrics was primarily a financial one, as the mental health department consistently lost money and a major funding source stopped supporting the agency. As a leadership representative noted:

> The [external funder] pulled an almost half a million dollar a year grant so we had to sink or swim. We had to either make some changes rather rapidly and overcome this loss or we had to say all right, this program is going away.

This statement suggests the loss of funding was one catalyst for hard choices that had to be made about the continuing provision of mental healthcare at the center. Thus, the main reasons offered by this interviewee for the center integrating care were "efficiency and cost savings. There were differences of opinion about the improvement in clinical care as a result of change in practice. But there was clear agreement on the improvement of efficiencies and cost savings." An example of cost savings offered by Site A's leadership was how pediatric mental health services have been offered since integration took place; in particular, increased focus on reducing no-show rates of pediatric mental health patients has meant more patient visits being billed as well as reduced operational costs.

A key element to making integration at Site A work was practitioner presence and support. "The loss of funding was the big impetus," according to a representative from leadership.

> But having the social worker in place made it possible for us to even conceive of it. I think there was a will to make it happen and to work through the difficulties and to just push through and make it work.

This statement indicates that, while financial constraints may have been the most compelling force to integrate physical and mental healthcare, there was also a commitment by leadership to work hard to make integration successful.

However, despite increased rates of patients accessing mental healthcare services on the pediatrics side, the decision to then integrate adult healthcare at Site A did not take place until after the PPACA mandate. One mental health leadership representative noted, "had not the ACA come up and they said they had to do this, I think we'd still be doing what we were doing. We wouldn't be doing this creative model." A point of interest is that while Site A has fully integrated pediatric services and is in the process of integrating adult services, substance abuse is separate from mental health and is not part of the integration process. A leadership representative stated, because there are both inpatient and outpatient substance abuse services, with complicated funding structures, it will remain separate from integrated healthcare.

In contrast, Site B is a family practice, where all services have been integrated in the provision of comprehensive healthcare since the center was established in the 1970s. The decision to integrate physical and mental healthcare was made by the then Director of Training for the mental health department and supported by other founding members. This move, informed in part by discussions with community members, was seen as the best way to improve patients' access to mental healthcare while improving health outcomes for the local community. As one manager at Site B noted, integration "worked out perfectly because it's so much easier for the patients for the care. Instead of sending them out somewhere, they can have behavioral health sessions here." The mission statement of the organization also indicates a core commitment to integrating healthcare provision for the local community. It reads, in part:

> [Site B] is committed to providing the highest quality, comprehensive, culturally competent and affordable primary healthcare services and selected specialties to families and individuals... We provide this healthcare to children and adults; the

> insured and uninsured; the employed and unemployed; and to all who dwell within our communities.[4]

This quote illustrates the ethos of the organization to providing comprehensive care to all individuals living in the community in which it is located.

Interestingly, while there are differences in the integration models implemented in the two case study sites, there are also varying levels of agreement in perceptions between leadership and management about what integration is and how integration is taking place within these organizations. For example, at Site A, leadership stated, "what we have is complete integration. We sit in the same offices. We share everything, medical records, staff, everything." At Site A, however, a few interviewees indicated some lack of trust in leadership's assertions that integration policy is being implemented to improve patient care, within the context of constrained resources. One manager reported that, while integration was a positive move for the center, "I worry sometimes that integrated behavioral health is just a mechanism to really phase out a lot of the services."

Similar to the other Site, leadership at Site B notes that shared space is an important aspect of the agency's integration model. While, as previously mentioned, the agency has outgrown its current physical space, the new building, under construction, will allow for changes to current practice, and a reversion to the previous model, whereby providers from both disciplines are in close proximity to each other. Noted Site B's leadership:

---

[4] Information obtained from a publicly available source.

> They're [physical and mental healthcare providers] gonna be on the same floor. They're gonna be next to each other. They won't be the same exact offices but they will be basically just right next to each other. There will be the same lunchroom, same hallways.

In contrast to the other site, Site B's management perceptions aligned with those of leadership, perhaps because the agency was set up as a multidisciplinary system and thus has been providing integrated care with established practices for decades. A manager at Site B also referred to the previous model, before space constraints meant that physical and mental healthcare provision was separated:

> Because of space issues, we didn't have a built out wall. I'll show it to you, a bunch of offices over here. We had to see the patients in the exam rooms. Those were our only spots. So we actually had to sit and do our notes around triage nurses. But that was really helpful because we got to know them.

Furthermore, this individual noted that being separated was not beneficial to integrating care "I do think it feels different. Yeah. I don't like it… in the new building that's being built, on purpose I made it very clear that I thought it would be beneficial…so we will be." Indeed, Site B has been a forerunner in integrating physical and mental healthcare and, as these statements suggest, the agency is committed to moving forward with increased integration practices in the future.

It is clear that there are many definitions of integration within the broader parameters established by the federal government under the PPACA. As one leadership representative at Site A noted: "what the feds are requiring is very, very basic. They basically want all services provided at the FQHC in some kind of clear pathways of communication between the medical and the behavioral health services." Thus, because this definition of integration is so broad, agencies have broad discretion to interpret the federal government's call for integration along the aforementioned continuum of physical and mental healthcare provision from care coordination, through co-location, to full integration (Miller, et al. 2009). FQHCs therefore have a wide-ranging scope of practices to choose from in meeting this basic federal requirement.

Facilitators and Barriers to Integration

All interviewees at each site spoke about elements that both facilitate and create barriers to integration. Additionally, some of the key informants who have had experience in the integration of physical and mental healthcare noted features that were important to consider when integrating care. While people at different levels and in various positions offered a range of views on integration, there was considerable commonality in those elements identified as being most significant in impeding or facilitating integration across the FQHCs studied.

The conceptual framework underpinning this research notes that organizational structures and relationships among agency staff at every level affect how policy is implemented. Agency leaders make decisions about implementing federal, state and local policy and in creating FQHC practices. Middle managers implement and interpret policy in their interactions with staff, and frontline workers provide services to clients while also creating policy (Lipsky, 1980). There is an interactive dynamic between the three levels of agency workers with varying degrees of compliance and resistance. Each group can impact the attitudes and decisions of the others and create or reinforce both facilitators and barriers to integration.

Facilitators of Integration

This section highlights the factors that facilitate the integration process and offers explanations for the contributions they make to integration taking place. There are numerous, often inter-related facilitators, and the dynamics between them can be both complex and nuanced. These facilitators are: colocation of physical and mental healthcare providers; the warm hand-off; collaborative relationships between providers; strong leadership support; and a shared electronic health record.

Co-location of physical and mental healthcare providers. Respondents across all levels and at both sites, as well as some key informants, stated that the most critical factor relating to successful implementation of integration policy was the co-location of physical and mental healthcare providers. Given that the term integration has no clear meaning (see Table 5), it is important to define what co-location means to these interviewees. Co-location can mean the provision of services located within the same campus or organization. It can also mean the provision of services within the same building. Interviewees at the two case study sites defined co-location in the latter terms, referring to physical and mental healthcare services being provided in the same department, in the same physical space.

Respondents strongly argued that co-locating services within one department was the optimal way to ensure that integration works and that patients have improved access to mental healthcare. A member of medical leadership at Site A noted,

> one thing that I can't say enough about is proximity. We have them right next door to us, within our clinic. I think even having them across the hall reduces the level of communication, the intensity of communication, the quality of communication and all of that boils down to ending up with fewer referrals [to mental healthcare providers].

This respondent was one of many who noted the importance of proximity; the process of integrating care was expedited when both sets of providers were housed together as a multidisciplinary team, rather than as independent providers.

Medical providers were more likely to make referrals to mental health providers when they shared the same space. Furthermore, by being in such close proximity, physicians report being more likely to physically introduce patients to the mental health providers on staff. This warm handoff, in turn, increased patient uptake of referrals and follow-through with treatment. One point of interest, briefly mentioned previously, is that Site A was in the midst of renovations and the mental health providers had temporarily been relocated about 50 feet away from the primary care practice. Despite this short distance, referrals from primary care to mental health had dropped by almost 50% and interviewees strongly argued that this is because the teams were no longer situated in the same physical space. Said one frontline practitioner: "Our consultations, our warm hand offs, our referrals have dropped almost by 50% since we've been over here. So it just gives you an idea of how the physical integration affects the people we're serving." Thus, it was reported that this small gap of 50 feet had a huge impact on the numbers of patients being referred and accessing mental healthcare.

At Site B, respondents also supported the idea that colocation of providers was vital to successful integration. In prior years, all providers were on the same floor and interviewees stated that integration of care and the "warm hand-off worked well." However, the center has outgrown its space; at present, physical and mental healthcare are on separate floors and it was acknowledged that this separation has impeded integration. A new, much larger center that will encompass all services is currently being built. Every staff member at Site B had the opportunity to participate and provide feedback on the new building and each respondent spoke about the importance of co-location and shared space in integrating care. At present, even though there is only one floor separating the services, the number of referrals being made from primary to mental healthcare has dropped and management is in the process of addressing this issue to find a temporary fix until the new building opens.

The warm hand-off. Numerous respondents cited the aforementioned warm hand-off as another important prerequisite for successful integration. While co-location in itself led to more referrals being made by primary care to mental healthcare providers, it was this warm hand-off that actually increased the number of patients following up on the referrals and accessing mental health services. One frontline practitioner stated: "More clients follow through with referral since integration. It increases the probability, the warm handoff increases the probability that clients will engage with treatment." Interviewees stated that this increased patient engagement was due to patients being able to meet the mental health provider who would be involved in their care, in person, before making an appointment. The fact that their primary care doctor, with whom they had a relationship, made the introduction helped patients feel more comfortable in accessing mental health services. Moreover, by the primary care provider introducing the mental health provider as part of the patient's team, the provision of and accessing mental healthcare is normalized and stigma minimized. According to one frontline worker, "having behavioral health services in the clinic really helps. Stigma is more intense and more felt by someone who's given a number than if there's a warm handoff." This opinion was reinforced by statements made by another frontline practitioner, who stated that the warm hand off helped to "maximize the possibility that this patient will come in and kind of dispel some of the stigma and help them see we're not gonna tell them they're crazy or do anything harsh."

Collaborative relationships between providers. A third facilitating factor noted by respondents was the presence of a collaborative, collegial relationship between providers (Ospina & Foldy, 2010). Having physical and mental health providers who not only respect each other, but also understand their respective roles and who worked together to provide holistic care to patients promoted successful integration of care. Many respondents noted that it was important for physical and mental health providers to speak the same language and to develop treatment plans that focused on providing the most appropriate and effective care for patients. Co-location facilitated these relationships, as individuals who might not otherwise meet but for large agency-wide meetings, now shared space. This shared space not only included neighboring offices, but also shared lunchrooms and other facilities, which allowed for more social interaction and growth of personal and professional relationships.

Leadership in the medical team at Site A stated that, for primary care providers, one of the most important pieces that facilitated the integration process was having a mental health clinician already in place, embedded in the medical team. This person noted “we had a licensed social worker in the pediatric clinic who was very comfortable with the way the pediatricians worked and was able to interpret for both sides.” Having an intermediary or bridge-spanner already in place was also beneficial for patients according to leadership: “She helped the medical people understand where the behavioral health people were coming from. She helped the behavioral people understand where the medical people were coming from.” Having this person in place improved understanding and communication between the two disciplines, which in turn had a positive effect on integration and on patients accessing mental healthcare.

At Site B, where integration occurred at inception, being co-located in tight spaces was beneficial to facilitating integration. Said a management representative from the mental health discipline: “We were there all the time, in the faces of the providers, for better or for worse. I think, in retrospect, that was very forward.” Having the Director of Training present and working through challenges also aided integration. It is of interest to note that integration at Site B involved subsuming mental health services into the medical model, a change that necessitated alterations in practice on the part of the site’s mental healthcare but not medical providers. One manager notes “we were trained by him [Director of Training], which again at the time challenged all of our training of the sacredness of the therapy hour.” Mental health providers were also trained to “write our notes so that our primary care provider buddies would be more likely to be able to wade through it and get what they needed more quickly." There was no expectation, however, that the medical doctors would receive training to help them understand the culture of the mental health team. Such subsumation of mental healthcare into the medical model adds complexity to collaboration and to the facilitation of integration. It also creates barriers to integration, which will be expanded upon in the next section.

One manager at Site B stated that teamwork was the most important factor in making integration work. "I think you need to have medical, behavioral health and all the departments work as a team, communicating. If you communicate, you work, the work flows." Another element at both sites that improved collegial relations and increased the likelihood of referrals being made was having social interactions that allowed participants from various groups to get to know each other – "there was a lot of social interaction, just days and parties and this and that, and people got to know each other and it wasn't they and we anymore. It was us." As one respondent described, "the informal connections strengthen the program in a way that's hard to describe in a formal way." This quote also highlights the importance of providers sharing space, which allows for these informal relationships to grow.

Interestingly, some respondents had a different perspective on the formal relationships between mental health and medical providers. As one respondent stated, "there's not really a relationship, no. I mean, they probably could spot each other in a crowd. But outside of that, there's not like that professional relationship that really needs to exist." This indicates some degree of disconnection between how different respondents view relationships between staff and their multidisciplinary teamwork.

Strong leadership support. Strong leadership support for integration and mental healthcare was another component that respondents report is necessary for integration to succeed. Leadership and management at both sites, as well as some key informants, discussed the many challenges associated with integrating physical and mental healthcare in an existing setting. Integration is a difficult and costly process, with much investment being made in constructing or renovating space to allow for co-location of services within a multidisciplinary team. It requires fundraising and allocating resources to services, such as mental healthcare, that do not necessarily provide the agencies with a return on their investment. Thus, leadership had to support additional staff efforts in seeking out new resources, in order to fund integration practices. One leadership representative stated: “we’ve actually begun to apply for grants and that sort of thing to get more resources...[because] mental health reimbursements are lousy.” This allocation of staff resources to seeking out alternative funding options for mental healthcare indicates a commitment to integration practices at the FQHCs.

Difficulties also arise in integrating teams who are used to very different ways of practicing care, and leadership has to manage these challenges while being supportive of many different perspectives. As one respondent noted, “integration is easier said than done. It requires very, very consistent and very, very involved leadership because any one of these barriers might just blow up at any moment.” Another interviewee confirmed this view, stating that

> to actually have the commitment from the organization that it should happen, I think is essential because I think there are big operational shifts that sometimes

> have to happen as well as big cultural shifts that have to happen in order to do that.

These quotes highlight the complexity of integrating physical and mental healthcare and the commitment from agency leadership that is required for such integration to be successful.

Shared electronic health record. Another, more practical factor that promotes integration of care is the presence of a shared electronic health record. Respondents at both sites and several key informants spoke of the importance of having a shared medical record for integration. The absence of an electronic medical record contributes to fragmentation and separateness, which makes integration more challenging. Providers being able to see whom each patient is interacting with, what medications they take, and what treatment plans they have facilitates integration in a significant way. As one agency leader noted, “we can both communicate with it but we can also view each other’s medical records and learn from each other.” In this statement, the respondent is drawing attention to the usefulness of the electronic medical record to improve both communication between providers and patient care, as well as an educational tool.

Many agencies have already developed an electronic medical record and the PPACA, as well as other government sources, such as the American Recovery and Reinvestment Act of 2009 (U.S. Government Printing Office, 2009), provide funds to support such systems. However, as previously discussed, decisions made about who has access to what information are important to consider. Integration is most successful when all of a patient’s providers have access to his/her records so that the multidisciplinary team is aware of all health related issues and can make decisions about patient care while being in possession of all pertinent facts. When records are not shared, sub-optimal patient care may result, including drug interactions and side effects of medications being mistaken for symptoms of other conditions. Interviewees stated that a full, shared medical record, protected by HIPAA (U.S. Department of Health and Human Services, December, 2014), was an important tool in creating an integrated delivery system that addresses a range of health issues.

Barriers to Integration

Respondents at both sites, as well as some key informants, discussed the challenges associated with integrating physical and mental healthcare. The following section will explain these inter-related, multi-faceted barriers to integration, which include: interdisciplinary cultural conflict; differences in professional practice; power differentials and job insecurity; communication challenges; and subsumation of mental health services into a medical model.

Interdisciplinary cultural conflict. The development of a multicultural team poses challenges that can create or reinforce barriers to integrating care. The hierarchy is an important concept in the integration of mental healthcare as it creates power imbalances in integration practices. A key informant who was a mental health practitioner supports this argument. “There definitely is a hierarchy”, this interviewee reported:

> I think there's very much like an order of power and authority in medicine, there's like a prevailing sense of medical doctors having the most clout and psychologists and then social workers and probably LMHCs [Licensed Mental Health Counselors]. I think the social workers in our community health centers feel kind of marginalized and powerless.

The hierarchy reinforces cultural conflict and creates barriers to integration and access to care for patients with mental health needs.

This study found that conflict between the cultures of medicine and mental health was a significant barrier to integration. Indeed, the issue that interviewees at both sites and at all levels reported most often as a barrier to integration was this cultural conflict between medical and mental health practitioners. This is a very complex issue that was raised by individuals at every level in both organizations' hierarchy, though the lens of any given person influenced how it was interpreted. According to one interviewee at Site A, "there was a level of distrust, not sort of very focused distrust, but they do it this other way we don't 'approve of.' They do this. On both sides." One representative from leadership at Site A acknowledged that a disconnect between physical and mental health services still exists but was hopeful that it would disappear over time:

> But this kind of true, true integration, not just colocation but true integration where the whole behavioral group is actually part of the team physically, records shared that way, culturally, communication wise… I think that's a culture development over time.

Of course, culture clashes predate integration. This is reflected in the observations of leadership and management at Site A. In particular, leadership at Site A noted that potential cultural differences were considered during early stages of integration planning: "the other big sort of potential barrier was very different cultures of primary care staff and the behavioral health staff. So we spent a lot of time talking about that…I think the culture is a big barrier." Another member of leadership at Site A noted "it was very clear that if that [cultural conflict] was not addressed, that would remain under the surface causing problems forever." These quotes indicate that cultural conflict between physical and mental health providers has been apparent for some time.

The argument that interdisciplinary conflict pre-dated integration is also supported by data gathered from interviews with mental health frontline practitioners at Site A. According to one frontline practitioner from Site A, "barriers are that everyone has to be willing to change their behaviors and that doesn't happen across the board. You need compromise and collaboration." In this quote, the respondent underlines that change is required from both sides of the cultural conflict, not just one, in order for integration to succeed. One mental health provider from Site A stated: "I think it's gonna be pretty hard for more old school doctors who are really into being right to welcome in mental health providers." This individual was referring to doctors who had many years of experience working in the medical model, where physicians are at the top of the hierarchy, and posited that adapting to a more integrated inclusive model might be challenging for such medical providers. Although representatives from Site A's leadership stated that the conflict and tensions had since been resolved and that each group interacted well together, practitioners on the mental health side provided a different story of how the two groups work together. One mental health manager at Site A argued:

> It can't be us over here and them over there. I said they've got to talk to behavioral health to learn about this stuff. That's where that disconnect is. They still don't talk that much to behavioral health. They make all the decisions on their own and they don't bring us into it.

In this statement, the interviewee supported the theory that cultural hierarchies and conflicts exist, creating a barrier to integration practices.

Interestingly, Site A paid for mental health practitioners to enroll in a certificate program. One mental health frontline worker noted:

> It deals with these very things, these cultural things as well as some sort of practical things that come from these cultural points of view and deals with them head on and all our clinicians attended those programs and brought that information back to us.

However, none of the medical staff took the course, rather they learned about it from the attendees who presented on it at a staff meeting. This suggests that it was the responsibility of the mental health team to learn how to adapt to this new culture of providing care in the medical model.

Cultural conflict at Site B looked quite different to that at Site A, perhaps because integration of care has been in place for so much longer, prior to the employ of many of the workers. Because integration practices had been in place so long, for many Site B staff, this was the culture of the agency when they joined. However, cultural tensions still existed and were acknowledged to varying degrees by frontline staff that participated in this project. One issue was the difference in theories about how care should be provided. Some mental health providers wanted to engage patients in long-term therapy, whereas medical staff members, who have more control over resource allocation, expected short, effective, efficient interventions. Frontline respondents expressed frustration about the role of management in integrating care. One individual spoke of the cultural differences between workers who have contact with patients and provide direct care and those who are more involved with the logistics of running the agency. This person stated, “I think that management focuses on management and not really into the essence of why we’re here.” In this quote, the respondent calls attention to disconnect and conflict between workers who prove direct care and those who have influences over agency practices and resources.

Key informants also discussed the challenges of integrating two very different cultures into one multidisciplinary team. One key informant, who is a frontline practitioner at a non-case study health center, noted that primary care doctors do not have a full understanding of mental healthcare:

> They might say they’ll integrate it but they don’t want to be a part of understanding or identifying it. It’s integrated; it’s a good model. They’ll have everybody else do the work. But do they get it? Do they really get it? No.

Evidently then, not only are there cultural differences between physical and mental health providers, but how these differences are perceived and the impact such differences have are very different between physical and mental healthcare. A common thread among interviews with frontline practitioners and management in mental healthcare was this struggle between the two disciplines. Interestingly, the primary care providers did not appear to recognize the importance of this conflict, and frontline mental health workers did not report sharing their concerns with the medical team, thus it is not discussed or addressed.

Differences in professional practice. The varying perspectives on culture provided good insight into how agencies function and how differing disciplines interact with each other in integrating physical and mental healthcare. A cited example of such conflict at Site A was rate of practice; i.e. medical providers work very quickly and wanted the mental health providers to do the same and to see patients in clinical exam rooms as and when the medical providers requested a consult. However, the mental health workers believed that "patients wouldn't relax if they were in this brightly lit room with an exam table and a sink and a sharps container on the side." Furthermore, mental health practitioners viewed this type of practice as "just putting out fires"; that is, dealing with immediate symptoms only, rather than addressing root causes of problems.

These differences in physical and mental healthcare practices added complexity to integrating care. At both case study sites, medical providers reported being used to a very high-paced job, where they see up to four patients an hour in clinical exam rooms that are filled with medical equipment. Their medical approach is to identify the symptoms that the patient is experiencing and treating those, most likely with medication. There are significant power imbalances between medical doctors and patients, with providers being seen, and seeing themselves, as the experts in the patient's care.

Mental healthcare has a very different practice style. Mental health providers typically schedule 50-minute appointments with patients (the 50-minute hour). Mental health providers' physical environments traditionally have been offices with plants and bookshelves to create a welcoming, non-medical environment. The emphasis in mental healthcare is on developing a therapeutic relationship with patients who are seen as the expert in his or her own life. Mental health providers reported that they worked together with their patients to identify causes as well as symptoms of problems and developed goals to work towards solutions; there tended to be less of a power differential between providers and patients. One mental health frontline practitioner described the change in practice: “My work now is all about the outcome, not the process. We used to have two-hour team meetings to discuss cases. It changed to having to prove I’m doing enough to justify my job.” Such a statement suggests some frustration felt by mental health providers in adapting to the new model of integrated care dominated by the medical model (discussed in more detail below).

Key Informant interviewees who worked in the mental health field as program administrators, executives and clinicians also raised the issue of different practice styles in physical and mental healthcare as a challenge to successful integration. One key informant noted:

> One of the barriers or drawbacks has been that mental health is being treated more and more like physical health…everybody looks at behavioral health through this medical lens and it’s becoming too… It’s kind of like learning about women by studying men’s bodies.

This quote illustrates the respondent’s frustration at having to make mental healthcare fit the medical model. Thus, the predominance of the medical model, and the need for mental health providers to alter their practices styles to fit within it, can result in certain integration practices that create more barriers to accessing mental healthcare, rather than eliminating them.

Power differentials and job insecurity. The findings of this dissertation suggest that the considerable pressure felt as a result of cultural conflicts and different practice styles were further compounded by power asymmetry between agency leadership/management and frontline mental health staff. A prime example is the primacy given to the medical model in agency leadership and managements' views on productivity and success over the views of frontline mental health staff. Leadership spoke of the success of new integration practices as evidenced by increased numbers of patients accessing mental healthcare services. However, this emphasis on productivity rather than patient outcomes was stressful for frontline practitioners, as it was contrary to the discipline's aforementioned culture of more autonomous, therapeutic relationship building with patients.

Leadership at both sites acknowledged that integration has created a focus on the productivity of frontline mental health workers, with one member of management noting that this change in emphasis came about by "leadership saying this is the way it's got to be." Respondents report differing views on the impact that this emphasis on meeting targets had on the integration process. At Site A, one respondent, a frontline mental health practitioner, noted that when integration occurred in pediatric services, the eight existing mental health positions were reduced to three and this is framed as a positive move that has improved patient outcomes: "They were a little resistant at first but they did it. It's worked out great…their volume tremendously increased because now they were being more efficient." However, frontline workers at this clinic reported constantly feeling under pressure to meet productivity standards, not necessarily to provide good care. One respondent stated that the reason for taking the job was:

> Because I wanted to care for the patients. So we want the admin to be asking us what we think is important. Like here are the groups I want to run or here are the trainings I want to have so I can be a better provider, but instead the focus is on seeing as many patients as possible.

In this quote, the respondent draws attention to their frustration at not being able to provide enough clinical, therapeutic care to patients due to the pressure to meet targets.

Frontline respondents reported that their stress levels have increased since integration began when "the message we got is, 'if you don't like it, leave' and a lot of people did leave." These respondents stated that they now "focus on the numbers, on meeting the target, not on helping the patients." Other interviewee statements supported this perspective. Said one frontline worker: "We had to come up with a formula of productivity. The first year was challenging, this formula for productivity and meetings every week about how to be more productive, it's not the behavioral health model." Another frontline worker stated that the first year after integration took place was particularly difficult: "When we first integrated," this interviewee reported, "we spent a year not knowing if we were gonna have our job, not have our job, were we gonna meet our numbers, not meet our numbers." These statements suggest that the pressure that the frontline workers experienced have shaped their practice, which now focuses on meeting targets, rather than improving patient well being. Moreover, these frontline workers feel powerless to subvert agency policy and practices or do anything other than meet their targets.

Frontline practitioner's concerns about meeting targets were validated by statements from certain management respondents, with one mental health manager noting: "I tell them, 'I need you to understand that if your target is seven and yesterday you had three, then today I really need you to have eleven' because that's the only way we're going to remain on par." Furthermore, statements from key informant mental health providers indicate that this focus on productivity, rather than patient outcomes, is not isolated to the case study sites. One such respondent noted that they also experienced "way too many constraints. I wish I had more time with my patients." According to another key informant, "It's overwhelming actually, from the needs perspective to being able to meet the needs. There is a gap. A lot of patients do fall, at least that I know of, through some kind of crack." Note that these statements indicate that respondent believe that patient care has suffered as a result of frontline workers having to meet targets established by agency leadership and management, yet they feel unable to address their concerns about their patients because of their lack of power and their low place in the agency hierarchy.

Adding to feelings of stress and pressure, frontline practitioners noted that many of them are struggling financially as salaries are low. One frontline worker reported:

> it's very very difficult to get a salaried job; most of them are fee-for service… It's salaried here, but there's no raises. But that's the reality of it. We all have second jobs to manage financially because the salaries are so low.

This statement suggests that the respondent feels stuck in their current position of high stress and low wages. Although medical leadership representatives did not appear to recognize the pressures on their frontline practitioners, one mental health leadership representative did acknowledge these challenges: “the salary is a big issue. I understand because most of our staff…are working two and three jobs to make ends meet.”

Frontline workers expressed not being secure enough in their positions to discuss financial anxieties with agency leadership or management. “Well, our work is productivity now, it’s about numbers,” reported one frontline mental health worker.

> This is where the disconnect happens between the people who are designating the numbers and us who are actually doing the work. But we can’t say anything or complain because they already laid off people who didn’t like the new way, who didn’t want to change.

This statement suggests that financial stress and pressure to meet productivity targets exacerbate frontline worker’s feelings of job insecurity and powerlessness in addressing these concerns with agency leadership.

Discretion and autonomy to alter agency policies and practices are important parts of frontline worker’s jobs and are often considered a benefit to jobs that are not well compensated (Lipsky, 1980; Isett et al., 2007; Jewell & Glaser, 2007; Evans, 2010). Such discretion and autonomy affords respect to the mental health clinician’s knowledge and experience, allowing for the use of clinical judgment in providing care and adapting practices as needed (Lipsky 1980; Flood et al., 1982; Peters & Pierre, 2003; Durant, 2010. However, the findings indicate that frontline respondents at the case study sites did not have the power, freedom, or discretion to alter policy or practice in this way. Rather, frontline workers reported that while they had some level of autonomy in their work, they did not subvert agency policies or practices, even those they felt might lead to sub-par patient outcomes. One respondent described the autonomy as being bounded, stating: “I feel like I can make decisions about what types of theory I use, my interactions and clinical judgment is…I can be completely autonomous as long as I’m working within the structure.” This individual stated that s(he) has autonomy in their clinical work with patients, but s(he) did not feel empowered to make any changes to the established agency practices and procedures relating to patient care and integration practices because those decisions were entirely within the purview of others, i.e., agency leadership and management.

Communication challenges. An important part of the cultural difference between physical and mental healthcare is the communication challenge or language barrier, including the use of medical and psychological terminology and jargon. As previously mentioned, medical and mental health practitioners used very different language in talking about patients and providing care, which can create confusion and raise or reinforce barriers to accessing care if it is not addressed. One respondent spoke about the challenges of addressing this barrier and argued that having an “interpreter” (the aforementioned intermediary or bridge-spanner) to help each side understand the other was the only solution. Said this interviewee: “I think having this social worker in the middle who kind of spoke both languages helped take away the they and convert the they into us, which I think is absolutely essential for successful integration.”

In the field of medicine, the language used is clinical and filled with complicated medical terminology; providers can be abrupt in clinical conversations with other providers, and use acronyms and scientific terms that are not readily accessible to non-medical staff. In contrast, mental health providers used non-clinical language that it is patient-focused and includes words that the patients use themselves. Mental healthcare workers also used psychosocial language that is unfamiliar to medical doctors and reported wanting to share more information with the physicians than these doctors wanted to hear.

All respondents acknowledged that such barriers were a problem in integrating care, and the solution was for mental health providers to learn the medical teams' language and adapt how they communicate to fit the medical model. While all providers are now using the same language, it is the language of the medical team that is in general usage and the language of mental healthcare has been lost. The medical providers did state "we are all speaking the same language now" but do not seem to have any awareness that the language everyone is speaking is theirs and not that of mental health. As one mental health provider noted:

> Learning for me was how to talk to the doctors; I had to change how I spoke when I talked to the doctors. They only want to know how the patient is now and what you're going to do next. It's like learning a new language. It's more outcome based rather than what led up to it.

This interviewee noted that the learning is one-sided, with only the mental health workers changing their practices, indicating a power differential between the two provider groups.

Subsumation not integration. Cultural, practice, and linguistic differences between medical and mental health create barriers to working together. Providers on both sides reported that their agencies have worked to overcome these barriers to integrate both teams and both styles of practice. However, close analysis of the data indicated that what actually resulted is that, rather than true integration taking place, mental healthcare has been subsumed into the medical model, as evidenced in the aforementioned communication change whereby mental health providers have adopted the language of the medical model.

This subsumation model, rather than one of equal contribution from the two disciplines, creates another barrier to full integration, as it becomes the established practice of healthcare delivery. This is a problem because such a model does not give mental health an equal footing with physical health. Rather it maintains the status quo whereby mental health is lower on the agenda and, as such, receives less attention and resources than physical health. It also reinforces the idea that mental health is less important and allows for the continued reproduction of stigma associated with mental illness. Interestingly, the subsumation of mental health by physical health is only openly acknowledged and discussed among mental health frontline workers who report that they cannot address this issue with management or leadership for fear of losing their jobs. Such subsumation is unrecognized by interviewees who were providers in physical healthcare, who, as previously discussed, report that “complete integration” exists.

Indeed, interviews uncovered widely differing views on how integration policy has been implemented. Significantly, medical staff members considered that integration is working well, the team is cohesive, more referrals are being made to mental healthcare providers and more patients are following up on these referrals and are accessing care. This view, that cultural conflict has been recognized and addressed to create one integrated team, was supported by statements from leadership and medical providers, such as:

> What we had might have been ‘oh that’s mental health, I don’t really want to deal with it, I just want to hand it over to you and you take care of it’. In reverse, it was ‘oh those doctors, they don’t take the time to understand this patient’s issues. They kind of lay down the law and keep going’, that kind of thing. That doesn’t happen now.

Frontline mental health clinicians report that, while more patients are indeed being referred to and are accessing mental health services, the culture of mental healthcare has disappeared. Instead of the aforementioned 50-minute hour and developing therapeutic relationships with clients, mental healthcare workers report that they now have to focus on productivity, with an emphasis on quantity rather than quality of care. Said one mental health practitioner: “You can’t have the old behavioral health model, even though it’s valuable, in this climate. Behavioral health is not a moneymaker.” This quote indicates that worker’s awareness of the loss of the previous mental healthcare model; note that this worker understands that the rationale for changing models is financial.

Despite holding the viewpoint that they brought mental healthcare into their existing department, rather than created a new, unified one, medical staff still considered this to be integration of care. There does not appear to be recognition on the part of the medical team that anything other than integration has occurred. A medical provider made a telling statement:

> I don’t even think of it as a partnership anymore because partnership, you’re kind of making the assumption that there are two separate parties. I only keep calling them they because it was a they to begin with and now they’re actually just part of our team.

The person making this statement indicated no awareness that (s)he was talking about subsumation rather than integration by stating that mental health providers had become part of *“our”* team. This was not an isolated statement. Another medical provider, in talking about introducing patients to mental health providers said, “I think the difference is for us to be able to say ‘oh they’re right here, they’re part of my team’.”

In contrast, respondents on the mental health side had very clear opinions about this difference, with one practitioner stating, “We’re not merging. That’s not what’s happening. We’re not merging, no. No, we’re not merging. They’re taking us and we’re going.” Note the respondent’s choice of words in this quote, indicating vexation with what has taken place, i.e., subsumation. Key informants working as mental healthcare providers reported similar experiences of subsumation in their own agencies, One key informant stated; “they’re [agency leadership] medicalizing mental health too much, it feels like it’s taking away from mental health a little bit as opposed to a real space created for mental health.” In this quote the respondent draws attention to the loss of mental health identity into the medical model.

Mental health managers also described subsumation when talking about integration, although this was not always recognized. In discussing training s(he) received about integrating care, a manager noted:

> Our health psych professor talked to us about how best to collaborate with our medical providers and he would say you have to just walk into their offices every single day and talk about the Red Sox or do your notes next to them. You guys have to integrate. You have to be a team.

This person did not appear to recognize that all the effort and change was expected of and being made by the mental health practitioners to become part of the medical team, rather than all parties working together to create a new, more equal team.

Furthermore, as noted above, frontline mental healthcare interviewees report that they have: changed their professional language in order to communicate more effectively with medical providers; altered their practice from focusing on patient centered care to meeting productivity targets; and relocated from individual offices to shared spaces, now meeting patients in more clinical settings. Agency leadership and management, as well as medical providers, also spoke of the changes that have been made within the agencies in the pursuit of care integration. When describing these changes, examples of adaptations to practice were made exclusively by the mental healthcare team. There was no acknowledgment that this may be a problem to consider, nor were there any suggestions that the medical providers make any compromises or changes to their culture to accommodate changes brought about by integration.

To recap, all respondents stated that integration had improved access to care, but there were differing thoughts about how this was achieved and if integration had really taken place, or if mental health had merely been subsumed into the medical model. Frontline staff members in particular stated that such organizational changes indicated the priorities of the agency, that is, physical over mental healthcare.

Summary

This chapter examined the main research findings relating to the integration of physical and mental healthcare in the two case study sites. The integration of physical and mental healthcare is a complex issue with many, often interacting components. Analysis of the data found that there is not one clear definition of integration, rather there is a continuum, ranging from care coordination to full integration. Moreover, while staff members at both sites had similar responses when asked about integration, integration meant very different things to different groups within these organizations. The medical staff was very positive about integration; they noted that co-located services, the warm handoff and a shared electronic medical record are important elements of integrating care. Significantly, medical staff considered that integration had taken place, that the providers work together as a team and that more patients are accessing mental healthcare. Thus the medical providers described integration as successful.

Mental health providers, however, described a rather different experience, with a cultural shift from therapeutic relationships and a focus on the patient, to a model of meeting productivity targets. While mental health providers agreed that more patients are accessing care, their perception was that the medical model has subsumed mental health, rather than integrated with it. Another issue raised by mental health providers is that while all providers are now using the same language, it is the language of the medical team that is in general usage and the language of mental healthcare has been lost. However, frontline mental health practitioners feel powerless to address these concerns with leadership, as they are fearful of losing their jobs.

In short, all respondents stated that integration had improved access to care, but there were differing thoughts about how this was achieved and if integration had really taken place, or if mental health had merely been subsumed into the medical model. This study found both facilitators and barriers to implementing integration policy. The co-location of providers within the same department, a warm hand-off, collaborative collegial relationships, strong leadership support and a shared electronic health record all facilitate integration. However, interdisciplinary conflict, power differentials and job insecurity, communication challenges and the subsumation of mental health into the medical model pose barriers to successful integration.

CHAPTER 8

THE ROLE OF STIGMA AND OTHER SIGNIFICANT CHALLENGES TO SUCCESSFUL IMPLEMENTATION OF INTEGRATION PRACTICES

This is the second of two chapters discussing the main findings from this research about the implementation of integration policy. The previous chapter examined the varied and complex issue of the implementation of integration policy in FQHCs, while this chapter examines findings pertaining to stigma and to addressing the gap between patient need and access to services. Extant research offers various explanations, including economic and socio-cultural, for the disparity between the prevalence of mental illness in US society and the numbers of people receiving mental healthcare (Palpant et al., 2006; Cunningham, 2009; Corrigan & Shapiro, 2010). Such research also suggest that stigma plays a significant role in perpetuating this gap in service provision. This study suggests that stigma, and in particular, institutional stigma, is a major contributing factor of the aforementioned disparity. It also suggests that other elements contribute to the above-mentioned disparity and are worthy of consideration. These factors relate to the function of the boards of directors at the case study sites and the evaluation process used by FQHCs to determine the efficacy of integration practices.

Stigma’s Effects on Implementation Practices and Access to Services

A primary underpinning theory of this research is that both public (individual) and institutional stigma impact the implementation of mental health policy and create barriers to accessing mental healthcare. All respondents in this study stated that the stigma associated with mental illness remains a problem in society, but few acknowledged the function of stigma within their own organization.

Each interviewee noted that stigma exists in their patient populations and in the communities in which they are located. Respondents noted that stigmatizing views about mental illness held by their patients’ reinforced barriers to accessing mental healthcare. Said one mental health leadership representative: “A lot of it is cultural. The families don’t always feel comfortable going into mental health counseling and see a psychiatrist.” The support staff at these centers is mostly comprised of residents from these local communities, while, as aforementioned, the clinical providers tend to come from outside the community. However, few interviewees report or recognize any stigma in support or clinical staff. In the few instances where stigma is attributed to staff members by agency interviewees, it is generally in relation to medical doctors -- “I know some of the doctors here are not really comfortable with mental health issues” -- who typically are not from the local community.

Despite what interviewees report, careful analysis of site interviews, background data and direct observations indicate that stigma exists in each FQHC studied, as well as in those FQHCs with which key informants are associated. Results indicate that stigma affects the provision of and access to mental healthcare. Moreover, stigma exists more at the institutional than at the individual level. The presence and impact of both public and institutional stigma is evidenced in numerous ways, which are described below.

Public Stigma

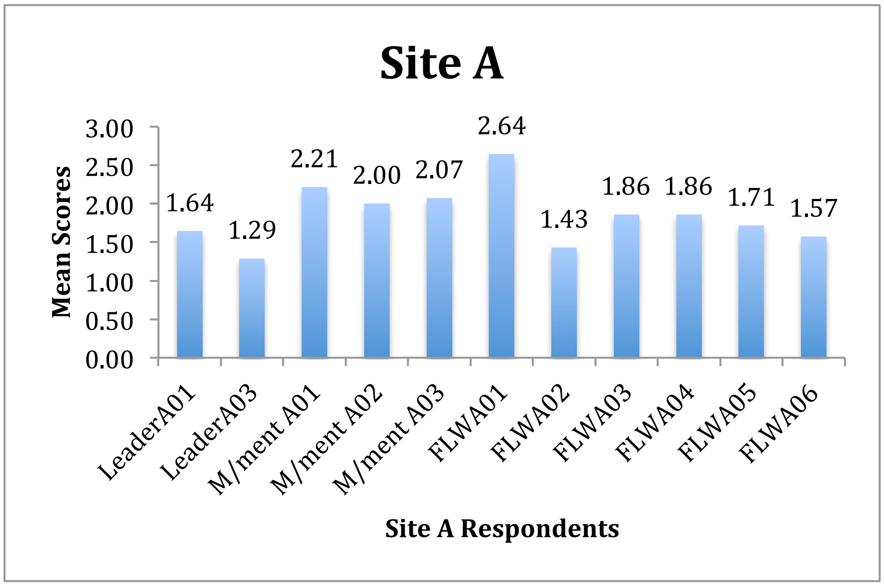
All respondents at each case study site were asked to complete a short survey about mental illness, and 19 out of 21 did so. The goal of the survey was to uncover stigmatizing attitudes, i.e. public stigma; the respondents were unaware of this purpose. As previously noted, this Likert scale (Appendix D) consisted of 14 statements, 7 positively associated with stigma and 7 negatively associated, that respondents marked along a 5-point scale from strongly disagree (1) to strongly agree (5). For analysis purposes, the negatively associated statements were reverse-coded so that, for all statements, mean scores ranged from 1 (least stigmatizing) to 5 (most stigmatizing). Table 6, below, displays mean, mode, and median scores for each individual who completed the survey. As previously noted, the Cronbach's alpha has an estimate of 0.692, which indicates adequate, or acceptable, reliability (Zaiontz, 2014).

Analysis of the stigma instrument indicates a moderate rate of stigmatizing perceptions and attitudes among respondents at the case study sites. The charts below (Figure 2.1 and 2.2) display the range of mean scores at each site, first by role (i.e. leadership, then management, then frontline workers), and secondly by level of stigma from the lowest score to the highest. At Site A, mean scores ranged from 1.29 to 2.64, and at Site B from 1.86 to 2.64.

Table 6: Survey Instrument Total, Mean, Mode, and Median Scores by Study Site

	Total Score	Mean	Mode	Median
Site A				
LeaderA01	23	1.64	1.00	1
LeaderA03	18	1.29	1.00	1
M/ment A01	31	2.21	1.00	2
M/ment A02	28	2.00	1.00	2
M/ment A03	29	2.07	2.00	2
FLWA01	37	2.64	2.00	2.5
FLWA02	20	1.43	1.00	1
FLWA03	26	1.86	1.00	1.5
FLWA04	26	1.86	1.00	1
FLWA05	24	1.71	1.00	1.5
FLWA06	22	1.57	1.00	1
Site B				
LeaderB01	26	1.86	1.00	1
M/ment B01	28	2.00	2.00	2
M/ment B02	31	2.21	1.00	2
M/ment B03	37	2.64	3.00	3
M/ment B04	37	2.64	3.00	3
FLWB01	28	2.00	1.00	1.5
FLWB03	26	1.86	1.00	1
FLWB04	31	2.21	1.00	2
Leader -Representative from Leadership				
M/ment - Representative from Management				
FLW - Frontline Worker				
Cronbach’s alpha: 0.692				

Figure 2.1: Range of Survey Mean Scores by Agency Role



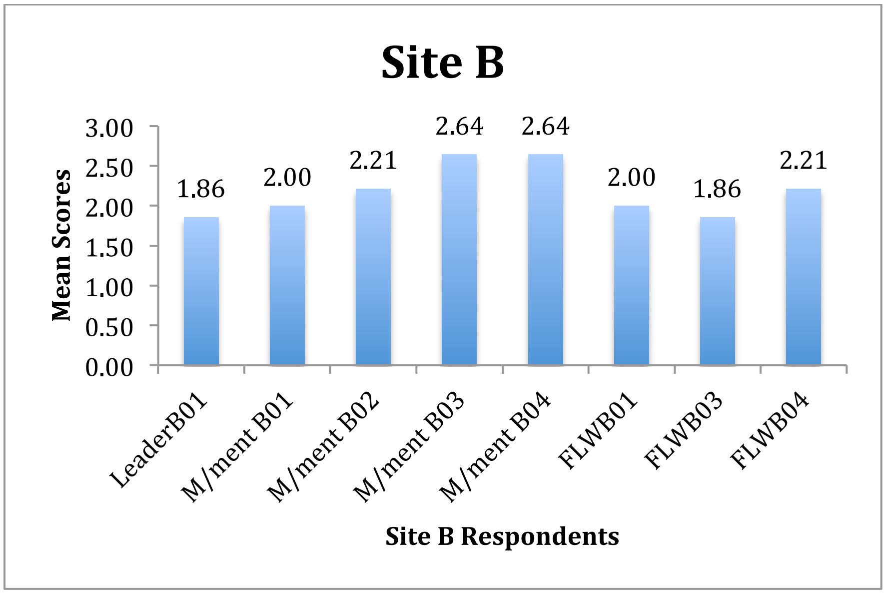
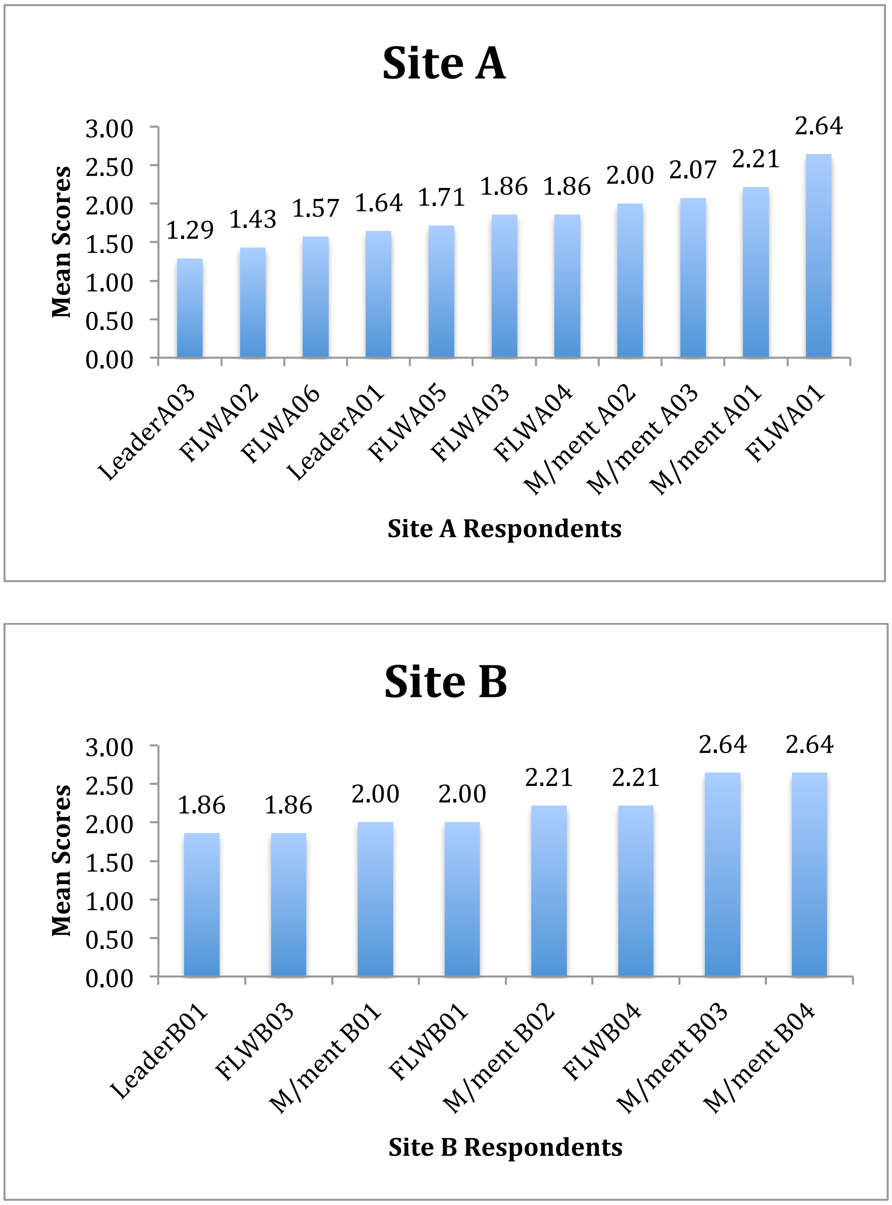


Figure 2.2: Range of Survey Mean Scores, Lowest to Highest



There are three interesting points of comparison relating to stigmatizing attitudes within the survey instrument data: between the three levels of agency workers; between Site A and Site B; and between mental health related workers (including leadership, management and frontline practitioners) compared to all other, non-mental health related respondents.

A one-way ANOVA was used to compare the means of leadership, management and frontline workers to determine if there were any significant differences between stigmatizing attitudes of the three levels of agency workers (Figure 3, below).

Figure 3. One-Way ANOVA

SUMMARY

Groups	*Count*	*Sum*	*Average*	*Variance*
Leadership	3	4.79	1.60	0.08
Management	7	15.79	2.26	0.08
Frontline Workers	9	17.14	1.90	0.13

ANOVA

Source of Variation	*SS*	*df*	*MS*	*F*	*P-value*	*F crit*
Between Groups	1.024372155	2	0.51	4.92	0.02	3.63
Within Groups	1.665208941	16	0.10			
Total	2.689581096	18				

A statistically significant difference, as determined by one-way ANOVA (F(2,16)= 4.92, p= 0.02) was found between the three groups. This test does not, however, identify where the difference is, therefore a t test (Wonnacott & Wonnacott, 1990) was carried out on each pair of means; i.e., between leadership and management, leadership and frontline workers, and management and frontline workers (see below). As the null hypothesis for each comparison is that there is no statistically significant difference between the mean scores of each group, the tests are two-sided. A p-value $\geq$0.05 means that the null hypothesis is accepted.

Comparison of Leadership and Management

T-Test: Two-Sample Assuming Unequal Variances

	Leadership	*Management*
Mean	1.60	2.26
Variance	0.08	0.08
Observations	3.00	7.00
Hypothesized Mean Difference	0.00	
df	4.00	
t Stat	-3.34	
P(T<=t) one-tail	0.01	
t Critical one-tail	2.13	
P(T<=t) two-tail	0.03	
t Critical two-tail	2.78	

Comparison of Leadership and Frontline Workers

T-Test: Two-Sample Assuming Unequal Variances

	Leadership	*FL Workers*
Mean	1.60	1.90
Variance	0.08	0.13
Observations	3.00	9.00
Hypothesized Mean Difference	0.00	
df	4.00	
t Stat	-1.51	
P(T<=t) one-tail	0.10	
t Critical one-tail	2.13	
P(T<=t) two-tail	0.21	
t Critical two-tail	2.78	

Comparison of Management and Frontline Workers

T-Test: Two-Sample Assuming Unequal Variances

	Management	*FL Workers*
Mean	2.26	1.90
Variance	0.08	0.13
Observations	7.00	9.00
Hypothesized Mean Difference	0.00	
df	14.00	
t Stat	2.20	
P(T<=t) one-tail	0.02	
t Critical one-tail	1.76	
P(T<=t) two-tail	0.05	
t Critical two-tail	2.14	

These results indicate that leadership and frontline workers have less stigmatizing attitudes than management respondents. Moreover, there is no statistically significant difference between leadership and frontline workers (two tailed p-value = 0.21). However, when comparing results from leadership and management, where the leadership mean score was 1.6 and the management mean score was 2.26, suggesting more stigmatizing attitudes among management representatives, the p-value of 0.03 means that the null hypothesis of no difference between the mean scores of these two groups is rejected. Furthermore, when comparing the mean scores of management (2.26) and frontline workers, (1.9), which indicates that management respondents have greater stigmatizing attitudes than frontline workers, the p-value of 0.05 means that again, the null hypothesis of no statistically significant difference between the mean scores is rejected.

In comparing results from Site A and Site B, preliminary testing of the variances indicated that they were not the same, therefore a t-test assuming unequal variance was used (see Table 7.1, below).

Table 7.1: Comparison of Survey Mean Scores: Site A and Site B.

Site A Mean Score	Site B Mean Scores
1.29	1.86
1.43	1.86
1.57	2.00
1.64	2.00
1.71	2.21
1.86	2.21
1.86	2.64
2.00	2.64
2.07	
2.21	
2.64	

T-Test: Two-Sample Assuming Unequal Variances

	Site A	*Site B*
Mean	1.84	2.18
Variance	0.15	0.10
Observations	11.00	8.00
Hypothesized Mean Difference	0.00	
df	17.00	
t Stat	-2.08	
P(T<=t) one-tail	0.03	
t Critical one-tail	1.74	
P(T<=t) two-tail	0.05	
t Critical two-tail	2.11	

The total mean score for Site A (1.84) was lower than for Site B (2.18), suggesting that stigmatizing attitudes are more prevalent at Site B. The p-value is 0.05, therefore the null hypothesis that there is no difference between the mean scores of the two sites is rejected.

A comparison of total mean scores for mental health related professionals and non-mental health related professionals suggests that non-mental health staff have more stigmatizing attitudes about mental illness than mental health professionals (see Table 7.2, below).

Table 7.2: Comparison of Survey Mean Scores: Mental Health Related Staff and Non-Mental Health Related Staff.

MH Related Staff	Non MH Related Staff
1.29	1.64
1.43	1.86
1.57	2.00
1.71	2.21
1.86	2.21
1.86	2.64
1.86	2.64
2.00	
2.00	
2.07	
2.21	
2.64	

T-Test: Two-Sample Assuming Unequal Variances

	Mental Health Staff	*Non-Mental Health Staff*
Mean	1.88	2.17
Variance	0.13	0.14
Observations	12.00	7.00
Hypothesized Mean Difference	0.00	
df	12.00	
t Stat	-1.69	
P(T<=t) one-tail	0.06	
t Critical one-tail	1.78	

P(T<=t) two-tail	0.12
t Critical two-tail	2.18

These results indicate that some level of stigmatizing attitudes exist within both professional groups, with the non-mental health related respondents providers having a higher total mean score. However, while the mental health staff mean score was 1.88, and the non-mental health staff mean score was 2.17, suggesting that this latter group held greater stigmatizing beliefs, the p-value of 0.12 means that the null hypothesis is accepted and that any differences between the mean scores are not statistically significant.

A t test was also carried out to uncover differences between physicians and non-physicians (Table 7.3).

Table 7.3: Comparison of Survey Mean Scores: Physicians and Non-Physicians.

Physicians	Non Physicians
1.64	1.29
1.86	1.43
	1.57
	1.71
	1.86
	1.86
	1.86
	2.00
	2.00
	2.00
	2.07
	2.21
	2.21
	2.21
	2.64
	2.64
	2.64

T-Test: Two-Sample Assuming Unequal Variances

	Physicians	*Non Physicians*
Mean	1.75	2.01
Variance	0.02	0.16
Observations	2.00	17.00
Hypothesized Mean Difference	0.00	
df	3.00	
t Stat	-1.82	
P(T<=t) one-tail	0.08	
t Critical one-tail	2.35	
P(T<=t) two-tail	0.17	
t Critical two-tail	3.18	

The mean scores of physicians was 1.75, compared to 2.01 for non-physicians, suggesting that physician held less stigmatizing views However, given a p-value of 0.17 and the fact that only two of the nineteen respondents who completed the survey were physicians, this difference is not statistically significant.

Thus, analysis of the data suggests that moderate levels of stigmatizing attitudes exist in each case study site. Furthermore, greater stigmatizing attitudes were found at Site B, when compared to Site A, and in management, when compared to leadership and frontline workers, with these results being statistically significant. However, no statistically significant differences were found when comparing mental health related workers and non-mental health related respondents, or between physician and non-physicians. It is acknowledged that the power of the tests to detect statistical significance is limited by the small sample size.

Respondents further indicated their attitudes about people living with mental illness during the course of the interviews. When interviewees were asked about what had influenced their own perceptions of mental illness, the factor most likely to minimize stigma was that they, or someone they knew (such as a family member or friend) had been diagnosed with a mental illness. One key informant shared: “One of my sisters...became anorexic. She had a total breakdown”; another stated, “I have a mentally ill daughter”; while a third reported “I’m in AA obviously and I’d probably say 85 to 90% of the people in with me have had some kind of mental health problem, like mine.” Note that these individual were open in sharing information about their personal experience of mental illness. They spoke about the many difficulties that people living with mental illness experience in terms of exclusion and isolation. As one key informant stated: “I have a mentally ill daughter and nobody is better connected than I am to the human services and healthcare system. And we’ve been on our own for all these years that she’s been mentally ill.” With this statement, this respondent raised the problem of access to care, even for people who have resources and connections.

A second factor that appeared to minimize stigmatizing beliefs was professional education and training. Frontline mental health providers all reported significant education about mental illness that reduced stigmatizing views. “I had a rotation in psychiatry in med school” reported one psychiatrist, while a social worker noted, “ongoing reading and training and clinical experiences influence me a lot.” Professional training continued at the case study sites, and leadership cited such training as important in addressing the problem of stigma, although, as previously noted, physicians are not required to attend such trainings.

One assumption of the original framework of this dissertation was that the media played a significant role in perpetuating stigmatizing attitudes and perceptions about mental illness within FQHCs. However, the findings from this research did not support this assumption. Interestingly, one respondent noted that the media played a positive role in challenging stigmatizing attitudes: “there is something in the media about a person who’s been successful with mental health issues, kind of in recovery, that kind of thing, is helpful overall in addressing stigma.” While this person acknowledged that such positive media coverage is rare, it is useful to understand that role models can challenge long-held stigmatizing views.

In analyzing both verbal and non-verbal communication, leadership respondents appeared most guarded in their responses when being recorded. For example, a leadership representative at Site A presented much differently in their multiple interactions with me, depending on the circumstance of the meeting. During the first meeting, to discuss the center being a case study site, this individual exhibited a lot of passion for integration and also for this research. (S)he made strong statements about problems in patients accessing mental healthcare. This respondent noted that the “social workers are overworked and underpaid and have far too much paperwork” which limits their ability to provide optimal care. Furthermore:

> The different streams of funding don’t meet the needs of the less seriously mentally ill, for example for kids with adjustment disorders, there is no funding for groups. [External funder] offers money but the stipulations are impossible to meet and so the Center can’t take the money, which is really frustrating.

I expected similar behaviors and responses during the interview but this was far from the case. Indeed, this respondent appeared to have adopted a different persona in the interview, and was very restrained in answering questions about challenges to integration. It seemed that in an informal setting, this person spoke much more openly and honestly about issues and concerns about the FQHC and the ability of patients to access care. However, during the interview, the presentation was that of an official agency representative who was much more careful about word and language choice while being recorded. While this person raised no objection to being recorded, they nevertheless appeared to be very mindful that what was being said was on the record and so was guarded in their responses.

Such behavior may be explained by Goffman (2010), who posited that social interactions are influenced by individuals wishing to project positive images of themselves, and the agencies that they represent, when engaging with others. These images are adaptable depending on the situation and actors involved. Goffman argues that public settings are a stage. In private, or when they do not feel that they are representing an agency, individuals are able to cast off this mask and be themselves (Goffman 2010). It seems that this respondent may have felt that (s)he was in a private place during our initial, unrecorded introductory meeting but in a public place during the recorded interview.

Perhaps because they were being careful, respondents generally did not make any blatantly stigmatizing statements about people living with mental illness. This may be the result of social desirability bias, or it may be a true reflection of people's actual attitudes and perceptions about mental illness. For example, one individual marked each negatively associated question on the stigma survey with "strongly agree" or 5 (which was reverse scored to 1 for analysis purposes), suggesting that they held no stigmatizing attitudes towards patients, which, of course, may be the case. In particular, this individual used people-first language; "people we serve who have addictions and co-occurring disorders" indicating a non-stigmatizing attitude, and was open in talking about prevalence.

Interestingly, one frontline respondent, (not a mental health provider) at Site B, Bc004, had a mean score of 2.21, suggesting that this individual holds some stigmatizing attitudes about mental illness. An incident (s)he described illustrates some of these attitudes. The worker was discussing the process of engaging with a patient and noted "the first thing I tell them is that I'm not a social worker because that would be scary for them, like there was something wrong with them or they'd be in trouble." It appeared that the worker did not perceive that such an attitude about social work and the type of clients who access mental health services was at all stigmatizing or stereotyping when, in fact, they were, in part, stigmatizing.

There was some recognition by some interviewees that certain staff members may stigmatize patients living with mental illness. Only a few individuals acknowledged this and there was some difference in opinion about which staff held the most stigmatizing attitudes. One management respondent stated: "I feel like historically medical providers in general have not been that open to mental health." This view is supported by another manager, who noted:

> There are some unspoken values that I think sometimes come out in terms of behavioral health needs…every now and then something comes up and it's like oh that's a behavioral health issue, we [doctors] don't deal with people who are crying and talking about problems.

Note that, in the opinion of these respondents, physicians were the most likely staff group to stigmatize mental illness but such stigma is not addressed, perhaps because of physicians' primacy within the agencies studied. These quotes thus highlight agency power differentials, with physicians being at the top of the hierarchy.

A leadership representative made a statement supporting this view, noting that support staff did not stigmatize mental illness but medical doctors did. In this person's view, "medical problems are still seen as legitimate and mental health issues are still seen as shameful or not legitimate" by the primary care doctors on their staff. Another interviewee noted some discomfort among primary care doctors treating patients who are living with a mental illness: "I think there can still be sometimes an equation of mental illness and just being a difficult person." Thus the patient is blamed for the illness, or for displaying symptoms of the illness. Such attitudes, in turn, can create barriers to accessing care. Indeed, one respondent noted that doctors describe those patients who do not respond well to traditional psycho-pharmaceuticals as "treatment resistant," as if they are responsible for their body's response to the drugs.

Although some respondents used non-discriminatory language, this was not the case for everyone. Furthermore, most respondents did not use people-first language – even many of those who started off doing so, stopped at some point during the interviews. For example, patients are referred to as "hallucinating schizophrenic", "behavioral patients" or "damaged clients." A few individuals did use people first-language such as "people with schizophrenia" but they were in the minority. Frontline practitioners and representatives from leadership at both sites were more likely to use people first language (i.e. a person living with schizophrenia rather than a schizophrenic) whereas managers were less likely to do so. This finding is consistent with the aforementioned stigma survey, which found that management respondents held more stigmatizing views that did leadership or frontline workers. At one meeting observed by this researcher, the word “normal” was used to describe a non-mental health related behavior or concern which could be indicative of how mental illness is perceived at the agency.

It was very clear to respondents that the stigma associated with mental illness was a very powerful force in their communities with one interviewee observing, for example, that: “There’s absolutely a stigma in the community.” Respondents noted that there is a cultural aspect to the stigma associated with mental healthcare and mental illness. This is reflected in the observations of one respondent who stated:

> I think there’s great issue of stigma and then within this community there’s a minority issue of stigma. Mental health in the black and the Latin minority communities is something that is so not talked about, that it’s almost considered a sign of weakness.

Some leadership and management representatives spoke about wanting to address the problem of stigma in their patient population. It was felt that integration has played a role in minimizing the level of stigma associated with mental illness already. “There are certain communities where the stigma is greater than in certain other communities,” confirmed one leadership representative. “That said, in an integrated program, nobody knows what you’re sitting in the waiting room for.” Moreover, another respondent from leadership stated:

> We’ve tried very hard to make mental health screening very normative. We say, oh we ask these questions to everybody, we offer this service to everybody. We don’t want anything to get to the point where your child needs intensive services

> but we offer this to everybody. Everybody gets stressed and here's something we can offer if you're stressed, that sort of thing. One of the examples I use a lot is if your child can't see the blackboard, you wouldn't think twice about getting them glasses. If your child is having a headache every day after school because the teacher is yelling or somebody is bullying them on the bus, that's no different from needing that extra little support to deal with that particular issue. That really works very well with families.

Other respondents stated that, not only has integration reduced stigma among patients, it has also reduced it among staff – despite most interviewees claiming that staff members had not stigmatized mental illness. This disconnect suggests that these individuals may not always recognize stigma when it occurs, or they may call it by another name. As one individual noted, "maybe what you're calling stigma and I'm calling lack of compassion is the same thing." Another person stated, "maybe I'm blind, but I don't see it. I'm so used to it. I'm too close to it." This statement supports the existing finding that stigma, and particularly institutional stigma has been so ingrained in agency policies and practices that it is often unrecognized by agency workers (Falk, 2001; Corrigan & Shapiro, 2010; Kobau, 2010).

Public stigma in different types of illness. One area where the evidence suggests that public stigma is found is in staff perceptions about different types of mental illness. Frontline practitioners at both case study sites, as well as key informant clinicians, report that illnesses such as schizophrenia, borderline personality disorder, and eating disorders are even more stigmatized than other mental illnesses. For example, a leadership representative from one of the case study sites noted that substance abuse is less stigmatized in their medical community than mental illness.

> We used to complain all the time because the doctors never got any background in addiction. And now they're starting to do that. But the mental health, I think…Sometimes they'd rather have a [patient with] a substance abuse problem than say, the mentally ill because mentally ill is different…We do much better in substance abuse than mental health. Is that [stigma] a reason?

In referring to the stigmatizing attributes of another provider, a key informant reported:

> There's a lot of ignorance about mental health within the medical health professionals. It's a very strange thing because on the one hand, they're very knowledgeable and aware of how to seek it if a patient has mental health issues they need assistance with. At the same time, there's a lot of stigma. If they're depressed, the doctor is great. Even if they're bipolar, medical doctors seem to get excited to meet people with cases of bipolar and are fascinated by it. But when it's schizophrenia…

In this quote, the participant draws attention to discomfort that physicians may feel in providing care to or interacting with people living with mental illness, particularly serious mental illness.

Similar views were supported by statements made by a number of other key informants who are clinicians practicing in the mental health field. One key informant raised another example of societal assumptions being reflected in workers' decisions and actions in describing how patients with serious mental illness do not receive appropriate care and support:

> I'm meeting with the medical providers of this young man who has the diagnosis of paranoid schizophrenia. There is some physical issue going on at the same time. He's becoming incredibly physically ill and having to be hospitalized. Each time that I've attempted to talk to his medical treaters, they say well he has schizophrenia, as if that's supposed to explain why he's becoming so medically ill.

Thus this patient did not receive appropriate care for his physical health problems because of the stigma associated with his mental illness.

Public stigma in the referral process. Generally speaking, primary care doctors are the gatekeepers to accessing mental health services at the two FQHCs studied. However, as aforementioned, at Site B, while the warm hand-off is the preferred practice, it does not always occur. Some frontline workers noted paternalism in referral making, when primary care doctors do not tell the patient that they are referring them to the mental healthcare department. Making the referral in this way was not the result of a decision that the patient and primary care provider made together. Rather, the MD made the decision that the patient needed to access mental health services and referred them without their knowledge or consent. Frontline mental health providers reported that this occurs frequently and that they then have the responsibility of informing the patient that they have been referred. On the other hand, mental health providers reported that the opposite never occurs, that is, referrals being made from mental health to primary care without patients being aware that such communication has taken place.

There are several explanations for referrals being made from primary care to mental healthcare providers without a patient’s knowledge. One is that physicians appear to consider the team to be their team; there is a hierarchy and they are the leaders. Indeed, there is a history of paternalism in the medical model; in practice, as earlier findings suggest, integration means mental healthcare being subsumed as a part of this medical model rather than as a co-equal participant. For this reason physicians may believe that they do not need to ask permission or consent from either the patient or mental health provider when making referrals to the mental healthcare providers on the care team. One respondent stated,

> we do try to educate the providers and medical providers in general about when you generate the referral. Like make sure you have a conversation with the patient, explain the services a little bit, make sure they’re interested and tell them they will receive a letter, all of that stuff… it’s not like their first priority.

In other instances, mental health providers argue that physicians do not wish to interact with patients who are tearful, instead referring them to mental healthcare, with or without their consent.

Institutional Stigma

The conceptual framework of this research posits that institutional stigma exists and that it impacts how policies are implemented. Because such stigma is often unrecognized, underlying power structures remain unchallenged. This lack of recognition, in turn, leads to stigmatizing practices being reproduced, even if the policies being implemented are not in-and-of-themselves stigmatizing.

Although the above findings suggest that some staff members hold stigmatizing attitudes toward people living with mental illness, data gathered for this study indicate that stigma is apparent more at the institutional than the individual level. Some respondents acknowledge the existence of stigma within the structure of their organizations, although in an indirect way: “Stigma is more of a societal thing but it is institutional [though] less here than in the community.” This frontline worker admitted that stigma is present in the agency but then qualified that statement by staying that there is less stigma in the agency than in the community. Interestingly, one frontline practitioner at Site A, who scored highest for positively associated statements on the Likert scale, indicating some stigmatizing attitudes, was also the respondent who was most aware of, and thoughtful about institutional stigma during the interview process. This individual described how the agency, while trying to avoid discriminatory processes, has established practices that are intended to reduce stigma but in fact have the opposite effect.

One such practice this person mentioned was the creation of barriers to accessing mental health records in the Electronic Medical Record (EMR) at Site A. The barriers were put in place to protect patient privacy around mental healthcare, but this respondent stated that the message (s)he received was that mental illness was shameful. In describing the privacy walls in the EMR, this person noted, “the mental health services have historically overcompensated for stigma and now we’re kind of stuck in some ruts that almost make it worse.” Thus, by including mental healthcare the EMR in such a way, the agency had actually contributed to perpetuating stigma associated with mental illness.

Another proposed practice at Site B was the leadership suggestion of separate waiting rooms for physical and mental healthcare in the new building that was being built. One manager viewed this plan as stigmatizing and creating a barrier to integration:

> Every now and then it comes up. Like with a conversation about waiting rooms for example in the new building. Should we have behavioral health in a separate waiting room? I was like well that kind of doesn’t support integration. And why would we be in a different waiting room? Behavioral patients aren’t in a different room now.

This quote draws attention to the respondent’s awareness of potentially stigmatizing new practices; such awareness did not appear to be present in many other interviewees.

That most individuals do not appear to be aware of institutional stigma suggests that stigmatizing practices and procedures within their agencies are accepted as the norm and go unchallenged. Indeed, no respondents, either staff members at the case study sites or key informants, reported being aware of any policies in their organizations that specifically address the stigma associated with mental illness and how it is manifest within these organizations. Organizational culture literature explains that this acceptance of, or, at least, failure to recognize, stigmatizing practices occurs because such cultures are based on agency-wide, often unstated assumptions, values, and beliefs that are accepted as the norm (Rousseau, 1989; Kreitner et al., 2001).

Institutional stigma and the electronic medical record. Interviews revealed several ways in which institutional systems perpetuate and reproduce notions of stigma. For example, as alluded to earlier, the electronic medical record, or EMR, is shared among providers but there are limits on who can access notes written by mental health providers. Some respondents at both sites and key informants who work at other FQHCs all noted that this was a problem. One such key informant, who is a mental health provider, described the process of accessing mental health records: “There is an extra layer of confidentiality. They [physicians] can read our notes but it’s not immediately visible to them. They actually have to go through another hoop before they can read ours, but we can read theirs.” Thus additional layers of protection are added to mental health records and limit who can access them.

One frontline practitioner at Site A argued that creating extra barriers to accessing mental health notes impacts patients:

> Like, a doctor having to say to a patient, ‘can you tell me a little bit about how therapy is going?’ and maybe the patient thinking ‘well why don’t you know because you told me I have a shared electronic record?’ Do they come back and say ‘well those notes are protected differently. Are you telling me there’s something weird about me going to therapy that even you can’t read about it?’

This response highlighted the potential for exacerbating stigma by having this extra layer of security in the EMR. Moreover, another mental health provider at Site A noted that any provider can access sensitive physical information but all mental health related information has an added layer of protection:

> There can be very sensitive medical information, yet our working with [patients] has all these securities that maybe somebody else's very delicate medical situation doesn't have. We can read their entire medical chart but the doctor can't read the session notes. But that to me only perpetuates stigma.

Thus institutional stigma exists, and is reinforced in continuing practices such as these limitations to accessing the EMR.

Similarly, a frontline worker at Site B reported that although patient medical records would soon become available to all, administration was still considering a security wall to limit who could read patients' mental health records. The respondent reflected that this might suggest the presence of some institutional stigma, that mental illness still needs to be shrouded in secrecy because it is more shameful. The respondent noted that this was an interesting insight that (s)he had not previously considered, reinforcing the argument that the long-standing stigmatizing practices often go unrecognized in organizations.

The issue of the added layer of security for mental health records and whether or not this constitutes institutional stigma is very complex and nuanced. It may be argued that the center is merely protecting patient's privacy and trying to stop them being labeled by other providers by adding this extra level of protection. An opposing viewpoint may be that by buying into this idea of the need for extra privacy for mental health issues, compared to physical ones, the notion that there is something wrong with accessing mental healthcare is underscored, which reinforces the stigma associated with mental illness. Perhaps the agencies are being paternalistic by providing extra security and protection to their patients, but if no agency is prepared to challenge this status quo and make sharing all information normative, then societal views, and the need to be protected from them, will not change.

Institutional stigma in resource allocation. A review of the literature (Upshur, 2005; Allen et al., 2009; Alexander & Wilson, 2010) and of the data obtained from interviews with key informants and individuals at each case study site indicate that physical health is proactive and preventative, whereas mental health is reactive. Patients are generally not informed about mental health services available at the FQHCs before they present with a problem or a need to access mental healthcare. This happens partly because of the culture and history of providing mental healthcare, which traditionally has not been preventative, and also because agencies will not fund preventative mental health services as they do primary care and dentistry.

One assumption within the initial conceptual framework was that resource allocation and service provision does not reflect prevalence of mental illness within the population. Furthermore, resource allocation that is incommensurate with need creates a large barrier to successful integration. This study found that resources allocated to mental healthcare at both case study sites do not meet the needs of the patient population and local communities. Given that only 4.94% of patients at Site A and 4.2% at Site B accessed mental health services in 2012, while 30 to 50% of people experience some form of mental illness in their lifetime and 15 to 30% are diagnosed in any given year (Mackenzie et al, 2007), such allocation strongly suggests that neither site is meeting societal need. This low uptake of services may also be due in part to the racial composition of the communities in which the FQHCs are located. Numerous prior studies have found that non-whites encounter more barriers to mental healthcare and receive fewer services than whites (Barnes, 2008; Horvitz-Lennon et al., 2009; Agency for Healthcare Research and Quality, 2013).

There are a few interesting differences in how the two sites fund mental healthcare (Table 2). A cursory examination of resource allocation data for Site A would suggest that this FQHC allocates a significant proportion of its resources to mental health services. Approximately 32% of operating revenue is allocated to around 5% of their total patient population. In contrast, Site B assigns 8% of its operating revenue to mental health services, with such care utilized by 4.2% of the patient population. However, costs of mental health services at Site A are bundled into the behavioral health category which includes not only mental health services but also substance abuse services, but the same is not true at Site B. Given that substance abuse services at Site A include inpatient and outpatient services, as well as transitional, permanent and group homes, it is assumed that payment for such services constitutes a large percentage of the behavioral health budget. This suggests that mental health services are inadequately resourced at Site A as well as Site B. Interestingly, the substance abuse program is not included in the agency's integration plans and will remain a stand-alone service, even though its funding is tied to mental health. This researcher requested more detailed data on budgets and resource allocation to separate funding streams, but this information was not provided.

One reason for the disparity between physical and mental health services funding may be that mental health is further down on the agenda when resources are distributed because it is not seen as important as physical health. Interviewees noted that when patients present with a mental health concern, they are often ignored in a way that does not happen with physical health issues. In referring to patients in psychiatric distress, one mental health frontline practitioner stated that management has advised:

> If the person really, really gets bad, they can call the BEST [Boston Emergency Services] team or they can go to the emergency room and that's obviously not effective care. If we said 'this person has chest pain, well they can go to the emergency room or whatever', that would not work.

Thus a difference in how physical mental illnesses are treated and resourced is revealed. An analysis of the data finds that the view that medical costs are more legitimate than mental health costs is pervasive across the two case study sites. One interviewee explained that: "It could be that the mental health issues are not seen as quite as acute or dangerous or important as physical health issues." Another person stated:

> I don't think the people sort of at the top of the food chain would ever say no, mental health is not as important but somehow we're at a point where we're not meeting that need and it's not seen as much of an emergency.

Insights about the relative importance of physical and mental health in resource allocation decisions are also supported by interviews with key informants who are mental health practitioners, when discussing practices within their agencies. One respondent noted:

> The more mentally ill the patient, it's like the less the health center is capable of doing for them. 'Well you know, they have schizophrenia. There's just so much we can do for this patient. They're going to always be chronically ill, they have schizophrenia'. And I know this because I have at least 12 cases of patients who don't speak English who have the diagnosis of paranoid schizophrenia and there's

> nothing for them…there's no program for them to be in. They won't do the in home visits for them. It's like they'll save it for the chronically physically ill. If the person has a bum leg, they'll go and make home visits. But if someone has schizophrenia, they won't go and make the home visits. It's like well they should be able to get themselves here. Or they're just so sick, we can't do anything for them because it's a mental illness.

This respondent provides a clear example of stigmatizing practices that result in sub-optimal care for patients.

Another significant concern raised by interviewees pertains to the organization of the clinics and allocation of employees. Specific mention was made of the availability of support staff to both physical and mental health providers. At Site A, on the medical side, there are receptionists, intake administrators, and patient coordinators who help patients navigate the center but the same resources are not provided on the mental health side. This creates barriers to patients trying to understand and effectively utilize all appropriate services. As one manager stated:

> I think the central intake person is going to be crucial, crucial, crucial to that. Or at least a front desk staff that understands the organization as a whole and then how to facilitate appointments for primary care and mental health. Right now we don't have that and I think we lose some people along the way.

This quote provides an example of stigma in resource allocation with the medical system receiving more resources than the mental health one. More systems appear to be in place to support the mental health side at Site B, perhaps because this center has had many more years than Site A to work out issues and identify what works and what does not when integrating care. As one respondent from Site B noted, “we have systems in place to coordinate that care, to make it faster, easier in being able to document. So even when we are in different locations, we have integrated care.”

Stigma in providing culturally competent care. An important difference in how resources are allocated is the provision of bi-lingual staff for patients accessing mental health versus physical health services. Given that 95.7% of patients at Site A and 81.7% at Site B (Table 2) belong to a racial or ethnic minority, having staff who speak a language other than English is crucial to increasing access and providing effective mental healthcare. At Site A, there are bi-lingual staff members and providers in multiple roles and at all levels on the physical health side. However, there are few bi-lingual staff in pediatric mental healthcare and none in adult mental healthcare, despite the fact that this FQHC is located in a primarily Spanish speaking community. One manager stated, “we have a backlog of maybe 90 or so patients who we can’t see because they speak Spanish and we don’t have anybody to see them.”

Leadership and management at Site A acknowledge that this lack of bilingual providers is a significant problem for integrating and increasing access to mental healthcare. Despite this awareness, these interviewees also acknowledge that they have no plans to change this arrangement or provide resources to hire a bilingual employee. Any patients who are Spanish speaking and wish to access mental health services are referred to other providers in the community.

Another issue is that the ethnic/racial characteristics of the mental health providers at Site A do not match those of the patients. Reported one respondent from mental health leadership: “I do think that there is much to be said for – efficiency is one thing – but also much to be said for a clinician who mirrors the person that you’re serving.” However, again, there are no plans to increase the racial or ethnic representation in mental health providers. Financial constraints are viewed as a barrier to addressing this somewhat hidden issue. As one manager stated, “those things that are harder to see, we kind of place less value on. And because of that, I think we’re going in the direction of spend less and less and less.” This quote highlights the challenge of mental health being lower in the agency hierarchy, with less power when advocating for resources.

In contrast, at Site B, almost all of the employees, on both the physical and the mental healthcare sides, are bilingual or multilingual. One manager noted,

> I always want high quality service provision of care. I want it to be culturally competent as much as possible. For example, for choosing staff members or trainees, I’d like them to be bilingual if at all possible, or trilingual or multilingual.

This response suggests a commitment to removing barriers to accessing care for all patients, regardless of race or ethnicity. Furthermore, a criterion for hiring new staff is that they be at least bilingual. Brochures and posters on display in Site B are provided in English and Spanish, and often in several other languages that reflect the community in which this FQHC is sited. There were no posters or brochures at Site A, but this may be a temporary condition while the center is undergoing some construction.

A number of reasons may explain this difference in availability of bilingual providers between Sites A and B. A particularly strong explanation is the variation in reasoning for integrating care. As previously stated, Site A implemented integration policies for financial reasons and Site B prioritized integration because leadership felt that it was the best way to provide effective and appropriate care to patients. Thus it may be argued that Site B has more of a commitment to diversity in staffing to reflect the patient population, as well as offering appropriate mental health services and facilitating access to such services, while at Site A, mental health is much further down the agenda and an important facilitator of patient access to services, staff from minority populations, for example, is lacking.

Boards of Directors Roles and Responsibilities.

One of the important characteristics in site selection was the composition of the organizations' boards of directors. According to public information available on the FQHCs websites, gathered prior to the start of this study, Site A's board of directors did not have at least 51% patient representation, whereas the board of Site B did. The issue of patient representation on boards is important for several reasons. Firstly, as mentioned previously, FQHCs are required by federal regulation to have at least 51% patient representation on their governing boards (U.S. Department of Health and Human Services, September 2014). However, this study found that, despite some respondents claiming otherwise, the boards at each case study site do not meet this requirement. Another reason was the assumption prior to starting the research that boards of directors have a major role in writing and developing policy. However, early in the interview process, it became evident that this policy-making role was not a reality in practice. On the contrary, the boards at each site appeared to have no role in policy creation or development. Rather, they approve policy brought to them by agency leadership and make suggestions for changes.

Board composition. As aforementioned, publically available information indicated that Site B had 51% patient representation on its board, while Site A did not. However, analysis of interviews from participants at both sites indicates that these rates of representation are not reflected in actual practice.

Site A. Governance at Site A is more complicated than at Site B, as it has four boards - the Health Services, Community Services, Real Estate, and Foundation boards. Furthermore, medical services and mental healthcare are overseen by two different boards, Health Services and Community Services, respectively, which may pose a challenge to integrating care. Indeed, a description on the center's website states that the Community Services board "oversees all of [Site A's] services that are not health related, including Adult Education, Child and Family Services and Behavioral Health Services." The division of responsibility between the two boards, therefore, suggests that center leadership does not consider mental or behavioral healthcare as part of overall health healthcare, that it is somewhat distinct, or separate. A representative from leadership in the medical team stated that this governance arrangement has been in place for many years. There is a plan to integrate board oversight: "outpatient mental health services…will now fall under the joint purview of both boards.” However, this agency leader had no sense of when this change will occur.

According to Site A leadership respondents, the Foundation, Real Estate and Community Services boards do not have not 51% patient representation; in addition, only the Foundation board has responsibility for programmatic decisions, budgeting and governing the center. An operations manager noted that the “foundation board is all finance people. It’s all finance people and I’ve never met them” even though this person’s role is related to finance. Thus, the Community Services board, on which mental healthcare is represented, plays little, if any role in the programmatic and budgeting decisions critical to the agency. Thus, not only does the board responsible for mental health lack 51% patient representation, but also it has no role in important agency decisions.

In Site A, the Health Services board has responsibility for six areas of healthcare: pediatrics, adult medicine, OB/GYN, eye, dental and community care (HIV services). It has 12 members, most of whom are medical and other professionals. The mental healthcare team is overseen by the Community Services board, which has nine members. This latter board is the smallest in the center and is populated by volunteers who are interested in mental health or substance abuse issues. Potential members apply to sit on the board and the president makes decisions about who is accepted.

Site A respondents had varying opinions about the composition of the Health Services board with representatives from leadership and management stating that the board had at least 51% patient representation. Responses from frontline workers indicated that some did not believe that the boards had at least 51% patient representation, while others stated that they did not know who sat on the board. One agency leader stated that having 51% patient representation was helpful as it gave the clinic's patients some input into and influence over board processes. However, another member of the leadership group described meeting the patient requirement by having "community members" on the board. When pressed about who these individuals were, this respondent stated that these community members were not necessarily patients at the center and then went on to acknowledge: "Well actually, not all of them live in the community. Some of them live outside the community."

Managers had varying opinions about whether or not the Health Services board had 51% patient representation, with one describing membership in rather vague terms such as "people who've had a history with [Site A], knows somebody who's had a history with [Site A]" rather than being actual patients. Most frontline practitioners stated that they did not know who sat on the Health Services board and could not comment about whether or not any of them were patients.

Developing an understanding of the true nature and role of the boards was challenged by this researcher being unable to interview any board members despite making numerous requests to do so. The contact person at Site A, who had been extremely helpful in facilitating interviews with staff members, rejected the idea that talking to a board member would add any useful data to the research, but would not explain the reasoning for this point of view.

Site B. Governance at Site B is much more straightforward as there is only one board of directors. This board consists of 20 members, of whom it appears only four are patients at the center. Again, this researcher was unable to procure interviews with any board members due to reluctance from center leadership; this was framed as the board members being very busy and not having anything useful to add to this project.

Initially, interviewees stated that the board had at least 51% patient representation; several noted that such representation is a federal requirement. Some respondents were adamant that the board met this requirement, while others clearly stated that it did not. Some managers stated that there were no patients on the board, while other stated that there were a few. One interviewee said:

> Our board is probably fairly representative of other boards of community health centers in that we have some folks who are true, real utilizers of all of our services, including primary care, but then we also have a number of board members who really don’t use us for their primary care but might use us for some piece of their ancillary care, whether that’s eye services or eyewear, dental, other things like that.

This finding suggests that centers may be somewhat flexible in how they characterize board members as patients in terms of their use of center services, in order to meet the federal requirement.

One of Site B’s agency leaders initially stated that the board meets federal guidelines: “As a federally funded community health center, there is a strict set of rules that we need to follow.” However, this same respondent became more candid as the interview went on:

> I've worked at other health centers where this bylaw was really stretched...They would just tell folks 'Can you just buy a pair of eyeglasses once a year so that we can keep you on the board'. We do a much better job than that.

This leadership representative spoke about the responsibilities of the board in relation to the day-to-day functioning of the center and also to fundraising. As previously discussed, FQHCs are often financially constrained and have to seek out additional resources to meet patient need. This respondent noted that, because of the pressure to fundraise,

> There's always a pull to try to have board members who can help access funding streams and who are connected within community organizations whether public or private to help make those connections and facilitate that networking. And those folks are not going to be of the same demographics as the patients that we need to serve that tend to be the uninsured, the most vulnerable, the most at risk communities in our area.

Other interviewees reported constraints on patient board participation such as patients not having English as a first language, having limited education and experience in professional arenas and having other responsibilities, such as childcare and working two or three jobs. One leadership representative summarized the issue by stating,

> I would not say that the majority of the people on the board really have an experience of knowing what the health center is like as users. We are better than most places but it's still a really big challenge.

While some interviewees had a good understanding of the composition of the board, others reported quite the opposite. This lack of knowledge is reflected in statements such as “I’ve never spoken to anyone on the board” and “I met the board once; I don’t think that they are patients.” Several managers at Site B stated that they could not comment on patient representation as they did not know who sat on the board, while another stated, “I wish there were more people like me, people that represents the community, like more patients on the board.” The rationale for this was that board members who are not patients do not know what patients really need and do not necessarily make the best decisions about service provision. One individual noted that the “main members of the board have been on the board for a very, very long time, actually I think since the founding of the health center.” Other respondents stated that board members were business owners or healthcare workers who had lived in the community for a long time. In addition to suggesting that board members may not accurately reflect the composition of the community the center serves, findings suggest that board members may be more representative of older populations living with the center’s catchment area.

Board members interactions with staff. Board members at both case study sites played similar roles in interacting with agency staff and being involved in creating policy. At Site A, leadership meets with the boards on a regular basis to present issues; for the Health Services board, this occurs monthly while the Community Services board meets bi-monthly and the Foundations board meets quarterly. Managers make occasional presentations to the boards and all staff and board members have a chance to meet at an annual breakfast. Representatives from management felt that it was useful to meet with the boards to educate them about the work that is being done in the center -- “I don’t think people have a clue about how busy we are and how much work we’re doing and what the needs are, so it was kind of nice to say it to somebody besides ourselves.”

The levels of interaction between the board and staff members were similar at Site B. Board meetings take place monthly; these are regularly attended by senior leadership while managers attend occasionally to make presentations and share data, although this does not happen regularly. One manager stated that the last time (s)he attended a board meeting was 2 years prior, while another reported never having communication with the board. A third described a gulf between the board and agency workers, stating, “employees really don’t know how that thing works. It’s like different worlds. We don’t know who made the decision, was it supported by the board, what’s the board’s role in this.” One manager noted that the focus is on metrics, not on staff:

> I do know that they want numbers. How many patients enrolled in the Affordable Care Act? I haven’t heard them ask how many of your staff are happy or how many of your staff have worked extra in order to fill out that application that took an hour and a half?

Frontline practitioners report even less interaction with the board, with either one or no interactions taking place over the past several years.

The role of the board in agency policy making. A review of the literature suggests that boards of directors have considerable influence in organizations, both in terms of leadership and in terms of innovation (Harrison & Murray, 2012; Jaskyte, 2012). Thus, as previously stated, prior to commencing the study, an assumption was made that boards of directors of the FQHCs have a major role in writing and developing policy. However, respondents at both sites stated that the boards had no role in establishing the specifics of center policy, rather they would amend or approve policy brought to them by agency staff, or make recommendations for the implementation of federal or state policy. Ultimate decision making authority over center direction rested with agency leadership and staff. Thus, one manager stated that while "my policy would have to be signed off by the board, I'm sure they don't read every single one of them. They trust us that we know what we're talking about." According to another manager, the board tasked agency leadership to identify specific programs that could be integrated after financial considerations had already led agency leadership to conclude that integration was necessary.

Actors in policy creation and implementation. Both leadership and management interviewees stated that ideas for agency practice come from all staff levels, that is, there is both a top down and bottom up approach to policy creation. Managers use their discretion to implement changes to practice and report that they encourage frontline workers to make suggestions for improvement. "It comes from bottom up and top down," reported one manager. In terms of general mental health related practices, this manager stated: "most of our policies that have been written for behavioral health were all staff written." However, frontline practitioners report less communication and involvement in policy making --"I think probably most of that conversation is at the level of our board of directors and people who are at the top of the pyramid" -- although some respondents noted that their ideas were encouraged and implemented:

> I think, as far as I know, the behavioral health policies and procedures are more managed just within our department. I'm sure if we need to make some kind of large change it would go higher up than that but most often it's things that can be done on our own.

In this instance, the respondent is referring to small changes within his or her own work, rather than practices that would significantly impact how integration happens at the FQHC.

In general, leadership representatives from Site A noted that integration practices were developed and implemented by the senior leadership team and the clinical directors, not the board. Rather it is the responsibility of the board to approve policies and perhaps make recommendations for changes. Interviewees at Site B report similar processes, with the board approving rather than creating policies. Furthermore, at both sites policy changes that are made from day-to-day during the normal course of agency operations do not go to the board, instead team leaders or clinical directors approve them.

Measurements of Success.

An important finding from this research is that success is measured by the number of patients accessing mental healthcare, not by improved patient well-being. Many interviewees, particularly frontline workers, were unaware of evaluation policies and practices at their centers, apart from themselves being evaluated on whether or not they met productivity targets. Data on measuring the success of center integration policy therefore came from agency leadership and management and is limited as a result. However, the available data tell a striking story about the level of importance placed on the efficacy of integration in increasing patient access to mental healthcare and on providing appropriate and effective mental healthcare.

An examination of the data indicates that success is measured by the quantity not quality of care. That is, integration practices are seen as successful if they result in more patients accessing services; there is no evaluation of whether or not patient mental health outcomes have improved. All respondents stated that integration had been successful in terms of more patients accessing mental healthcare services at each site. Although there were disagreements between medical and mental health staff about the process of integration, as was discussed in the previous chapter, all noted that referrals to mental healthcare had increased. At Site A, from 2010 to 2012, referrals from primary care to mental healthcare increased by 70.4%. At Site B, referrals increased by 40.7% for the same period (HRSA, 2014).[5]

Leadership and management respondents also noted that an analysis of their metrics showed an increase in numbers of patients actually accessing care, that is, following up on referrals and utilizing services. Indeed, publicly available data indicates that the number of enrolled patients from 2011 to 2012 increased by 406 at Site A and 139 at Site B.[6] Thus, in highlighting success, interviewees emphasized process over outcomes; goals for mental health pertain to access not improved patient mental health.

---

[5] These data were obtained from publicly available records but more detailed information on evaluation processes and outcomes was unobtainable from either site. Updated financial reports were requested from both agencies but, although promised, they were not forthcoming.

[6] More current data were not available.

“What we have done so far is we’ve looked at a lot of process measures where we’ve done really quite well,” observed one leadership respondent.

> A lot of the cost measures are quite significant. Our operational costs and savings. Then we’ve looked at process measures such as no show rates, number of warm hand offs, number of intake appointments capped and we’ve scored significantly higher in all of those post-integration. And we’ve looked at provider satisfaction, and that’s improved, both behavioral health providers and medical providers. We haven’t looked at outcomes.

This quote calls attention to the agency priority to measure quantity, i.e., numbers of patients accessing care, rather than quality, i.e., improved patient outcomes. While patient satisfaction surveys are administered, this occurs when patients arrive for appointments, rather than after they have met with their providers, rendering these data somewhat meaningless for evaluating performance from the patient perspective.

Another measurement is that of frontline worker productivity, in terms of number of patients seen, rather than in terms of patient well-being. As one mental health clinician stated,

> I don’t know that we have an exact evaluation process, aside from did we do it or not? Are treatment plans getting completed once every three months and then getting checked? Has the case conference happened? Yes or no. Multidisciplinary case conference, has it happened? Yes or no.

This participant had no awareness of any other evaluation practices at the center. As previously discussed, frontline workers reported feelings of anxiety at having to meet their productivity targets, and state that this, rather than providing the best possible care, has become the focus of their work. One individual stated, “We had to really be able to show the financial people about statistics. We were under a microscope and had to meet numbers to keep our jobs.” All evaluation metrics at both cases study sites measure important process indicators (i.e., follow through on referrals, numbers of warm hand-offs, and so on), as well as provider productivity and provider satisfaction; there are no plans to measure patient outcomes, if any, resulting from improved access to mental healthcare.

Summary

This chapter discussed research findings related to addressing the disparity between patient need for mental healthcare, and their access to services. In light of considerable existing research on the role of public stigma (that is, stigma held by individuals) in policy implementation, it was anticipated that analysis of the data would uncover similar results. However, while stigmatizing attitudes were found to exist to some extent in individuals at each case study site, it was minimal to moderate. The level of public or individual stigma at case study sites was assessed by analysis of data from interviews and from the stigma instrument (Likert scale) administered to 19 of the 21 respondents at the sites.

There were three interesting points of comparison in the data: between the three levels of agency workers; between Site A and Site B; and between mental health related workers compared to all other, non-mental health related respondents. This research found moderate levels of public stigma at each site, with greater stigmatizing attitudes at Site B, when compared to Site A, and in management, when compared to leadership and frontline workers, with these results being statistically significant. However, no statistically significant differences were found when comparing mental health related workers and non-mental health related respondents, or between physician and non-physicians.

One area where public stigma was evidenced was in in the treatment of different kinds of mental illness, with illnesses such as schizophrenia being much more stigmatized than depression, for example. The referral process was another area where public stigma was evident, with some medical doctors referring patients to mental health providers without the patient's knowledge or consent. This referral practice indicates reluctance on the part of these doctors to engage with patients about their mental health needs, and one reason for that is public stigma. This conclusion is supported by interviews with respondents at both sites, as well as key informants, who stated that while most FQHC staff does not stigmatize mental illness, medical doctors do.

Evidence from this research suggests that institutional stigma, that is, agency policies, practices and structures that, whether intentionally or not, limit treatment opportunities for people living with a mental illness, has as strong presence at both case study sites. Such institutional stigma has significant impact on how integration policy is implemented at the FQHCs. Stigma was found in many aspects of the FQHCs studied, including in the electronic medical record, in resource allocation, and in providing culturally competent care. Institutional stigma was unrecognized by most respondents at each case study site, thus the underlying power structures remain unchallenged. As a result, stigmatizing practices are reproduced on an ongoing basis.

Other important findings relate to the boards of directors. First, case study site selection had been based, in part, on whether or not the FQHC boards of directors met the federal requirement of being at least 51% patient representative. From publically available data, it was assumed that one site met this requirement, while the other did not. However, this study found that neither site has 51% patient representation on their boards. Leadership and management at both FQHCs denied that this was the case, with the exception of one leadership representative at Site B, who initially stated that the board met the federal requirement, before acknowledging that it did not. The lack of patient representation in the boards is significant as this means that patient opinions and expertise on their own needs are missing.

Second, board members have little interaction with agency staff, with the exception of leadership. FQHC workers question the strength of board members' connections with the agencies. Third, it was expected that the boards would play a major role in policy making, but this happens very rarely, rather boards generally amend and approve policy brought to them by agency leadership.

A final important finding is that these FQHCs measure the success of integration solely by process indicators, such as the numbers of patients accessing mental health services, rather than by improved patient outcomes from the utilization of such services. Despite having metrics and practices in place to assess outcomes for physical health, the same evaluations are not made in mental healthcare. Respondents at the leadership and management levels noted that this was a problem, but also noted that they had no current plans to address this problem.

To recap, this chapter reports on the case study findings that stigma, and in particular, institutional stigma, is a major contributor to the disparity between the numbers of individuals in need of mental healthcare and those that actually access services. Other important factors that contribute to this disparity are the function of the boards of directors at the case study sites and how these FQHCs measure success of integration policy implementation.

CHAPTER 9

DEVELOPING A NEW FRAMEWORK FOR FEDERAL INTEGRATION POLICY IMPLEMENTATION IN FQHCS

This dissertation sought to answer the following research questions: Does stigma impact the implementation of mental health policy and affect access to treatment in FQHCs for people living with mental illness? And, if stigma does impact mental health policy implementation and access to mental healthcare in FQHCs, how does this occur? These research questions were underpinned by the literature review and conceptual framework that was developed prior to beginning the research. A process of refinement and modification of this framework (Figure 1), based on the research findings, resulted in the development of a new model to describe how stigma affects the policy process at the point of implementation. This chapter discusses theories of the original concept map and assumptions upon which the research was based, in light of the research findings. It also describes the new model that was developed from the findings. Some arguments of the original framework are supported by these findings, while others are rejected. Data that corroborates working assumptions, as well as describes unanticipated findings is analyzed; together these elements allow for the implementation model to be adapted and refined and for theory to be created. A discussion of what these findings mean and what conclusions may be drawn from them follows.

A Critique of the Theories Informing the Original Conceptual Framework

The conceptual framework as outlined in the concept map (Figure 1) posited that, in addition to the stigma associated with mental illness, theories of street-level bureaucracy, and organizational culture and relationships were significant in how integration policy was implemented. This conceptual framework also posited that agency workers' perceptions of mental illness are influenced by personal and professional experiences, as well as by aspects of their political and economic environment and the communities in which they work and live. Such perceptions shape the decisions and actions taken by workers in the course of their job. The following section critiques the theories that informed the original conceptual framework in the context of the study's findings about the integration of physical and mental healthcare in FQHCs.

Assessing the role of stigma in FQHCs.

One of the main theories underpinning this research was that stigma impacts the process of integration policy implementation, thereby creating barriers to treatment and negatively impacting outcomes for people living with mental illness. The study examined the role of two distinct types of stigma: public and institutional stigma. Public stigma refers to stereotyping and discrimination that the public, as individuals, display towards people living with mental illness. Institutional stigma is evidenced in agency policies, practices and procedures that discriminate against and reduce choice among people living with mental illness, whether such discrimination is intentional or not (Heflinger & Hinshaw, 2010).

Public Stigma. The conceptual framework of this dissertation theorized that societal assumptions about people living with mental illness are reflected in the views and behaviors of agency staff and that stigma creates barriers to treatment and services for FQHC patients. The framework argued that worker attitudes are influenced by many factors, including personal and professional experience, the culture of the organization, the political climate and culture of the community in which the FQHCs are located and by the media. Such attitudes have influence on the decisions and actions of these workers (leadership, management, and frontline staff) in implementing policy and developing integration practices. Staff members are part of society, thus it makes sense that their views and attitudes may reflect those of the public and of the communities in which they live. Certainly, stigma remains a barrier to accessing mental healthcare in these communities. Analysis of the research findings suggest that there is some evidence of worker attitudes reflecting wider societal stigmatizing beliefs and of such beliefs affecting day to day operations through their impact on worker attitudes.

Respondents at both case study sites denied the presence of stigmatizing attitudes among mental health providers. However, analysis of the findings suggests the presence of stigmatizing beliefs among medical providers. Such stigmatizing beliefs by medical providers affect patient access to mental healthcare, especially among people living with serious mental illness and schizophrenia. First, managers and frontline workers in mental healthcare reported that medical doctors stigmatize patients presenting with a mental illness, and that such stigma has been present for some time. Second, key informants reported that people with serious mental illness do not receive appropriate care because of negative and stigmatizing views held by other staff, primarily medical doctors and nurses.

These findings are supported by the literature, which finds that many medical providers hold stigmatizing views about mental illness. Such views, in turn, contribute to a reluctance to provide primary care to people living with mental illness, and in particular serious mental illness (Goldberg & Huxley, 1980; Lawrie, 1999; Green, 2000; Lauber et al., 2006). One explanation for such attitudes, and the barriers that such attitudes create in access to care, is that people living with mental illness are seen as “less than” and as “other” (Goffman, 1984). They are socially constructed to be excluded from the dominant group in society (Fraser & Gordon, 1994) and it is this exclusion that leads the dominant group to view the needs of “others” as less important than those of the “normals” (Goffman, 1984; Wilson, 1989). Moreover, because they are excluded, their needs can be ignored without consequence to deserving populations (Lipsky, 1980; McSween, 2002; Corrigan, 2007).

Interestingly, all respondents at both case study sites and certain key informants reported significant stigma associated with mental illness in the communities in which they are located. Interviewees spoke, often at length, about how such stigma is operationalized by their patient populations and how it limits the number of people willing to access mental health services. However, very few respondents stated that any staff members hold stigmatizing attitudes, even though many of them come from the communities in which the FQHCs are located. It is arguable that this stigma continues to be reflected not only in the patient population, but also in the staff members who live in these communities, but other than the aforementioned examples, such stigmatizing views were not detected. This conclusion is reinforced by the stigma instrument, which did not indicate a large presence of public stigma at either site but rather low to moderate levels. Managers were found to hold more stigmatizing attitudes than either leadership representatives or frontline workers but there were no statistically significant differences, in terms of stigma, between sites or between mental health and non-mental health providers.

One explanation for low prevalence of stigmatizing attitudes among agency workers may be that staff was provided with training on all aspects of healthcare, including mental illness. “We really try to provide the education so they understand about what trauma informed care is.” reported one member of leadership.

> So when you have a client who is getting triggered, who is acting in ways that might be seen as provocative [by staff]…they can have an understanding, rather than getting themselves agitated or upset or being disparaging – this person is manipulating – [staff] can view it instead as part of the mental health issue.

Interestingly, physicians were not required to attend such trainings. This is reflected in the observation of one leadership interviewee, who noted: “The staff attends a lot of these in services, at least the nursing and medical assistant staff.” The lack of physician participation at such trainings is an issue because it reinforces the hierarchy, that doctors have more power and their time is too important to spend in training about understanding different illnesses and behaviors. Managers in mental healthcare recognized that this is a problem: “we have to get someone in here to train these physicians. They’re a very diverse group over there but they don’t get it.” However, because leadership of the FQHCs is comprised, in considerable part, of medical doctors, shifting power imbalances and challenging the status quo is very difficult.

There are several other possible explanations for such limited reporting of stigma among case study site staff. One is that respondents might want to portray their agency favorably; while another is that they did not feel empowered to make negative comments, and so did not report much stigma in staff. The exception was the reporting of the presence of stigmatizing attitudes among medical doctors, perhaps because they do not come from the local community or because they hold in a higher place in the agency's hierarchy of influence when compared to other providers. There were insufficient numbers of medical providers to identify a statistically significant difference between the attitudes of medical providers and other staff in terms of stigma. However, as aforementioned, results do indicate that non-mental health related respondents exhibited higher levels of stigma than mental health related respondents on the stigma instrument, though the result did not achieve statistical significance.

Institutional Stigma. While there is little evidence of case study site staff members attitudes affecting patients on an individual basis, analysis of the data found such attitudes reflected at the agency level, in policies and practices, that whether intentional or not, reproduce the idea that mental illnesses are shameful and of less consequence than physical illness. This supports existing research that posits that while explicit bias has declined in recent years, implicit bias remains (Christensen et al., 2012). Thus, during the analysis, it became evident that institutional stigma exists, with respondents at both sites and some key informants acknowledging the existence of institutional practices and procedures that reinforce stigmatizing beliefs about mental illness, whether purposeful or not.

The power of institutional stigma lies in the fact that, because it often goes undetected, it can readily reproduced. An example of this dynamic can be found in the proposal by leadership at Site B to have separate waiting areas for physical and mental healthcare in the new building, where that is not the current practice. As previously noted, frontline practitioners at Site B stated that such separation would increase stigma and created barriers to integrating care and to normalizing the idea of attending to mental healthcare. This separation reinforces the notion that people living with mental illness are somehow “other” (Goffman, 1984), with shameful conditions and thus should be kept apart from the “normals” who are attending to their physical health issues. Not only does this idea suggest a move away from, rather than towards integration, it also suggests the potential creation of an agency practice that may, unintentionally, promote and perpetuate stigma towards mental illness by separating the receipt of mental healthcare from physical healthcare. Thus this proposed shift from integrated waiting rooms to separate ones supports the theory that institutional stigma is often invisible and is readily reproduced (Falk, 2001; Corrigan & Shapiro, 2010; Kobau, 2010).

Many respondents, both at the case study sites and key informant interviewees, mentioned policies and practices that were not recognized as stigmatizing, even though they were. One example of such a practice was the creation of additional security barriers to accessing mental health provider patient notes in the electronic mental record. Agencies argue that such extra security is intended to protect patient privacy. However, stating that mental health records need greater security and privacy protection than physical health records reproduces the idea that mental illness is separate and somehow shameful. Such barriers in electronic medical records exist both at case study sites and in agencies with which key informant mental health providers are affiliated. It is unsurprising that the perpetuation of institutional stigma, as evidenced in this example, may go unrecognized as it is often complicated and nuanced. Furthermore, if a stigmatizing policy has been in place for many years, its nature is likely to be unrecognized and thus go unchallenged.

Additionally, analysis of direct observations and agency documents reveal institutional stigma. At Site A, the Community Services board oversees mental health while the Health Services board oversees other health services. As aforementioned, publicly available information on the Community Services board notes that mental health services are unrelated to health. The fact that mental healthcare is under the purview of a different board than health services indicates that agency leadership considers physical and mental health to be unconnected. As such, it may be argued that, despite having integration policies in place, agency leadership does not consider mental healthcare to be part of overall health but, instead, something separate and distinct. At Site B, analysis of direct observations of staff meetings found that mental health providers were concerned about whether or not their notes in the electronic medical record would be available to other providers. While appreciating the confidentiality issues and desire to protect patient’s privacy involved in determining access to patients’ electronic health information, keeping mental health notes secret and separate from medical notes reinforces the idea that there is something shameful or stigmatizing or harmful about sharing this information.

Institutional stigma is also found in allocation of resources to different services. A clear and striking example of such institutionalized stigma is found at Site A, where no adult mental health providers speak Spanish or indeed any language other than English, despite the fact that the majority of the population of the local community does not have English as a first language. Therefore, many patients requiring access to mental health services, but who do not speak English, go unserved. In contrast, staff members at all levels in adult primary care are bilingual or multilingual to enable patients to obtain access to physical healthcare. Leadership and management at Site A acknowledges that not having any mental health providers who speak a language other than English means that many of their patients are not able to access needed healthcare. They also acknowledged that there are no plans to direct resources to address this gap in healthcare provision and do not expect any additional funding will be made available in the foreseeable future.

Street level bureaucracy. It was expected that policy implementation and practice would come from all staff levels, both top-down (leadership and management) and bottom-up (frontline practitioners). On the one hand, managers reported using their discretion to implement changes to practice and to encourage frontline workers to make suggestions for improvement. In comparison, frontline practitioners reported little communication and involvement in developing practices with management and leadership. Although some frontline mental health workers noted that ideas pertaining to increasing their productivity were encouraged, the potential to develop or amend practices that affect integration and patient access to mental healthcare was minimal at best. Thus the research indicates that the top-down approach to integration practice development was predominant in the two FQHCs studied.

Still, analysis of the findings indicates that frontline workers do feel that they have some discretion in their work, and some leeway in how they interpret certain policies. This finding is, in part, consistent with theories of street level bureaucracy which posit that frontline practitioners have some discretion in their work that may allow them to ignore official agency edicts while, effectively, creating agency policy and practices through day-to-day decisions made during the course of their work. Indeed, a working assumption of this dissertation was that if agency policies were not conducive to providing optimal care to patients, then frontline mental health practitioners might subvert those policies in ways contrary to agency expectations to patients' benefit. The latter expectation, in particular, derived from the corollary assumption, outlined previously, that worker's decisions and actions would be influenced by their attitudes and beliefs about people living with mental illness.

Contrary to expectations and despite some evidence of discretion, frontline mental health practitioners failed to subvert even those agency policies not believed to be in their patients' best interests. The primary reason: fear of losing their jobs. Job insecurity was particularly evident at Site A, where frontline practitioners report many colleagues were laid off when integration was first implemented. Indeed, feelings of job insecurity were especially strong in the first year after the agency began to integrate physical and mental healthcare, which resulted in high levels of stress among frontline mental health workers. Furthermore, the message they received about the new model was, "if you don't' like it, leave." However, these workers are aware that they would encounter similar pressures, should they look for work elsewhere. This argument is supported by data from key informant interviews. “I think the mental health profession feels under pressure. We’re gonna lose our jobs. We’re secondary anyway and now we’re gonna be even more secondary.” Another constraint on frontline workers is the scarcity of salaried frontline practitioner jobs elsewhere. These features, both individually and combined, make many practitioners fearful of non-compliance with policy or of conveying any dissenting views to management or leadership. Feelings of conflict therefore go unexpressed. Many frontline workers articulated, both verbally and non-verbally that they were relieved that the interviews were confidential, highlighting their concern that leadership and management would learn of their complaints.

Beyond fear of losing their jobs there are several other, and not necessarily mutually exclusive reasons, that frontline workers were not innovative in subverting or changing agency practices. Frontline practitioners at both sites reported that the primary emphasis of their work was meeting productivity targets. Having such large caseloads and pressure to meet targets inhibits the development of clinical relationships with patients, which has a negative affect on mental health outcomes (Corrigan, 2007). This pressure on productivity was particularly evident at Site A, where workers stated that they focused on meeting their targets rather than on producing good work. Statements from management indicate that concerns about meeting productivity targets were not unwarranted, which is reflective of frontline workers relative powerlessness in the agency structure and hierarchy. This notion is supported by key informants from other FQHCs who also reported being under pressure to meet productivity targets and that this focus could result in less than optimal outcomes for patients.

Another reason that frontline workers were not innovative in subverting or changing agency practices is that the mental health department was subsumed into the medical model, thereby reinforcing the power imbalance and hierarchy in favor of the latter over the former. The fact that medical providers report that true integration has occurred and that they do not recognize the loss of the mental health culture suggests that the status quo of the hierarchy has not been upset.

Boards of directors. One of the inclusion criteria for case study site selection related to patient representation on the boards of directors at each FQHC. Prior to beginning the research, it was believed that Site A did not have the federally mandated 51% patient representation on the board, but Site B did. This distinction was considered important as it was assumed that board members had some role to play in policy creation and development. It was also anticipated that boards that had at least 51% patient representation would be more likely to create, develop and implement policies that addressed the needs of the patient population.

Analysis of the data shows that these two assumptions made about the boards of directors were erroneous. The first was the issue of patient representation. Leadership at both sites stated clearly that their board of directors had a least 51% patient representation, whereas other staff members at the management and frontline practitioner levels stated that this was not the case. I was unable to gain access to any board member for interview, despite repeated requests and was unable to clarify the composition of the boards, though it was clear that boards at neither Center reached the 51% threshold.

Results highlight struggles FQHCs faced in meeting the 51% patient representation mandate.

This finding suggests that the current mandate has little impact on board composition, though leadership at both FQHCs denies that their boards are not at least 51% patients for fear of losing federal funding and support. Moreover, this finding supports existing research that most boards of directors of FQHCs do not meet the patient representation requirement (Wright, 2013). That boards are not majority patient matters because if the board does not accurately reflect the community in which the FQHC is located, its members may not be aware of the needs of the local population, which can hinder appropriate service provision (Wright, 2013).

The second assumption made about the boards of directors prior to commencing the study was that the boards at each case study site had an important role in policy creation, development and implementation. The role of the board in these processes, as well as having significant patient representation, are important because these, in theory, provide a platform for patients in decision making about policy implementation and in the functioning of the FQHC (Wright, 2013). Some extant research suggests that boards of directors are an important component of executive leadership and of the governance of the FQHCs (Harrison & Murray 2012) and contribute to innovations within the agency (Jaskyte, 2012). However, other literature suggests that boards, even those with majority patient representation, do not have a major role in decision-making in FQHCs. Rather it is the executive director and other agency leaders, including medical providers, who have influence in "identifying community needs and making decisions about CHC service offerings" (Wright & Martin, 2014, p. 942).

Analysis of the data indicates that the boards of the FQHCs included in this study do not have a significant role in agency practice creation or implementation. Respondents at all three staff levels (leadership, management, and frontline worker) in each case study site reported that the board's role was to approve or amend agency policy and practice rather than to create them. Some respondents even raised doubts that the board members read all of the policies put before them. One respondent did provide what was described as a rare example of the board developing policy but in this case, the board provided a broad outline and asked agency staff to fill in the details. Thus the assumption that the board was a vehicle for the voice of the community is unsupported; furthermore, the boards do not play a significant role in developing programs and services.

Implication of Study Findings for the Original Framework

The conceptual framework on which this dissertation is based argued that policy is created, developed and implemented at three levels, that is, by leadership, management, and frontline practitioners (see Figure 1). The ensuing practice then impacts patient outcomes. Stigma, which influences how policy is implemented through its impact on agency staff, creates or reinforces barriers to accessing mental healthcare; this then results in less than optimal patient outcomes. The conceptual model that informed this research posited that agency staff attitudes about people living with mental illness are shaped by five components: personal experience; professional experience; organizational culture; environment; and media. Such attitudes shape workers' decisions and actions in creating, implementing and complying with policy, in service delivery, and in resource allocation. The result on patient outcomes can be positive or negative, depending on the attitudes of the workers.

A careful reflection on the analysis of the data obtained from the research allows for this model to be refined, and a new, more explanatory model to be developed. This new model provides a better understanding of the issues involved in policy implementation, and of the role of stigma in this process. A discussion of how the data analysis shaped the existing conceptual model to inform the revised model follows.

Influences on attitudes. As aforementioned, the conceptual framework stated that there were five main influences on worker's attitudes about people living with mental illness. However, analysis of the findings does not wholly substantiate this argument. Respondents at both case study sites as well as key informants stated that personal and professional experience and training as well as agency culture, the contributed to their attitudes about mental illness (see Table 4). Interviewees noted that having experienced a mental illness themselves, or having had a family member, friend, or neighbor with a mental illness, was a major contributor to their knowledge of and perceptions about mental illness. While all respondents considered their attitudes about mental illness to be positive, those respondents with such personal experience were much less likely to hold stigmatizing views of mental illness than others. Those respondents who had received professional education and training also reported less stigmatizing attitudes, although as previously noted, medical doctors were identified by their colleagues as more likely than other groups to stigmatize mental illness.

Interviewees, particularly policy makers and advocates, reported being influenced by their community and the political and economic environment, but did not report significant media influences on their attitudes. Messages from the media about mental illness often reinforce negative and erroneous stereotypes, portraying people living with mental illness varyingly as dangerous, incompetent and unproductive in society (Rochefort et al., 2002; Quigley, 2007; Williams, 2007; Hinshaw & Stier, 2008). Interestingly though, respondents at both sites and certain key informants stated that patients' perceptions of mental illness were influenced by the media and by the communities in which they live, resulting in clients stigmatizing people living with mental illness. However, all respondents at both case study sites denied any such media impact on agency staff, even though many staff members come from the same communities as their patients. Evidence from the study, however, suggests that the media plays a minimal role in the development of integration practices. A main exception was one respondent, a leadership representative at Site A, who noted that media reports about people living successfully with mental illness are helpful in addressing stigma which, in turn, promotes access to care.

It may be argued that organizational culture and training help to combat stigmatizing attitudes. As aforementioned, both sites have committed to integrating physical and mental healthcare, and to normalizing access to mental health services, which is a costly and long-term commitment. Leadership at both case study sites have also committed to ongoing training programs for all staff to educate them about providing inclusive, non-stigmatizing care to all patients.

Alternatively, FQHC staff may have denied significant stigma among most workers because they might not want to admit that any of their staff, with the exception of medical doctors, stigmatize patients living with mental illness. In contrast to frontline mental health practitioners, stigmatizing beliefs among medical doctors may be permitted or acceptable, perhaps because of the persisting hierarchy and on-going power imbalance that allows some behaviors and attitudes to go unchallenged.

Agency staff roles and relationships. The original framework posited that policy creation and implementation occurs at every level of staffing, with an ongoing dynamic of interaction between leadership, management and frontline workers that impacted the integration of physical and mental healthcare, service delivery and resource allocation. To a certain extent the analysis indicates that this is true; however, the views of leadership and, to a lesser degree, management, tend to predominate where the integration of medical and mental healthcare is concerned. It is also the responsibility of leadership to liaise with the board of directors and obtain their agreement to policy changes, though the boards themselves have very little involvement in policy creation. Thus, according to one representative from leadership at Site A, "the lion's share of the details of how policies are put together and then implemented really falls at the level of either the senior team or the clinical directors." The exception to this practice is large, strategic policies that impact the function of the agency, whereby the boards are "involved in a bigger picture sort of way."

The conceptual framework had suggested that the discretion available to frontline practitioners in applying policy would result in the creation of new practices, which would then improve patient outcomes. What actually occurs is that frontline practitioners experience considerable stress and pressure in their jobs. Moreover, they are aware of their lower status in the agency hierarchy, as compared to physicians, and feel powerless to address their concerns. Thus mental health providers focus more on meeting productivity targets than on the quality of their work. This has great potential to negatively impact patient mental health outcomes, while simultaneously indicating increased numbers of patients accessing mental health services. In other words, integration practices can been seen as successful because more patients are accessing mental health services, without any evaluation of the outcomes of these services.

Another important element in this dynamic is the relationship between the medical and mental health disciplines. The aforementioned subsumation of mental healthcare into physical health resulted in considerable turmoil for frontline mental health practitioners, and affected how physical and mental healthcare was integrated. Mental health workers lost important aspects of their culture and did not gain equality, or any more power, in the new model. This caused mental health providers serious concerns about their ability to provide high quality care to patients in an integrated setting. Resulting job insecurity created increased pressure for frontline workers, as they had seen colleagues, generally those with more experience and tenure, being laid off for not wanting to adapt to the new model.

An additional impact of the loss of experienced mental health workers due to organizational conflict resulting from the dominance of medical model is FQHCs being staffed with less experienced mental health providers who have even less power in the organization. The frontline workers who remained at the FQHC had to commit to the new model of care, with a change of culture and a heavy focus on meeting productivity targets. The result was even less emphasis being placed on the needs of the patient populations and, as such, on the quality of care that patients receive.

Patient outcomes. The conceptual framework posited that patient outcomes would be either positive or negative, depending on how worker and agency attitudes about mental illness impacted access to care and service delivery. However, there is no available data to ascertain whether or not such impacts occur. At both sites, outcomes are measured only in the numbers of patients accessing mental health services and not in the improved mental health of these patients. Success is anecdotally reported with no supporting evaluations. Leadership and management at these sites state that the measurement of mental health outcomes is important and would provide useful information; such data is gathered for numerous physical health conditions such as diabetes and hypertension. These same respondents also note that they have no plans to invest resources in gathering and analyzing these data, indicating that, despite integration being in place, mental health still occupies a lower rung on the agenda than physical health.

It would appear that the only measure used to assess whether or not the center is meeting the mandate for integration is that more patients are accessing mental health services. This metric, however, is appropriate only to the early stages of integration. Later stages require more sophisticated outcome metrics to discover the efficacy of the integration interventions put into place on patients' mental well-being. Thus, whether or not patients actually benefit from services appears to be of lesser priority than sites indicating that have improved rates of access to mental healthcare.

Pincus (2013) notes that a persistent problem in the delivery of mental healthcare is a lack of outcome measurement and best practice benchmarks to monitor results. While it may be argued that it is easier to measure changes in blood pressure than changes in mental health status, there are assessment tools available such as the PHQ-9, a depression-screening tool (SAMHSA, 2015). Crucially, Pincus observes, “outcome measurements are not widely applied in spite of reliable and valid instruments” (Pincus, 2013, p. 18). Insufficient use of existing measures and the lack of standardization in mental health assessment and practice result in the absence of datasets for in-depth analysis. If FQHCs are committed to improving patient outcomes and not just metrics such as increasing patient visits, then utilizing and analyzing existing mental health assessment tools would be a useful start. This, for example, might involve combining data on the numbers of patients using mental health services with data available from the EMR to analyze whether or not increased access contributes to decreased psychiatric inpatient stays or emergency room visits for mental health related needs.

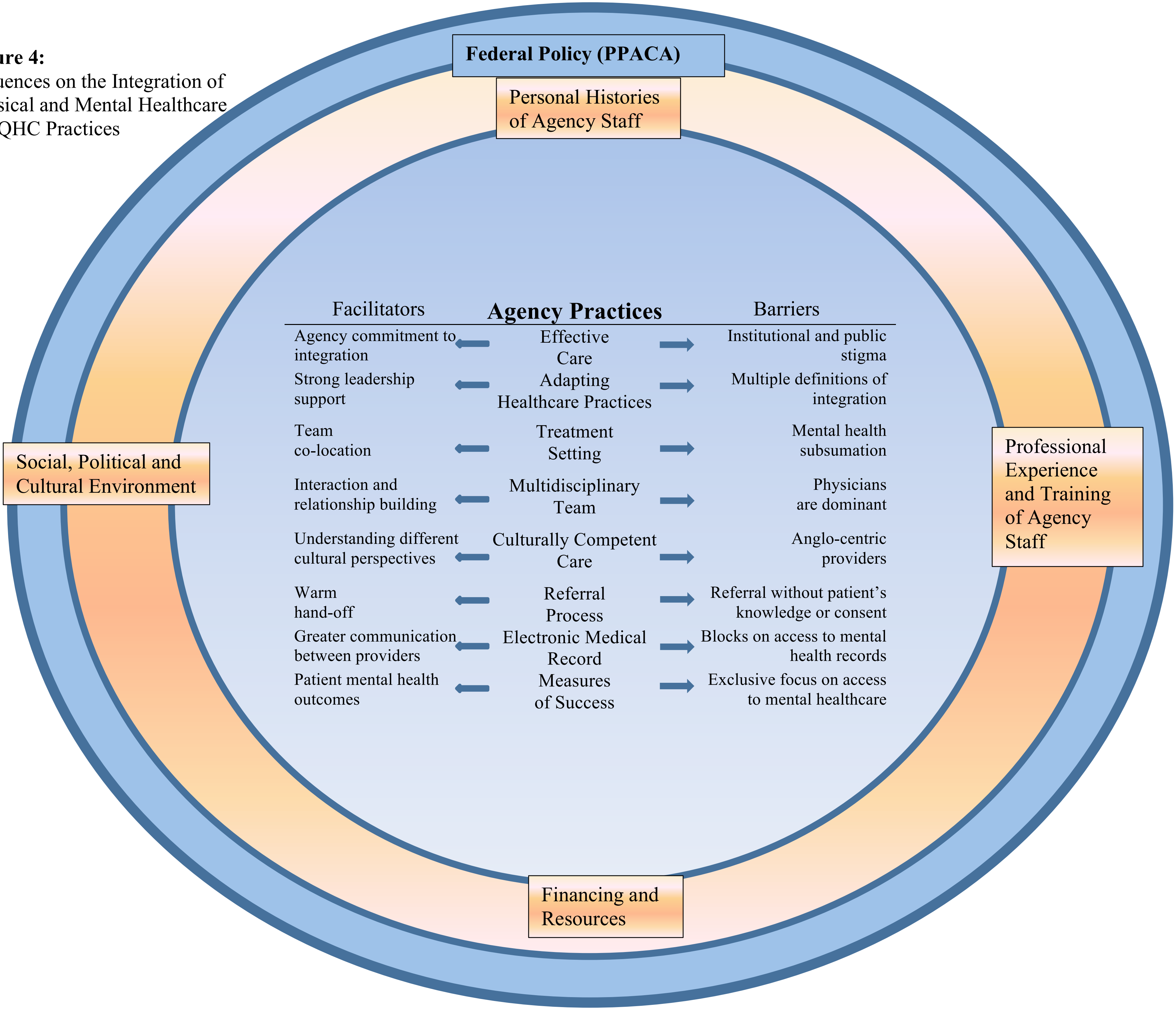
The Development of a New Integration Implementation Model

The concept map or framework (Figure 1) that framed this research posited that stigma interferes with integration policy implementation in FQHCs, resulting in outcomes that may differ from the intent of the original policy makers. This concept map stated that the interaction of stigma with the implementation process contributes to insufficient integration between medical and mental healthcare and, as such, the continuing disparity between the prevalence of mental illness and the numbers of people accessing mental healthcare and services. The original framework argued that agency staff members' perceptions about people living with mental illness are influenced by a number of factors: the FQHC organizational culture; personal experience of mental illness; professional experience of mental illness; the political, economic and cultural environment; and media. The decisions and actions of agency staff are influenced not only by these perceptions of people living with mental illness, but also by dynamics between leaders, managers and frontline practitioners at the FQHCs. This original concept map posited that the influences on decisions and actions result in either positive or negative outcomes for patients, depending on how much of a role the stigma associated with mental illness plays in the process of policy implementation.

In light of the findings from this research, the original concept map (Figure 1) has been modified and supplemented to create a new model (Figure 4, below) that better explains which elements exert the strongest influences on the integration of physical and mental healthcare in FQHCs and, in turn, access to mental healthcare and patient outcomes. The new model, in part, focuses on how agency practices take place within the context of existing influences on attitudes to mental healthcare and resource allocation, including, but not limited to personal and professional influences. These influences in turn exist within the larger federal context of the PPACA (2010).

The adapted framework supports the original model's argument that agency staff member's perceptions of mental illness shape their decisions and actions in the workplace. However, the findings from the study suggest that the dynamics between different levels of workers have less impact on integration than the dynamics between medical and mental healthcare providers. Significantly, while there is some evidence of public stigma in implementing integration practices, institutional stigma has much greater impact on agency practices of integrating physical and mental healthcare. Furthermore there are several facilitators and barriers that affect how integration policy is implemented.

Figure 4:
Influences on the Integration of Physical and Mental Healthcare in FQHC Practices



Facilitators	Agency Practices	Barriers
Agency commitment to integration	Effective Care	Institutional and public stigma
Strong leadership support	Adapting Healthcare Practices	Multiple definitions of integration
Team co-location	Treatment Setting	Mental health subsumation
Interaction and relationship building	Multidisciplinary Team	Physicians are dominant
Understanding different cultural perspectives	Culturally Competent Care	Anglo-centric providers
Warm hand-off	Referral Process	Referral without patient’s knowledge or consent
Greater communication between providers	Electronic Medical Record	Blocks on access to mental health records
Patient mental health outcomes	Measures of Success	Exclusive focus on access to mental healthcare

Influences on integration practices. Federal policy, i.e. the PPACA (2010), mandates that FQHCs integrate physical and mental healthcare. Thus, this research examined the implementation of national integration policy at the local level, i.e., in FQHCs. Specifically, it focused on whether stigma interfered with this implementation process, thereby creating barriers to care and negatively affecting patient's mental health outcomes. The framework that was developed from this study indicates that there are four main influences on agency practices of integrating physical and mental healthcare within the broader context of federal law.

A significant influence on integration is FQHC staff perceptions; that is, their personal histories and experience of mental illness. Specifically, if someone has experienced a mental illness themselves, or had a family member, friend, or acquaintance with such an illness, they are less likely to hold stigmatizing beliefs than those without such an experience. Having personal knowledge of mental illness raises awareness about the realities of such illness, as well as the psychological, physical and societal challenges of accessing needed care and services. Individuals who hold less stigmatizing views are more likely to provide care that is respectful of the patients, and to promote practices that encourage the normalization of mental illness and integration of physical and mental healthcare. Indeed, public stigma has a much less significant role in affecting the implementation of integration policy than does institutional stigma. Non-stigmatizing staff attitudes are evidenced in FQHCs in several ways. For example, they are evidenced in conversations with patients about mental health being part of overall health and by medical and mental health providers' willingness to work together to provide patients with a multidisciplinary team. Such practices promote increased access to mental healthcare as well as effective integration of care.

Another important influence on integration practices is the respondent's professional experience and training. Having a mental health qualification at any level (MSW, Psy.D, for example) provides staff members with a good understanding of mental illness that results in non-stigmatizing attitudes. This understanding is reinforced by on-going training at the FQHCs themselves. Indeed, one-way leadership can exhibit a strong commitment to addressing and eliminating stigma and raising awareness about appropriate treatment of people living with mental illness is by providing on-site education for all staff. Results indicate that all staff, with the exception of physicians, is required to attend such trainings at the FQHCs studied, which is an interesting finding, given that the data suggests physicians are the group most likely to stigmatize mental illness. In-house training for all staff—medical and mental health—is one way to address stigma within the FQHCs and to encourage the development of a true integration model, rather than the subsumation of mental health into the medical model.

A third influence on the development of effective integration practices relates to financing and resource allocation. Commitment and experience in integrating care are necessary but not sufficient conditions; for true integration to take place, sufficient resources must be allocated to the task. The low level of resources allocated to mental healthcare at the two case study sites hampered integration efforts. While data on operating revenue allocated to mental healthcare at Site A were not available, at Site B, only 8% of such revenue was assigned to mental health services. Furthermore, in 2012, 4.9% of patients at Site A and 4.2% at Site B accessed mental health services, which is not reflective of prevalence of mental illness in the general population of around 50%. Financial constraints can also hamper integration practices by precluding the provision of culturally competent care. None of the adult mental health providers at Site A speak a language other than English. As a result, many patients who only speak Spanish have been unable to access care, thus effectively limiting integration practices to English speaking patients.

The final element related to integration practices has a lesser impact than the three already described. The social, political, and cultural influences of the environment or community in which the agencies are based have some influence on integration. The political climate is particularly important, as changes in state and federal funding sources can promote or curtail effective implementation of integration practices. So too can the level of patient representation on FQHC boards. It had been anticipated that patient representation of at least 51% on the boards, as federally mandated, would result in practices that reflect the needs of the local community and patient population. However, analysis clearly indicates that neither site's board meets the 51% threshold. It is likely that the absence of the patient voice in the development of integration practices results in the selection of less effective practices by agency leadership.

Together these four influences - personal, professional, financing and resources and social, political and cultural influences - shape agency practices in integrating physical and mental healthcare in FQHCs. However, there are other factors that both facilitate and create barriers to integration of care and, as such, influence access to mental health services and patient mental health outcomes.

Facilitators and barriers to agency integration practices. Successfully integrating physical and mental healthcare requires the effective provision of appropriate care to FQHC patients. This is facilitated by the agency commitment to integration. As previously stated, integrating physical and mental healthcare is a complicated and costly process that requires buy-in from agency staff. Integration is therefore facilitated if agency staff believes that it is the best way to provide care to patients. It is also facilitated when, as is the case in the two case study site, agency staff takes pride in their agencies having begun integration practices prior to being mandated to do so by the federal government. A major barrier to providing effective and appropriate care to patients living with mental illness is the presence of public and, to a greater degree, institutional stigma. Public stigma affects the implementation of integration practices through its impact on the referral process and, in particular, the treatment of different kinds of mental illness.

In order to adapt healthcare practices to integrate care, strong leadership support is required. Such support, in turn, helps to promote commitment from other staff members. A barrier to successfully adapting practices to integrate physical and healthcare at FQHCs is the fact that there are multiple definitions of integration. Unless all agency personnel are clear about what exactly integration means in their center, integration practices may fail or be less than optimal in providing quality care to patients.

Another important factor impacting integration is the establishment of an effective treatment setting. Co-locating medical and mental health providers in the same department supports these practices, with shared office and social space; such co-location also allows for social interaction and formal and informal relationship building. Furthermore, co-location allows for informal consultations and education about each other's professional cultures and practices. Provision of space to allow for co-location requires a commitment from agency leadership, such as has been seen at both case study sites. Site A is undergoing some refurbishment and construction and, while the two disciplines are currently separated, they will be reunited once the building work has been completed. At Site B, a new building is under construction; all levels of agency workers had the opportunity to provide feedback on plans for the new center and physicians and frontline practitioners will be co-located in the same office space.

One barrier to the establishment of an effective treatment setting is the subsumation of mental health into the medical model. True integration requires the development of care teams where both the medical and mental health disciplines are equal. This point is pertinent as frontline workers who do not feel empowered to resist the subsumation of mental health into the medical culture may not be capable of providing what they consider to be optimal care. The pressure that frontline workers experience to meet productivity targets, their feelings of job insecurity and the power differentials between such workers and physicians and agency leaders, result in these practitioners focusing on numbers, rather than developing effective therapeutic relationships with their clients.

Another important agency practice is the formation of multidisciplinary teams that communicate well. The success of such teams is facilitated by the development of collegial, collaborative respectful relationships, where each member of the team has equal value. In this respect a barrier to integration is interdisciplinary conflict due to physicians' higher placement in the agency hierarchy and to cultural differences between physicians and mental health providers. One implication of physician hegemony is the dominance of medical language and loss of much of the language of mental healthcare. The hegemony of the medical model also creates power differentials, with mental health providers experiencing considerable job insecurity and stress, but not feeling able to raise their concerns with leadership. As aforementioned, the top down approach dominates; as a consequence, the agency hierarchy creates power imbalances between medical and mental health staff that reinforces the medical model and limits frontline mental health practitioner participation in developing agency policy and practice. Such limitations and conflicts do not promote equitable collegial relationships or successful integrated working practices.

True integration in FQHCs that are located in areas with large minority population requires culturally competent integrated care. An understanding of the different cultural perspectives of health and illness facilitates such care. While such understandings promote integration, the dominance of Anglo-centric providers and a paucity of bilingual staff can create barriers to integrating care for all patients, especially for those who do not speak English. The dearth of culturally competent care is one reason that extant research finds that minority populations experience even great challenges in accessing mental healthcare than do whites (Barnes, 2008; Horvitz-Lennon et al., 2009).

An effective process for referring patients from primary care providers to their mental health colleagues is crucial to increasing the number of patients accessing mental healthcare and potentially to improved patient outcomes. Shared space between primary care and mental healthcare practitioners results in increased referrals. Shared space is important because having all providers in one setting, in one team normalizes access to mental healthcare, thereby reducing stigma, while ensuring that patients do not have to go elsewhere for mental health services. Shared space also increases the likelihood of a warm hand off whereby physicians introduce patients to mental health providers in person. When physicians introduce patients in person, patients are more likely to follow up with appointments for mental health services, both because a personal contact has been made and because of the relationship and trust patients have in their physicians. A major barrier to successful referral practices occurs when physicians make referrals to mental health providers without the patient's knowledge and/or consent. Lack of patient involvement adversely impacts the development of collaborative relationships with mental health providers. It also indicates to patients that their mental health concerns are of lesser importance because those concerns do not warrant discussion with their primary care providers. Such referral practices are not reflective of the multidisciplinary team model, which has been shown to improve access and patient outcomes. It also reduces the willingness of both the patient and the mental health provider to engage in integrated care.

The electronic medical record is another important practice that facilitates integration by allowing for greater communication and information sharing between medical and mental health providers about shared patients. Furthermore, it has the potential to significantly increase referrals to mental healthcare by reinforcing relationships between providers and encouraging a multidisciplinary approach to patient care. A barrier to the successful use of the electronic medical record is the imposition of additional layers of protection for mental health records, which limits who can access such records, thus impinging on successful integration. As already discussed, the practice of limiting access to mental health records may be in place to protect patients from disclosure of sensitive information but it also suggests that mental illness is shameful or damaging and thus reinforces stigmatizing perceptions of mental illness. Having the privacy wall also inhibits the multidisciplinary teamwork that is required for integration to succeed.

Finally, how agencies measure success is an important practice in integrating care. Viewing increased access to mental healthcare is a necessary but not sufficient condition for successful integration. This was the point-of-view of respondents at the two case study sites, all of whom believed that successful integration had taken place because there has been increased use of mental health services since integration practices had been implemented. However, neither site measures or has plans to measure patient outcomes, although valid and reliable measures exist. The lack of outcome measurement is a barrier to integration because, in focusing purely on numbers seen, the emphasis moves further away from the provision of quality, effective mental healthcare and more towards meeting productivity targets. Thus agency practices may move further away from a full integration model, because the focus is not fully on improved patient care.

Summary

This dissertation sought to provide answers to the following research questions: Does stigma impact the implementation of mental health policy and affect access to treatment in FQHCs for people living with mental illness? And, if stigma does impact mental health policy implementation and access to mental healthcare in FQHCs, how does this occur? The conceptual framework (Figure 1) that underpinned this research posited that personal and professional experience, as well as organizational and societal influences affect agency workers' perceptions of mental illness and their decisions and actions in the workplace Furthermore, the framework stated that dynamics between the three levels of agency workers affected decisions and actions in the process of policy becoming practice at the agency level.

While some components of the original framework remain in the new model (Figure 4), analysis of the data indicates that three of the original assumptions do not hold, at least in the context studied. First, it was assumed that interactions between leadership, managers and frontline workers were important in the development of integration practices. It was posited that each level of worker had influence on the others and that the autonomy and discretion of frontline workers or street level bureaucrats, resulted in a combined top-down, bottom-up approach to policy implementation and integration practices. However, given the power and control of the medical model, the power differential in agency structures and frontline workers having little job security, the top-down approach dominates.

The second assumption, later proved inaccurate, was that majority patient representation on boards of directors would result in integration practices informed by patients and designed to meet patient need. However, the findings indicate that neither site comes close to meeting the federal mandate for 51% patient representation, suggesting the absence of the patient voice from agency operations. The final false assumption also related to the boards. It posited that board members played an important part in developing integration practices. Contrary to expectations this study found that boards have very little role in agency policy and practice creation and implementation.

Analysis of the findings allowed for development of a refined and amended model or framework (Figure 4) that better explains the process of policy implementation and of integration practices at the two case study sites. The refined model narrowed the elements believed to impact the integration of physical and mental healthcare and affect access to mental healthcare services in FQHCs. Similar to the original concept map, this new framework states that various factors influence worker's attitudes about mental illness, which in turn affect integration practices. The new model, however, suggests that the dynamics between mental health and medical providers have a greater influence on integration policy implementation, rather than the relationships between different levels of agency workers. It also identifies crucial facilitators and barriers to integration, complex elements that both support and impede the process of policy becoming practice.

A major finding is that stigma affects the policy implementation process, thus creating barriers to treatment and access to care. The issue of the relationship between stigma and policy implementation is complex. It had been anticipated that public stigma, that is stigma held by individuals, would be an important element. Public stigma is found in various parts of the implementation process including in referral making and in the treatment of different types of mental illness. However, while this study found some public stigma, greater evidence of institutional stigma was uncovered. Institutional stigma is seen in several barriers to integrating care, including in service provision, in resource allocation, in the provision of culturally competent care. It is also seen in the electronic medical record, as, although this system allows providers to share information about patients, limitations are placed on who can access mental health records.

In addition to stigma, several barriers were identified to effectively implementing integration practices and improving access to mental healthcare in FQHCs. These barriers include: the presence of multiple, sometimes conflicting definitions of integration; the subsumation of mental healthcare into the medical model, as opposed to the development of a multidisciplinary team, with equality among providers; interdisciplinary cultural conflict and communication challenges; a lack of diversity in providers; referrals being made without patient's knowledge; barriers to accessing mental health providers' notes in the electronic medical record; and the exclusive focus on numbers served as the metric indicating success in integration to the exclusion of patient mental well-being due to a lack of measurement of patient outcomes.

Several elements were found to facilitate the implementation of policy and the integration of physical and mental healthcare in FQHCs. These include: agency commitment to integration; strong leadership support for integration; the co-location of physical and mental healthcare providers; collaborative relationships among providers; awareness of differing cultural perspective on health and illness; the warm hand-off when making referrals to mental healthcare; a shared electronic health record to allow for better communication between different providers on a patient's multidisciplinary team; and measurement of patient well-being in addition to numbers served as the metrics used to evaluate the success of integration practices.

To recap, in seeking to answer the main research questions, this dissertation finds that stigma, and in particular, institutional stigma does indeed impact the implementation of integration practices at FQHC, albeit in sometimes rather nuanced ways. The most obvious indicator of stigma lies in the above-mentioned unequal distribution of resources at Site A. A more nuanced way in which stigma impacts policy is evidenced in how the power imbalance and importance afforded to physical healthcare has resulted in mental healthcare being subsumed into primary care, as detailed in Chapter 8. The fact that such institutional stigma goes unrecognized by the dominant group indicates that it is part of the organizational culture and is resistant to change. Furthermore, numerous other facilitators and barriers were found at each case study site; these have influence on the integration of physical and mental healthcare, as well as on access to mental healthcare and on patient mental health outcomes.

CHAPTER 10

CONTRIBUTIONS AND RECOMMENDATIONS

The goal of mental health policy is to enable people to live independent lives as much as possible and to receive appropriate treatments (Corrigan, 2007). Although mental health should be seen as part of overall health, there is a hierarchy of resource allocation and agenda setting within both the physical healthcare and mental healthcare fields, resulting in insufficient investment in mental healthcare in the US. On the one hand, there has been consistent growth in the number of people diagnosed with a mental illness in the US (Cunningham, 2009). Indeed, mental illness is very prevalent, with about 30 to 50% of people having some kind of mental illness during the course of their lifetime and 15 to 30% being diagnosed in any given year (Mackenzie et al., 2007). In contrast, rates of mental health service utilization are low and previous studies have estimated that between 65 and 80% of people living with a mental illness do not get help (Mackenzie et al., 2007). Furthermore, as previously noted, spending on mental healthcare does not reflect prevalence of mental illness in the US with spending on mental healthcare as a percentage of total health spending ranging across states, from 0.61% to 5.52% in 2010 (Kaiser Family Foundation, 2011). This level of spending contrasts markedly with the prevalence of mental illness, with annual rates of diagnosis ranging from 16.7% in Maryland, to 24.2% in Rhode Island (Substance Abuse and Mental Health Services Administration, October 6, 2011).

That spending and use of mental healthcare services is not commensurate with the prevalence of mental illness suggests that US mental health policy regarding access to mental healthcare is important for both social justice and economic reasons. By being denied full access to the mental healthcare system, people's health outcomes and life expectancy may be seriously compromised (Colton & Manderscheid, 2006; Smaldone & Cullen-Drill, 2010). As aforementioned, the life expectancy for people living with a serious mental illness is 25 years less than the general population (Manderscheid, 2006; Alexander & Wilson, 2010; Miller and Prewitt, 2012; Woltmann et al., 2012), which is a serious social justice concern.

An inability to access appropriate treatment also has serious economic repercussions for those living with a mental illness. Depression is one of the most common disabling illnesses; by 2020 it is estimated to be the leading cause of disability worldwide (Gold & Shuman, 2009). Frank and Glied (2006, p. 2) report, "for the vast majority of people with a severe mental illness, a life in poverty is to be expected"; approximately 35% of people receiving social disability benefits and 28% of people receiving welfare benefits are diagnosed with a mental illness. High unemployment rates, ranging from 50% to 95 % depending on the illness (Linhorst, 2006; Satcher & Higginbotham, 2008), itself a social justice concern, mean that many people living with mental illness make limited contributions to the economic productivity, taxes, and consumer spending.

The PPACA sought to promote the integration of mental and physical healthcare in FQHCs to close the chasm in mental health treatment and prevalence in the US. The findings from this dissertation indicate that there are policy gaps in terms of defining what integration means, providing adequate funding for integration to occur, reporting on integration outcomes and addressing racial and ethnic disparities in service provision where integration take place. These gaps must be addressed in order to improve patient access to mental healthcare in FQHCs. This chapter highlights the contributions that this dissertation makes to the literature on stigma and mental health policy implementation. It also outlines policy recommendations to work towards achieving the goal of increased access to mental healthcare and improved patient outcomes, and makes suggestions for further research.

Contributions to the Literature

This dissertation reports findings from a rigorous qualitative research study that sought to address questions about the role of stigma in the implementation of integration policy. While answers to such questions have evolved from close analysis of the data, other, unanticipated, but equally important themes have also emerged. Additionally, this research makes a major contribution to three areas of literature: integration definitions and practices; stigma, and particularly, institutional stigma; and policy implementation and the integration of physical and mental healthcare.

One major finding is that a clear definition of integration is lacking and furthermore, what has occurred is actually the subsumation of mental health into the medical model, rather than true integration. This subsumation as important, as this practice does not challenge the dominant structures for providing healthcare in the US, nor does it give equal value to mental healthcare; the underlying power structures remain. This relationship between mental health and medical care in this study is consistent with the critical epistemology literature, which seeks to uncover inequality and disparity in society and to examine how power is reproduced and reconstructed. The dissertation finds that power imbalances exist in numerous ways; they are seen in the above-mentioned subsumation of mental healthcare as well as in the dominance of physicians in interdisciplinary conflict. Inequality is seen in the adoption of medical language, and the shift in emphasis from developing therapeutic relationships to meeting productivity targets. That frontline mental health providers do not feel empowered to address their concerns with FQHC leadership for fear of losing their jobs reflects these workers low place in the agency hierarchy, when compared to physicians.

A second contribution is that, while low to medium levels of public stigma are primarily found in the treatment of different types of mental illness and in referral processes, the role of institutional stigma is significant. While much has been written on how values and beliefs are institutionalized in an agency's culture (Rousseau, 1989; Kreitner et al., 2001; Hogan & Coote, 2014), little has been written on how institutional stigma is produced and reproduced, both in general and in FQHCs, specifically. Findings from this dissertation provide important information on how institutional stigma is invisible and reproduced in agency systems and impacts policy implementation, even if unintentionally. Acknowledging and understanding the role of institutional stigma is important; otherwise, disparities in access to care and other services that derive from it may go unaddressed. Failing to address barriers to treatment resulting from the exclusion caused by stigma has serious impact not only for individuals, but also for society as a whole. Therefore, this dissertation makes an important contribution to scholarship by elucidating the role of stigma in impacting access to treatment for those living with mental illness (Corrigan, 2006) due to its embeddedness in and understanding of FQHC integration practice.

Third, an important finding is that FQHCs measure success of their integration policies by the numbers of patients accessing mental healthcare, not by whether or not their mental health is improved. This finding is significant, because it can result in erroneous assumptions being made about the efficacy of agency practices and the reproduction of services that do not best meet patient need. While it is important to understand how certain practices increase the numbers of patient accessing mental healthcare, it is important that this number not be conflated with improved patient mental health outcomes. Metrics to uncover what impact integration has had on both access to services and the resulting outcomes are required to fully evaluate the level of success that integration has had in improving mental healthcare for FQHC patients. Thus this dissertation makes an importation contribution to the literature on the implementation of physical and mental healthcare integration policy by highlighting that both quantity and quality measurements are required to understand the efficacy of integration practices in FQHCs.

Policy Recommendations

This dissertation offers a major policy recommendation for FQHCs to address stigma and a number of policy recommendations for future amendments to the PPACA.

These latter includes: one clear definition of integration within the legislation; restructuring of mental healthcare funding streams to facilitate agencies accessing all available resources to address patient need; federally mandated reporting of mental health outcomes to improve FQHC accountability; and incentives for minority populations to enter the mental health profession. The aim of these recommendations is to promote equitable implementation of integration policy within FQHCs and to increase access to mental healthcare for those persons in need.

Policy recommendations for FQHCs to address stigma. The main recommendation relating to integration practices in FQHCs is to develop policies and practices to address the influence of both public and institutional stigma. Required training on inclusive, non-stigmatizing practices for all staff, including physicians, could reduce stigmatizing attitudes held by medical providers. This, in turn, may limit the influence of stigma in the treatment of different types of mental illness and in the referral process. This dissertation posits that reducing or eliminating stigma will have a positive effect on integration practices, resulting in increased access to mental healthcare and improved patient outcomes.

This dissertation also recommends that FQHCs tackle the role of institutional stigma in their agencies. This is a complex problem, made more difficult by the often-invisible nature of institutional stigma, but its influence is pervasive in many integration practices and therefore it must be addressed. Another challenge is to rebalance agency power structures so that providers in both medicine and mental health have a more equal voice in developing integration practices. FQHC leadership must recognize and challenge the subsumation of mental health into the medical model and persistent interdisciplinary cultural conflict, and the negative effect these factors have on integration efforts.

Recommendations for amendments to the PPACA mandate to integrate physical and mental healthcare in FQHCs. This dissertation makes several recommendations for amending federal policy, that is, the PPACA (2010).

1. **Develop a clearer definition of integration**. The lack of a clear definition in the PPACA (2010) of what integration means results in FQHCs interpreting such policy and developing integration practices in a variety of ways. FQHCs could comply with the letter but not the intent of the policy by, for example, developing a referral process whereby patients are referred to a local community mental health center for care. As one leadership representative noted;

   > I think it's going to be very tempting for health centers to take the lowest definition of integration and call it a day. That's not, I think, in the spirit of what the law intended. But that is going to be the easy out and I suspect that's what we'll see across the board for the most part going forward.

   Importantly, less than comprehensive integration may not be effective in achieving the PPACA's goals. This is reflected in extant research, which found that primary care referrals to community mental health centers, rather than to co-located mental health providers, may not improve population outcomes because they do not increase the numbers of patients accessing mental healthcare (Primary Care Behavioral Health, 2008). As previously noted, around 60% of patients do not follow up on referrals to outside providers (Primary Care

Behavioral Health, 2008). Thus, the preference should be to receive comprehensive healthcare, inclusive of physical and mental health, in one setting (Institute of Medicine, 2006; Health Connector, 2010; Possemato, 2011).

Integration is a complex and challenging process. It is important, therefore, to provide FQHCs with a roadmap for implementing comprehensive integration successfully in a manner consistent with federal intentions in this area. Respondents noted that a challenge in integrating care was in not knowing how to carry out the policy, thus having guidelines on integration practices would facilitate implementation of said practices. To facilitate the successful top-down approach to integration policy implementation, FQHC leadership, with guidance from federal regulations, must develop a clear plan, including resource provision, prior to the implementation of any integration practices or its modification, if integration has already taken place. Such a plan would clearly delineate each step, thus clarity is provided to the integration process. Having such a framework for integrating physical and mental healthcare limits the option for agencies to interpret policies in ways that do not fully taken advantage of the opportunity to improve patient well being.

Should the development and implementation of one integration plan become a federal requirement, with associated penalties for non-compliance, it may be argued that by mandating such a plan, smaller FQHCs, without the financial resources to comply, would be more likely to face sanctions. One way to address this potential problem would be to institute eligibility criteria so that

FQHCs have the option to apply to exemption based on hardship. Another solution may be federal subsidies for eligible FQHCs.

2. **Restructure funding for mental healthcare provision to encourage comprehensive integration.** Primary funding for integrating care comes from the Health Resources and Services Administration (HRSA), and from higher Medicare and Medicaid reimbursement rates for FQHCs than for non-FQHCs. However, certain funding streams for mental healthcare under the PPACA's mandate to integrate physical and mental healthcare are discretionary grants i.e. an application must be made for such funds (Brolin et al., 2012). Accessing such funding relies on the commitment, willingness and motivation of FQHC staff to apply for such grants, The optional nature of certain PPACA integration funding suggests that some individuals/organizations may opt not to apply for these grants, given considerable time constraints and pressures placed on FQHC staff, particularly if integration is not viewed as core to agency mission (Goldberg & Huxley, 1980; Steinmo & Watts, 1995; Maynard-Moody & Musheno, 2003; Lauber et al., 2006). This view is supported by the literature that argues that, in agencies with more than one culture, the dominant group may be resistant to taking on tasks outside their original purview (Brolin et al., 2012). In FQHCs the strength of the medical model and the power imbalances place less importance on mental health practice, than on medical care, thus applying for discretionary funds targeted solely for mental healthcare provision may not be deemed a priority by the dominant group, i.e. physicians and leadership (Berger &

Luckmann, 1967; Fraser & Gordon, 1994; Link & Phelan, 2001; Sabatier, 2007; Brolin et al., 2012).

In light of the above mentioned limitations on accessing resources, particularly discretionary grants, it is recommended that funding for integration is restructured, with funds specifically earmarked for integration, without the requirement of any additional applications. By allocating funds specifically for mental health services and the integration of care as part of the overall funding package, such services should be better resourced to meet patient need and improve outcomes. Furthermore, given the nature of discretionary grants, they are vulnerable to budget cuts and changes in administrative focus. Different political administrations have different foci and mental healthcare has traditionally been vulnerable to shifts in the political climate (Faiella, 1989; Cunningham, 2009). This point is particularly pertinent at this time, given the many challenges to the PPACA (National Conference of State Legislators, 2015). If implementers are unsure about the security of funding streams for integration practice, they may be reluctant to engage in practices that, while providing fully integrated care, are expensive to maintain. Thus, as aforementioned, funding that is earmarked specifically for mental healthcare is fundamental to providing a full range of healthcare services.

While such a policy change would require initial increased investment, it may be cost-effective in the long-term to the extent that it helps to improve access to mental healthcare (as measured by improved evaluation metrics), thereby enabling more people to be productive members of society, and to remain living independently in the community (Goldman et al., 2009). This dissertation has highlighted that policy outcomes do not always reflect intent of policy makers. The provision of and access to mental health services to meet patient need will only occur if the PPACA mandate to integrate physical and mental healthcare is implemented successfully and as intended. Facilitating access to adequate funding streams plays an important role in promoting success in this regard.

3. **Mandated reporting of mental health outcomes.** The current measurement of success of integration used by the FQHCs is how many more patients access mental health services. As previously noted, the focus is on quantity, not quality, and while it is certainly good that more patients have access to mental health services, it is also important that they receive effective and appropriate care once they have been connected to such care. SAMHSA (2015) provides a range of assessment and monitoring tools that are straightforward and provide good indicators of certain aspects of patients' mental health, such as anxiety and depression, which account for a significant proportion of mental illnesses experienced in US society (NIMH, 2012, see Appendix G). Mandated reporting of mental health outcomes from integration practices is not a particularly onerous requirement; FQHCs already have systems in place to gather data on physical health outcomes. What is required then is a commitment to do the same for mental health outcomes, utilizing mental health quality of care indicators (Shield et al., 2003). One option would be to offer financial incentives to encourage

FQHCs to achieve integration over time, with different metrics for the early, mid and fully integrated stages.

4. **Develop incentives for minority populations to enroll in training programs for mental health providers.** The current lack of diversity among mental health professionals, and particularly in social work, creates a barrier to the integration of physical and mental healthcare and to improved patient outcomes (Barnes, 2008). Patients want to meet with providers with whom they feel some connectedness and with whom they feel have some understanding of their experiences and issues (Cooper-Patrick et al., 1999) but, as previously noted, only around 10% of mental health professionals identify as non-white (American Psychological Association, 2015). Additionally, the lack of providers who speak a language other than English has serious consequences for non-English speaking patients' ability to access mental healthcare, as is evidenced in the finding of this research. As many frontline practitioners are social workers, the lack of diversity in this profession is of particular concern in diverse communities. Furthermore a lack of minorities involved in practice and program and policy planning can result in culturally insensitive, inappropriate services being delivered.

    To address problems relating to a lack of diversity in mental health providers, financial incentives for and raising awareness about careers in the mental health field among minority population should be provided. The PPACA already provides incentives in the form of scholarships and loan forgiveness programs for certain primary care physicians, nurses, physician assistants, mental health providers, and dentists (US Government Printing Office (a) 2011). Such

> incentives could be tailored to encourage individuals from minority populations to enter traditionally white career fields, such as social work (American Psychological Association, 2015). Having more providers from minority populations will begin to rebalance the current Anglo-centric provision of mental healthcare. It will also increase the potential for sensitivity and awareness within FQHCs of differing cultural perceptions of mental illness. Furthermore, as noted, patients prefer to have providers who resemble them in some way. Thus, by having FQHC mental health providers from minority populations, who speak two or more languages, more patients may access mental healthcare and encourage ongoing integrated practices.

Suggestions for Future Research

While this dissertation provided answers to several important questions about policy implementation, and in particular, the role of stigma in the implementation of integration practices, it also gave rise to new ideas that merit scholarly inquiry. It is evident from this study that the numerous definitions of integration in merging the disciplines of medical and mental healthcare pose challenges to FQHCs seeking to comply with the PPACA mandate. Additional research into how integration is being interpreted and applied would add to existing scholarship on the efficacy of integration in improving access to mental healthcare. Moreover, further research on measurements of success in addition to rates of access to care would aid those researchers and policy analysts seeking to understand if integration improved actual patient outcomes, or just increased the numbers of patients using available services.

The subsumation of mental health into the medical model is worthy of future inquiry. This important issue has implications not just for patient outcomes, but also for frontline mental health practitioners in terms of their own life opportunities. A detailed examination of the role of the hierarchy in agency functions would be helpful in uncovering power differentials between physician and mental health providers, and may offer suggestions to address any imbalance in equity and equality between the two disciplines.

A significant issue warranting further research is that of measuring stigma. This is a complicated and challenging process and involves addressing such factors as participant bias and of how the instrument is administered, which could introduce researcher bias (Fink, 2009). The stigma instrument utilized in this study had some value but its reliability might be bolstered by administering it on-line or in some other setting whereby respondents feel that they can answer honestly without consequence, and to larger numbers of participants. Having the respondents in this study complete the instrument while I was present may have impacted their answers. While these individuals had been assured of confidentiality, the added layer of privacy accorded to an online instrument also adds anonymity, which may encourage more honest reporting. Thus some refinement of the administration of the survey could yield important results for future scholars.

Another interesting topic is that of the composition and roles of boards of directors in FQHCs. While anecdotal evidence from this study suggests that few, if any, FQHCs actually have at least 51% patient representation on their boards, empirical study of this topic would be useful for several reasons. First, it would provide an understanding of the extent to which FQHCs are non-compliant with this mandate and allow for a study into whether such a mandate has value. It may also provide options for other, more successful ways for patients' voices to be represented within these centers.

Finally, a study of funding sources for integration is warranted, as it would help determine to what extent FQHCs are applying for discretionary grants. Such research into financial resource availability and the extent to which FQHCs apply for discretionary grants may uncover reasons why such applications are limited and may highlight alternative avenues for funding that FQHCs are unaware of.

Study Limitations

This dissertation uncovers important findings about the integration of physical and mental healthcare in FQHCs. Furthermore, it provides an understanding of how stigma affects the implementation process, thus creating or reinforcing barriers to accessing mental healthcare and affecting outcomes for FQHC patients living with mental illness. However, some limitations to this study are acknowledged. First, the research took place in two FQHCs and while assumptions can be made about how they compare to the broader population of agencies, it is impossible to know exactly how similar, or dissimilar their policies, practices and outcomes are to other FQHCs. Therefore, the results of this dissertation are not transferable to all other FQHCs, although they may apply to some degree to FQHCs with characteristics similar to the two case study sites studied.

Second, despite numerous attempts, I was unable to speak with a board member at either case study site. As a result, the data on the views, roles and responsibilities of the board was gathered from study participants and from publicly available information and may not be entirely accurately.

A third limitation of this dissertation is that, again, despite several requests I was unable to obtain current data related to service utilization and finances from either site. Thus some of the data analyzed in this study are from several years ago, the most current such data available being from 2012.

Finally, this study acknowledges that there are numerous factors (insurance coverage and patient choice, for example) in accessing care that also impact the integration of physical and mental healthcare. Barriers to accessing mental healthcare include, but are not limited to a lack of parity between coverage for physical and mental illnesses (Frank et al., 1996, Smaldone & Cullen-Drill, 2010), providers not accepting Medicaid insurance plans (Richard, 2003) and correlations between stigmatizing attitudes and compliance with a treatment regimen (Sirey et al., 2001). However, these factors were beyond the scope of this dissertation.

In Conclusion

The public provision of mental healthcare has a long history in the US (Surgeon General, 2011). State Mental Health Authorities have, for more than 160 years, been responsible for the provision of care for their mentally ill residents, so practices are well established. However, as has been discussed, of the millions of Americans diagnosed with mental illness every year, a large proportion do not receive treatment or services available at FQHCs and other facilities. This lack of uptake of mental healthcare suggests that current practices may be, at best, inefficient in providing appropriate services and treatment to people living with mental illness. This matters because the failure of mental health policy implementation and practice has significant impact on the life opportunities and outcomes of those who depend on FQHCs for treatment, and, as previously discussed, have adverse economic implications for society (Salkever et al., 2000). Furthermore, it is important to understand the role of stigma in mental healthcare and policy and to recognize that stigma is a fluid concept that can change over time (Fine & Asch, 1988; Bowman, 1987).

The integration of physical and mental healthcare in FQHCs is one approach to addressing the gap between prevalence of mental illness and access to mental healthcare, and to reducing the stigma associated with mental illness. However, integration is a difficult and costly process, with much investment required to construct or renovate space to allow for co-location of services within a multi-disciplinary team. It requires fundraising and allocating resources to services, such as mental healthcare, that do not necessarily provide the agencies with a return on their investment. It also requires a commitment from agency staff to adapt to new policies and practices in providing patient care. This is particularly true for mental health providers working in FQHCs where mental health is subsumed into, rather than integrated with, the medical model,

The successful implementation of mental health policy to achieve intended aims remains an unrealized goal. While achieving these goals of increasing access to mental healthcare, improving mental health outcomes and making mental health part of overall health will be challenging, this dissertation makes progress in developing an understanding of some of the elements that interfere with the process of integration policy implementation. By refining the conceptual framework of this study, a greater understanding of the role of stigma in policy and of the power of institutionalized stigma is provided. Dissemination of these findings will help to inform better practices and promote more equitable implementation of policy so that the original goals of policy decisions are more likely to be achieved.

APPENDIX A.

STIGMA MODEL

	Public Stigma	Institutional Stigma
Stereotype	Negative belief about people with mental illness	Negative belief about people with mental illness
LEADS TO:		
Prejudice	People with mental illness are dangerous	Mental illness is less important than other health issues
RESULTS IN:		
Discrimination	Social exclusion and isolation, withholding of treatment and services	Lack of appropriate care and resources

Adapted from: Corrigan, P. W., & Shapiro, J. R. (January 01, 2010). Measuring the impact of programs that challenge the public stigma of mental illness. Clinical Psychology Review, 30, 8, 907-922.

APPENDIX B.

INTERVIEW PROTOCOLS

Interview Guide – Agency Leadership

Interview Number: ____
Date/Time of Interview:____
Place of Interview:____
Interviewer:____
Interviewee Job Title:____

Consent Form Signed at Interview: YES/NO

A: Information/questions about the interview

1. I am conducting research on the implementation of mental health policy at your Centre and I am interested in the integration of physical and mental healthcare. I am trying to learn more about how this centre functions and to discover how integration takes place here. I would like to understand what the successes and difficulties have been. I am very interested in your perspective on how mental health services and programs are provided by this health centre. I would also like to hear your views on what has worked and what has been less helpful in the integration process. M y objective is to learn from your experience and knowledge. This interview is confidential and any unintentional disclosure of identifying information will not be documented.

2. Discuss content and expected length of interview and ask if any questions about the project.

3. Ask if any questions about consent, recording and confidentiality. Sign form.

B: Questions about interviewees' role, agency oversight and policy development

1. What is your role at this health center?

2. What is your professional background and training?

3. How did you come to be in your current position? Can you describe your career path?

4. How does communication between you, management and practitioners take place?
5. What is the composition of your Board?
6. Do you think that the board reflects the population that this center serves?
7. When did this agency become a Federally Qualified Health Center (FQHC)?
8. Has earning FQHC status affected how the agency provides services to different groups?
9. How does the Board make decisions about allocating resources to provide treatment and services for a range of illnesses?
10. Can you describe how the board develops and creates policy for mental health care?
11. Do other levels of agency workers (i.e. management, practitioners) have input into policy development?

C: Questions about policy implementation

1. How effective is this center in implementing policy as it is devised by the board?
2. Has earning FQHC status affected how the agency implements policy?
3. What challenges, if any, do you see in integrating care?
4. What is the board's process for evaluating the extent to which implementation is consistent with the policy it sets forth?

D: Questions about integration of physical and mental health care

1. Can you describe the range of treatment and services that are provided at this organization?
2. Can you outline the mental health services you provide?
3. Where do your patients go if more specialized services are required?

4. How has the integration of physical and mental health care occurred in this health center?
5. Has integration impacted the relative weight or emphasis given to mental health and medical needs?
6. Have there been many changes in service provision since integration began?
7. Can you describe any factors that have facilitated the integration process?
8. Can you describe factors that have impeded the integration process?
9. Has integration impacted performance and outcomes of the center and has it affected the ability of the center to meet your patients' needs?

E: Questions about decision-making processes.

1. What factors do you have to consider when making decisions about allocating resources?
2. Can you talk me though a specific example of how you implement policy and allocate resources to different programs and services?
3. Can you describe any resistance to implementing integration policy? Where does such resistance arise?

F: Questions about perceptions regarding mental illness

1. How did you develop your understanding and knowledge of mental illness?
2. How do you think society in generally views people living with mental illness?
3. What is your view of the media portrayal of mental illness?

(The following question will be asked if the interviewee brings up the issue of stigma. If the interviewee does not mention stigma, the researcher will preface the questions with the following: "In compiling my literature review, I noticed that the issue of stigma and mental illness is a recurring theme. I would be interested to hear your thoughts on this subject.)

4. Does stigma associated with mental illness impact how you do your job?

5. How does the agency address issues of stigma of mental illness? Are there policies in place to address stigma
6. Have you witnessed any stigmatizing events/attitudes in this agency?
7. If so, what was the individual and agency response?

F: Wrapping Up

1. Is there anything else you would like to tell me about the mental health services at this center?
2. Is there anything else you would like to discuss further?
3. Are there other people at this Center whom you think I should meet with?
4. Is there anything you would like to ask me?
5. May I contact you again in the future if I have any additional questions?

THANK YOU

Interview Guide – Management

Interview Number: ____
Date/Time of Interview:____
Place of Interview:____
Interviewer:____
Interviewee Job Title:____

Consent Form Signed at Interview: YES/NO

A: Information/questions about the interview

1. I am conducting research on the implementation of mental health policy at your Centre and I am interested in the integration of physical and mental healthcare. I am trying to learn more about how this centre functions and to discover how integration takes place here. I would like to understand what the successes and difficulties have been. I am very interested in your perspective on how mental health services and programs are provided by this health centre. I would also like to hear your views on what has worked and what has been less helpful in the integration process. M y objective is to learn from your experience and knowledge. This interview is confidential and any unintentional disclosure of identifying information will not be documented. Do you have any questions about this project?

2. Discuss content and expected length of interview and ask if any questions

3. Ask if any questions about consent, recording and confidentiality. Sign form.

B: Questions about interviewees' role in the organization

1. Can you tell me about your role at this center?

2. What is your professional background and training?

3. How did you come to be in your current position? Can you describe your career path?

4. How involved are you in decision making about policy development and implementation, particularly in integration policy?

5. How would you describe your communication between practitioners and agency leadership?

6. What is your role in facilitating any such communication?

7. Do you experience any problems with balancing the needs/wants of leadership with that of practitioners?

C: Questions about patient population and information sharing

1. Can you describe the range of treatment and services that are provided at this organization?
2. According to my research X number of patients are registered at this health center. Do you think this number is accurate? Of those, how many, or what proportion, utilize your mental health services and programs?
3. What strategies do you use to reach potential patients and inform them about the services you provide?
4. How effective do you think these strategies are in reaching new clients?

D: Questions about agency oversight and policy implementation

1. Do you think that the board reflects the population that this center serves?
2. How effective is this center in implementing policy as it is devised by the board?
3. What challenges, if any, do you see in integrating care?
4. Have there been many changes in service provision since integration began?
5. Can you describe any factors that have facilitated the integration process?
6. Can you describe factors that have impeded the integration process?
7. What factors influence program administration in the agency?
8. Do you have to adapt your administration of programs to respond to limited resources, demand for services or other factors such as characteristics of the community, agency, clients, etc.?
9. Do you have autonomy to make changes to program administration or is there a more formal process of change?

E: Questions about the integration of physical and mental healthcare

1. Can you describe the range of treatment and services that are provided at this organization?
2. How has the integration of physical and mental health care occurred in this health center?
3. How has the integration of physical and mental health care impacted this center?
4. Have there been many changes in service provision since this integration began? Can you give me an example of something that has changed and how this change played out in this Center?
5. Has integration impacted the relative weight or emphasis given to mental health and medical needs?
6. Can you describe any factors that have facilitated the integration process?
7. Can you describe factors that have impeded the integration process?
8. Can you describe any challenges with the integration process?
9. What has been the agency response to integration challenges?
10. Can you outline the mental health services you now provide?
11. Has this level of provision changed since integration took place?
12. Do you think that the current level of provision is adequate to meet the needs of your patient population?

F: Questions about perceptions regarding mental illness

1. How did you develop your understanding and knowledge of mental illness?
2. How do you think society in generally views people living with mental illness?
3. What is your view of the media portrayal of mental illness?

(The following question will be asked if the interviewee brings up the issue of stigma. If the interviewee does not mention stigma, the researcher will preface the questions with the following: "In compiling my literature review, I noticed that the issue of stigma and mental illness is a recurring theme. I would be interested to hear your thoughts on this subject.)

4. Does stigma associated with mental illness impact how you do your job?

5. How does the agency address issues of stigma of mental illness? Are there policies in place to address stigma

6. Have you witnessed any stigmatizing events/attitudes in this agency?

7. If so, what was the individual and agency response?

G: Wrapping Up

1. Is there anything else you would like to tell me about the mental health services at this center?

2. Is there anything else you would like to discuss further?

3. Are there other people at this Center whom you think I should meet with?

4. Is there anything you would like to ask me?

5. May I contact you again in the future if I have any additional questions?

THANK YOU

Interview Guide – Practitioners

Interview Number: ____
Date/Time of Interview:____
Place of Interview:____
Interviewer:____
Interviewee Job Title:____

Consent Form Signed at Interview: YES/NO

A: Information/questions about the interview

1. I am conducting research on the implementation of mental health policy at your Centre and I am interested in the integration of physical and mental healthcare. I am trying to learn more about how this centre functions and to discover how integration takes place here. I would like to understand what the successes and difficulties have been. I am very interested in your perspective on how mental health services and programs are provided by this health centre. I would also like to hear your views on what has worked and what has been less helpful in the integration process. My objective is to learn from your experience and knowledge. This interview is confidential and any unintentional disclosure of identifying information will not be documented.

2. Discuss content and expected length of interview and ask if any questions about the project.

3. Ask if any questions about consent, recording and confidentiality. Sign form.

B: Questions about interviewees' position, patient population and information sharing.

1. Can you describe your role in this organization?

2. What is your professional background and training?

3. How did you come to be in your current position? Can you describe your career path?

4. How does communication between you, management and agency leadership take place?

5. What does an average week look like for you?

6. According to my research X number of patients are registered at this health center. Do you think this number is accurate? Of those, how many utilize your mental health services and programs?
7. What strategies do you use to reach potential patients?
8. What materials do patients receive about the mental health programs and services?
9. May I have copies of the materials that patients receive?

C: Questions about service provision and the integration of physical and mental healthcare

1. Can you describe the range of treatment and services that are provided at this organization?
2. What are the main activities?
3. What are the goals of this health center for mental healthcare?
4. What mental health services are provided at this center?
5. Do you think that the uptake of mental health services reflects actual prevalence in the general population?
6. Do you think services reflect actual need in your community?

D: Questions about the integration of physical and mental healthcare and policy implementation.

1. How has the integration of physical and mental health care occurred in this health center?
2. Have there been many changes since this integration began?
3. Has integration impacted the relative weight or emphasis given to mental health and medical needs?
4. Have there been many changes in service provision since integration began?
5. Can you describe any factors that have facilitated the integration process?

6. Can you describe factors that have impeded the integration process?
7. Of these, which are the most significant challenges to the integration process?
8. Can you describe how mental health care policy is developed in this organization?
9. Do you have input in policy development?
10. How effective is this center in implementing policy as devised by the board?
11. What problems, if any, do you see in policy implementation?
12. Do you have any leeway in your work in how you implement policy?
13. Do you have to adapt policy implementation processes to respond to limited resources, demand for services or other factors?

E: Questions about perceptions regarding mental illness

1. How did you develop your understanding and knowledge of mental illness?
2. What are the most important considerations/what influences you when treating clients/patients?
3. How do you think society in generally views people living with mental illness?
4. What is your view of the media portrayal of mental illness?

(The following question will be asked if the interviewee brings up the issue of stigma. If the interviewee does not mention stigma, the researcher will preface the questions with the following: "In compiling my literature review, I noticed that the issue of stigma and mental illness is a recurring theme. I would be interested to hear your thoughts on this subject.)

5. Have you witnessed any stigmatizing events/attitudes in this agency?
6. If so, what was the individual and agency response?

F: Wrapping Up

1. Is there anything else you would like to tell me about the mental health services at this center?

2. Is there anything else you would like to discuss further?
3. Are there other people at this Center whom you think I should meet with?
4. Is there anything you would like to ask me?
5. May I contact you again in the future if I have any additional questions?

THANK YOU

Interview Guide – Key informants
A: Information/questions about the interview.

1. I am conducting research on the implementation of mental health policy at your Centre and I am interested in the integration of physical and mental healthcare. I am trying to learn more about how this centre functions and to discover how integration takes place here. I would like to understand what the successes and difficulties have been. I am very interested in your perspective on how mental health services and programs are provided by this health centre. I would also like to hear your views on what has worked and what has been less helpful in the integration process. M y objective is to learn from your experience and knowledge. This interview is confidential and any unintentional disclosure of identifying information will not be documented.

2. Discuss content and expected length of interview and ask if any questions about the project.

3. Ask if any questions about consent, recording and confidentiality. Sign form.

B: Questions about interviewees' role and their knowledge and experience of integration of physical and behavioral healthcare.

1. How did you come to be in your current position?
   Probe for:
    - Role in their organization
    - Tenure
    - Professional background, qualifications and training
    - Career path
    - Full description of current position

2. How did you become interested in healthcare integration?

3. In your opinion, who has the most influence in creating agency policy regarding mental healthcare.
   Probe for:
    - Government agencies
    - Funders
    - Influence of internal vs. external factors
    - Agency boards/leadership/management/frontline staff
    - Full description of current position

4. Have you seen any significant change in mental healthcare since integration policy began to be implemented?
   Probe for:

- Degree of success in implementation of policy
- Increase/decrease in # of clients accessing services
- Service provision reflects prevalence of mental illness in the general population?
- Adequacy of service provision to meet need.
- Factors that have facilitated the integration process
- Barriers to integration

5. In compiling my literature review, I notice that the issue of stigma and mental illness is a recurring theme. I'm interested to know your views on the extent to which stigma is associated with mental illness and how you think stigma might impact policy implementation.

   Probe for:

   - Internal/external factors e.g. political environment
   - Impact at funder, leadership, management and practitioner levels.

C: Wrapping Up

6. Is there anything else you would like to discuss further about mental health, integration policy or any other issue?
7. Are there other people whom you think would be Key informants for this research?
8. Is there anything you would like to ask me?
9. May I contact you again in the future if I have any additional questions?

<u>THANK YOU</u>

APPENDIX C.

CONSENT FORMS

University of Massachusetts, Boston
Department of Public Policy

Consent Form for Research Project**, "Mind the Gap: An examination of the relationship between implementation of mental health policy and service utilization in Federally Qualified Health Centers."**
You are asked to participate in a research project that is studying the implementation of mental health policy; specifically, it is examining mental health policy regarding treatment within Federally Qualified Health Centers (FQHCs) in XXXXXX. The interview will focus on your professional role within the FQHC. This research is being conducted by Karen Monaghan at the McCormack Graduate School of Policy and Global Studies at the University of Massachusetts, Boston. Please read this form and feel free to ask questions. If you have questions at a later date, you may contact Karen Monaghan at karen.monaghan001@umb.edu.

The interview will take approximately 60 minutes and will be audio recorded and transcribed. You do not have to participate in this interview. If you decide to take part in the interview, you may terminate your participation at any time, without consequence, by informing the interviewer. The risk of participation is no greater than the risk ordinarily encountered in daily life or in the performance of routine examinations or activities.

The information you will provide in this interview will be kept confidential at all times. That is, the information gathered for this project will not be published or presented in a way that would allow anyone to identify you. None of the information will identify you by name. All information will be given a code number and access to the data will be limited to the researcher. The data will be stored in a locked file and destroyed after the research has been concluded.
You have the right to ask questions about this research before you sign this form and at any time during the study. If you have any questions or concerns about your rights as a research participant, please contact a representative of the Institutional Review Board (IRB), at the University of Massachusetts Boston, which oversees research involving human participants. The Institutional Review Board may be reached at the following address: IRB, Quinn Administration Building-2-080, University of Massachusetts Boston, 100 Morrissey Boulevard, Boston, MA 02125-3393. You can also contact the Board by telephone or e-mail at (617) 287-5370 or at human.subjects@umb.edu.

I HAVE READ THE CONSENT FORM. MY QUESTIONS HAVE BEEN ANSWERED.MY SIGNATURE ONTHIS FORM MEANS THAT I UNDERSTAND THE INFORMATION AND I CONSENT TO PARTICIPATE IN THIS STUDY.

Signature of Participant	Printed Name of Participant	Date
Signature of Researcher	Printed Name of Researcher	Date

CONSENT TO AUDIO RECORDING & TRANSCRIPTION

Mind the Gap: An examination of the relationship between implementation of mental health policy and service utilization in Federally Qualified Health Centers.

Principal Investigator: Karen Monaghan, PhD student, Department of Public Policy

This study involves the audio recording of your interview with the researcher. Neither your name nor any other identifying information will be associated with the audio recording or the transcript. Only the researcher and transcriptionist will be able to listen to the audio recording.

The recordings will be transcribed and erased once the transcriptions are checked for accuracy. Transcripts of your interview may be reproduced in whole or in part for use in presentations or written products that result from this study. Neither your name nor any other identifying information (such as your voice) will be used in presentations or in written products resulting from the study.

Immediately following the interview, you will be given the opportunity to have the audio recording erased if you wish to withdraw your consent to audio recording or participation in this study. The consent for audio recording is effective until June 30, 2015. On or before that date, the audio recordings will be destroyed.

If you do not wish to have your voice audio recorded, I will respect that request and refer only to my meeting notes.

By signing this form you are consenting to (please check boxes to indicate consent):

☐ having your interview audio recorded;
☐ to having the audio recording transcribed;
☐ use of the written transcript in presentations and written products.

By checking the box in front of each item, you are consenting to participate in that procedure.

Participant's Signature____Date____________

APPENDIX D.

STIGMA INSTRUMENT

UNIVERSITY of MASSACHUSETTS
BOSTON
100 Morrissey Blvd.
Boston, MA 02125-3393

Interview Code:____________________________

For each statement, circle the number to the right that indicates how much you agree or disagree with the statement, with 1 meaning Completely Disagree and 5 meaning Completely Agree.

Statement	Scale				
	Disagree				Agree
1. Most people with serious mental illness can, with treatment, get well and return to productive lives.	1	2	3	4	5
2. Virtually anyone can become mentally ill	1	2	3	4	5
3. The best way to handle the mentally ill is to keep them behind locked doors.	1	2	3	4	5
4. A group home or apartments for people with mental illness in a residential area will not harm property values.	1	2	3	4	5
5. Even if they seem okay, people with chronic mental illness always have the potential to commit violent acts.	1	2	3	4	5
6. There is still a lot of stigma attached to mental illness.	1	2	3	4	5
7. Locating a group home or apartments in residential neighborhoods does not endanger local residents.	1	2	3	4	5
8. I don't believe that mental illness can ever really be cured.	1	2	3	4	5
9. Having mental illness is no different from having any other kind of illness.	1	2	3	4	5
10. It is easy to recognize someone who once had a serious mental Illness.	1	2	3	4	5
11. In most cases, keeping up a normal life in the Community will help a person with a mental illness get better.	1	2	3	4	5
12. Mental health facilities should be kept out of residential neighborhoods	1	2	3	4	5
13. The mentally ill are far less of a danger than most people believe.	1	2	3	4	5
14. People with chronic mental illness are, by far, more dangerous than the general population.	1	2	3	4	5

APPENDIX E.

DATA ANALYSIS MATRICES [7]

Total Responses

Theme 1: Mental Illness

Prevalence	Need	Services	Access	Curability	Treatability	Attitudes	Language
24	83	155	223	4	12	33	51

Theme 2: Perceptions Of Mental Illness/People Living With Mental Illness

Stereotypes	Construction	Deserving	Undeserving
8	2	19	10

Theme 3: Influences on Perceptions Of Mental Illness

Personal	Professional	Organizational	Environmental	Community Culture	Media
43	40	11	14	20	12

Theme 4: Resource Allocation

Decision making	Funding	Power
67	125	45

Theme 5: Policy

Creation	Beliefs	Implementation	Evaluation	Compliance	Subversion
110	19	29	22	4	20

Theme 6: Integration

Purpose	Meaning	How	Actors	Facilitation	Impediment	Conflict	Outcomes
48	67	84	23	58	85	74	41

---

[7] These matrices provide information on the themes and codes that emerged from the literature review, conceptual framework and analysis of the data. The total responses are the number of times each time a code was identified in the analysis. The matrices by individual respondents note the number of times each respondent's interview was identified with the code.

Theme 7: Participants

Position	Qualifications	Experience	Tenure	Gender	Characteristics
57	45	79	34	28F 12M	62

Theme 8: Organization

Demographics	Money	Goals	Mission	Function	Changes	Culture	Compensation	Outreach
56	89	6	7	21	20	62	6	32

Theme 9: Board of Directors

Composition	Responsibility	Interaction	Role	Representative
19	17	20	20	22

Theme 10: Staffing

Leadership	Staff	Communication	Dynamics	Autonomy	Discretion	Pressure	Influence	Turnover	Layoffs
30	61	115	80	24	19	120	1	31	15

Theme 11: Stigma

Patients	Workers	CHC	Systems/Institution	Reproduction
66	60	19	83	15

Matrices by Individual Respondents

Theme 1: Mental Illness

Data Source: Org A	Preva lence	Need	Services	Access	Curability	Treat ability	Attitudes	Language
Leadership Aa001	1	2	3	6				1
Aa002	1	1	3	6				1
Aa003	3	7	5	9			2	4
Management Ab001	1	4	3	7		2	5	5
Ab002		5	4	11			1	1
Ab003		1	3	2				1
Frontline Ac001		6	4	3				1
Ac002	1	10	8	10		2	2	3
Ac003	1	1	1					
Ac004		3	3	3				
Ac005	3	1	8	5		1	2	2
Ac006	2	3	5	5				1
Reflection Memos				3			4	3
Background Info	1	2	2	1				3
Direct Observation			1	2				
Document Analysis	2	5	6	5				4

Data Source: Org B	Preva lence	Need	Services	Access	Curability	Treat ability	Attitudes	Language
Leadership Ba001		3	5	7			2	
Management Bb001		3	5	8				1
Bb002		2	4	9				1
Bb003		2	5	4				
Bb004		3	2	6				
Frontline Bc001		4	7	6				
Bc002			2	1				
Bc003	1	1	4	7				1
Bc004	2	2	2	4				
Reflection Memos			1	2			3	2
Background Info	2		2	1				
Direct Observation			1	4			2	3
Document Analysis	3	1	4	3				1

Data Source: Key informants	Preva lence	Need	Services	Access	Curability	Treat ability	Attitudes	Language
Leadership Ca001								
Ca002		1	1					
Ca003			1					
Ca004			3	6			1	3
Ca005			4	5		2	1	2
Ca006			4	5		2	1	2
Management Cb001		1	7	8				
Cb002					3		1	
Frontline Cc001		2	10	9	3	4	2	
Cc002		2	5	8	1	1	1	
Cc003			3	7			1	
Cc004			1			1	1	1
Cc005		1	3	6				1
Cc006			2					
Cc007		1	3	2			1	
Cc008		3	3	11				1
Cc009		1	4	6				2
Cc010		1	2	3				
Cc011			1	1				
Reflection Memos								1

Theme 2: Perceptions Of Mental Illness/People Living With Mental Illness

Data Source: Org A	Stereotypes	Construction	Deserving	Undeserving
Leadership Aa001				
Aa002				
Aa003	1		1	
Management Ab001				
Ab002				
Ab003				
Frontline Ac001				
Ac002	1			1
Ac003				
Ac004				
Ac005				
Ac006				
Reflection Memos	1		3	2
Background Info				
Direct Observation			1	
Document Analysis				

Data Source: Org B	Stereotypes	Construction	Deserving	Undeserving
Leadership Ba001				
Management Bb001				
Bb002				
Bb003				
Bb004				
Frontline Bc001				
Bc002				
Bc003				
Bc004				
Reflection Memos	2	1	3	2
Background Info				
Direct Observation	1		4	
Document Analysis				

Data Source: Key informants	Stereotypes	Construction	Deserving	Undeserving
Leadership Ca001				
Ca002				
Ca003				
Ca004			1	
Ca005				
Ca006				
Management Cb001				
Cb002				
Frontline Cc001				1
Cc002			1	
Cc003	2	1		4
Cc004				
Cc005				
Cc006				
Cc007				
Cc008				
Cc009				
Cc010				
Cc011				
Reflection Memos			5	

Theme 3: Influences on Perceptions Of Mental Illness

Data Source: Org A	Personal	Professional	Organizational	Environ mental	Community Culture	Media
Leadership Aa001		2				1
Aa002						
Aa003	2	1	4	1	5	
Management Ab001	2	2	2		2	1
Ab002	5			4	4	2
Ab003				2		
Frontline Ac001	3	1				
Ac002		1				1
Ac003		1				
Ac004						
Ac005	1					
Ac006	1	1			1	
Reflection Memos					1	
Background Info						
Direct Observation	2	5	1			1
Document Analysis						

Data Source: Org B	Personal	Professional	Organizational	Environ mental	Community Culture	Media
Leadership Ba001						
Management Bb001	1	1				
Bb002		1				
Bb003	1					
Bb004		1				
Frontline Bc001	1					
Bc002						
Bc003	1					
Bc004						
Reflection Memos						
Background Info						
Direct Observation	3	2	4			
Document Analysis						

Data Source: Key informants		Personal	Professional	Organizational	Environ mental	Community Culture	Media
Leadership	Ca001						
	Ca002						
	Ca003						
	Ca004	3	4		3	1	
	Ca005	4	2		1	1	1
	Ca006	4	2		1	1	1
Management	Cb001		1		1	1	1
	Cb002						
Frontline	Cc001	1	2				
	Cc002						
	Cc003	2	1		1	2	2
	Cc004						
	Cc005	1	1		1		
	Cc006						
	Cc007	4	4			1	
	Cc008	1	3				
	Cc009	3	3			1	
	Cc010						
	Cc011						
Reflection Memos		1					2

Theme 4: Resource Allocation

Data Source: Org A	Decision making	Funding	Power
Leadership Aa001		6	
Aa002	2	3	1
Aa003	6	9	
Management Ab001	1	4	1
Ab002	4	7	3
Ab003		4	
Frontline Ac001	1	2	
Ac002	7	5	4
Ac003	1	2	2
Ac004			
Ac005	3	1	1
Ac006	2		
Reflection Memos			
Background Info		2	
Direct Observation		1	
Document Analysis	1	4	

Data Source: Org B	Decision making	Funding	Power
Leadership Ba001	2	4	1
Management Bb001	1	1	1
Bb002	1	3	1
Bb003	1	1	1
Bb004		2	1
Frontline Bc001	1	2	
Bc002			
Bc003	2	3	1
Bc004			
Reflection Memos			
Background Info	1	1	
Direct Observation		1	
Document Analysis	1	2	2

Data Source: Key informants	Decision making	Funding	Power
Leadership Ca001			
Ca002		1	
Ca003			
Ca004	2	6	2
Ca005	1	4	1
Ca006	1	4	1
Management Cb001	2	1	1
Cb002			
Frontline Cc001	3	5	3
Cc002	3	6	4
Cc003	2	4	1
Cc004	1	6	
Cc005	5	7	3
Cc006			
Cc007	1	2	2
Cc008	3	5	3
Cc009		1	
Cc010	5	5	4
Cc011		1	
Reflection Memos	1	1	1

Theme 5: Policy

Data Source: Org A	Creation	Beliefs	Implementation	Evaluation	Compliance	Subversion
Leadership Aa001	4		1	1		
Aa002	2		1			
Aa003	6	3	1	3		
Management Ab001	3		1	2		
Ab002	3		1	1		
Ab003	3					
Frontline Ac001	4	1	6			3
Ac002	2	1	6			1
Ac003						
Ac004	1			1		
Ac005	4				2	
Ac006	1					
Reflection Memos						1
Background Info	1					
Direct Observation						
Document Analysis	2			1		

Data Source: Org B	Creation	Beliefs	Implementation	Evaluation	Compliance	Subversion
Leadership Ba001	4	2	1			
Management Bb001	2			1	1	
Bb002	5		2	3		1
Bb003	2					
Bb004	4		1	2		
Frontline Bc001	5	1				1
Bc002	1					
Bc003	4		1	2		3
Bc004	1					
Reflection Memos						2
Background Info	1					
Direct Observation						
Document Analysis	2					

Data Source: Key informants		Creation	Beliefs	Implementation	Evaluation	Compliance	Subversion
Leadership	Ca001						
	Ca002	1					
	Ca003						
	Ca004	11	8	3			
	Ca005	5	1				
	Ca006	5	1				
Management	Cb001	3		1	3		
	Cb002						
Frontline	Cc001	4	1			1	3
	Cc002	1		1			1
	Cc003	2	1	3			4
	Cc004			1			
	Cc005	3					
	Cc006						
	Cc007	1		1			
	Cc008	5					
	Cc009	2			1		
	Cc010	2			1		
	Cc011	3					1
Reflection Memos							

Theme 6: Integration

Data Source: Org A	Purpose	Meaning	How	Actors	Facilitation	Impediment	Conflict	Outcomes
Leadership Aa001	2	5	6	2	3	4	3	3
Aa002	4	3	3		5	2	2	4
Aa003	3	1	4	2		4	4	3
Management Ab001	1		3		4	3	8	1
Ab002		2	1		4	13	7	1
Ab003	3	1	1	1	3	1	2	
Frontline Ac001		3	1	3	4	3	6	1
Ac002	2		4		2	3	1	
Ac003	1	3	1		7	1	3	2
Ac004		1	1		1	1		2
Ac005	5	2	7	2		2	6	2
Ac006	1				1	1	1	2
Reflection Memos				1				
Background Info								1
Direct Observation		1				3		
Document Analysis	2							1

Data Source: Org B	Purpose	Meaning	How	Actors	Facilitation	Impediment	Conflict	Outcomes
Leadership Ba001			4	2	2	5		
Management Bb001	1	2	3		2	3	3	
Bb002			1					
Bb003		1			1	1		
Bb004	1	1	2	2	1	1		
Frontline Bc001		5	4		2	1		1
Bc002			1					
Bc003		1	1		2	1	1	
Bc004		1			1	1		
Reflection Memos	3				2	3		1
Background Info								1
Direct Observation								
Document Analysis	1							1

Data Source: Key informants	Purpose	Meaning	How	Actors	Facilitation	Impediment	Conflict	Outcomes
Leadership Ca001		2				2	1	
Ca002	1	1	2	1				
Ca003		1	3	1		1		
Ca004	3		1	1				
Ca005	2							
Ca006	2							
Management Cb001	2	5	4	2	3	6	2	
Cb002		1	1			2		
Frontline Cc001	1	3	6		1	1	4	3
Cc002	1	2	1			1		1
Cc003								
Cc004	3				1	7	14	1
Cc005	1							
Cc006			3					
Cc007	1	3			1	2	1	
Cc008	2	3	3	1			3	1
Cc009	1	1	5		2	1		
Cc010		6	5	1	1	2		7
Cc011	1	4	2	1	2	1	2	1
Reflection Memos		1	1			2		

Theme 7: Participants

Data Source: Org A	Position	Qualifications	Experience	Tenure	Gender	Characteristics
Leadership Aa001	1	1	1	2	F	
Aa002	1	1	1	1	F	
Aa003	1	3	1	3	F	
Management Ab001	1	1	2	1	F	
Ab002	1	2	2	1	F	
Ab003	1	1	1	1	F	
Frontline Ac001	2	2	3	1	F	
Ac002	1	2	1	1	F	
Ac003	1	1	2	1	M	
Ac004	1	1	3	1	F	
Ac005	2	1	3	1	F	
Ac006	1	1	4	1	F	
Reflection Memos						26
Background Info	6	3	1			
Direct Observation	1					
Document Analysis	4	2	1			

Data Source: Org B	Position	Qualifications	Experience	Tenure	Gender	Characteristics
Leadership Ba001	1	1	1	1	M	
Management Bb001	1	2	2	2	F	
Bb002	1	1	3	1	F	
Bb003	1		1	1	F	
Bb004	1	2	3	2	F	
Frontline Bc001	1	1	4	1	F	
Bc002	1		2	1	F	
Bc003	1	1	4	1	F	
Bc004	2	2	2	1	F	
Reflection Memos						17
Background Info						2
Direct Observation						
Document Analysis	4	1	3			

Data Source: Key informants	Position	Qualifications	Experience	Tenure	Gender	Characteristics
Leadership Ca001	1				F	
Ca002	1	1	1	1	F	
Ca003	1	1	2		M	
Ca004	1		4		M	
Ca005			1		M	
Ca006			1		F	
Management Cb001	1	1	2	1	F	
Cb002					F	
Frontline Cc001	2	3	2	1	F	
Cc002	1	1	1	1	M	
Cc003			1		M	
Cc004			2		M	
Cc005	2	1	2	1	F	
Cc006		1	1		M	
Cc007	2	1	1	1	F	
Cc008	2		1	1	M	
Cc009	1	2	3	1	F	
Cc010	2	1	1	1	M	
Cc011	1		2		M	
Reflection Memos	1		4			17

Theme 8: Organization

Data Source: Org A	Demographics	Money	Goals	Mission	Function	Changes	Culture	Compensation	Outreach
Leadership Aa001	2	4				2	7		
Aa002	1	5			1	2	3		
Aa003	2	10	1		1		2	3	
Management Ab001		1				1	3		4
Ab002		14							3
Ab003		4			4	1			
Frontline Ac001		3			1		1		1
Ac002	3				1		1		1
Ac003	1	3				1	4		
Ac004		1				2			1
Ac005		1				1	5		1
Ac006									
Reflection Memos	3						2		
Background Info	5	2	1	1	3				
Direct Observation	1	1							
Document Analysis	2	2	2		1				

Data Source: Org B	Demographics	Money	Goals	Mission	Function	Changes	Culture	Compensation	Outreach
Leadership Ba001	2	3				1	4		1
Management Bb001	1				1	1	1		3
Bb002	3	2		1			1		1
Bb003	2								5
Bb004	4	1				2			3
Frontline Bc001	1				1	1		2	1
Bc002							1		
Bc003	1							1	1
Bc004									1
Reflection Memos	2								
Background Info	2		1						
Direct Observation	5								
Document Analysis	4		1	1	2				

Data Source: Key informants	Demographics	Money	Goals	Mission	Function	Changes	Culture	Compensation	Outreach
Leadership Ca001									
Ca002		7							
Ca003		1							
Ca004	3	4							
Ca005									1
Ca006									1
Management Cb001	3	2		1					
Cb002		2					1		
Frontline Cc001		1			2		4		1
Cc002		5				1	2		1
Cc003	1	3		2			1		
Cc004		5					7		
Cc005		1							
Cc006					2				
Cc007		2			1		1	1	
Cc008		3				2	7		
Cc009	1						1		1
Cc010		1					3		
Cc011									
Reflection Memos									

Theme 9: Board of Directors

Data Source: Org A	Composition	Responsibility	Interaction	Role	Representative
Leadership Aa001	1	1	2	1	2
Aa002	1	1		1	2
Aa003	4	2	3	2	1
Management Ab001			2		1
Ab002	1	2	1	4	2
Ab003	1		1	1	1
Frontline Ac001					
Ac002				1	
Ac003					
Ac004					
Ac005					
Ac006					
Reflection Memos					1
Background Info					
Direct Observation		2	1	2	
Document Analysis	1	1			1

Data Source: Org B	Composition	Responsibility	Interaction	Role	Representative
Leadership Ba001	3	2	1	2	2
Management Bb001	1	1		1	1
Bb002		1	1	1	
Bb003	1		2	1	3
Bb004		2	1	1	2
Frontline Bc001	1		2		
Bc002	1		1		
Bc003					
Bc004					
Reflection Memos					1
Background Info	1				
Direct Observation					
Document Analysis	1	1		1	

Data Source: Key informants	Composition	Responsibility	Interaction	Role	Representative
Leadership Ca001					
Ca002					
Ca003					1
Ca004					
Ca005					
Ca006					
Management Cb001	1	1	1	1	2
Cb002					
Frontline Cc001					
Cc002			1		
Cc003					
Cc004					
Cc005					
Cc006					
Cc007					
Cc008					
Cc009					
Cc010					
Cc011					
Reflection Memos					

Theme 10: Staffing

Data Source: Org A	Leadership	Staff	Communication	Dynamics	Autonomy	Discretion	Pressure	Influence	Turnover	Layoffs
Leadership Aa001	1		6	2			1			
Aa002	1		3	4						1
Aa003	2	5	9	2		1	7		1	1
Management Ab001		2	10	4	1		3			1
Ab002		7	5	2			4			3
Ab003	1	3	2	2						
Frontline Ac001	1	5	4	7	1	1	4			
Ac002		3	5	3	2	2	3		2	1
Ac003	2	4	2		1		10			1
Ac004		5	4	4	1	1	4			3
Ac005	2	5	7	4	2	1	14			4
Ac006		1	4							
Reflection Memos				2	5	4	7		1	
Background Info	2									
Direct Observation	4		2	3			1			
Document Analysis	2									

Data Source: Org B	Leadership	Staff	Communication	Dynamics	Autonomy	Discretion	Pressure	Influence	Turnover	Layoffs
Leadership Ba001	3		4	2			5		5	
Management Bb001		2	1		1	1				
Bb002	1	2	3	4	1	1	4		3	
Bb003	1	1	5	2	3	3	1			
Bb004		1	8	1	1				1	
Frontline Bc001	1	2	2	2	1	1	8		3	
Bc002		2	1							
Bc003			5	2	1	1	9		7	
Bc004		1	4	1	1					
Reflection Memos				1			3			
Background Info										
Direct Observation	2		1	1					1	
Document Analysis										

Data Source: Key informants	Leadership	Staff	Communication	Dynamics	Autonomy	Discretion	Pressure	Influence	Turnover	Layoffs
Leadership Ca001										
Ca002		1								
Ca003										
Ca004										
Ca005										
Ca006										
Management Cb001		4	3				2			
Cb002										
Frontline Cc001	1		3	4	2	2	3			
Cc002		1	2	2			11		2	
Cc003	4	1								
Cc004				1			2			
Cc005										
Cc006										
Cc007			2	3			5		3	
Cc008		2	4	7			3			
Cc009		1	2	1			1			
Cc010		1	1	2			1			
Cc011			2	4			6	1	2	
Reflection Memos										

Theme 11: Stigma

Data Source: Org A	Patients	Workers	CHC	Systems/Institution	Reproduction
Leadership Aa001	2	2		2	1
Aa002	2	1	2	3	
Aa003	5	5	2	6	
Management Ab001	3	3	1	1	
Ab002	2	1		1	
Ab003	1	1		1	1
Frontline Ac001				2	2
Ac002	2	2	3	3	
Ac003	1	3		1	
Ac004	2	1		2	
Ac005	1	2	1	4	
Ac006	1	1		3	
Reflection Memos		1		4	
Background Info					
Direct Observation		1		2	
Document Analysis					

Data Source: Org B	Patients	Workers	CHC	Systems/Institution	Reproduction
Leadership Ba001	1	2	1	1	1
Management Bb001	3	2		2	1
Bb002	1		2	1	
Bb003					
Bb004	1				
Frontline Bc001	3	2		4	1
Bc002	1				
Bc003	1		1	1	
Bc004	4	2			1
Reflection Memos	1	1		1	
Background Info					
Direct Observation		1	1		
Document Analysis					

Data Source: Key informants		Patients	Workers	CHC	Systems/Institution	Reproduction
Leadership	Ca001					
	Ca002					
	Ca003					
	Ca004	5	1		1	
	Ca005	6	1		1	
	Ca006	6	1		1	
Management	Cb001	1	1	1	4	
	Cb002					
Frontline	Cc001	2	10	3	12	5
	Cc002	1	2		3	1
	Cc003	3			1	
	Cc004	3				
	Cc005	2				
	Cc006					
	Cc007	1	3			
	Cc008	1	3	2	2	
	Cc009	3	4		12	
	Cc010					
	Cc011		1		1	
Reflection Memos						

APPENDIX F.

CODE BOOK

Theme	Code	Definition
Mental Illness	Prevalence	Prevalence of mental illness in the community
	Need	To what extent agency services address prevalence
	Services	Service provision by agency
	Access to care	Ability of patients to access services
	Curability	Perceptions on cure of different types of mental illness (MI)
	Treatability	Perceptions on treatment of different types of mental illness (MI)
	Attitudes	Differences in how agency responds to various MI such as neurosis vs. psychoses
	Language	Use of people first language e.g. "Person living with schizophrenia" not "schizophrenic"
Perceptions of MI	Stereotypes	Use of stereotypes to classify patients
	Construction	Social construction of mental illness
	Deserving	Groups who are deserving of care/services
	Undeserving	Groups who are undeserving of care/services
Factors Influencing Perceptions	Personal	Personal experience of MI (self/family/friends etc.)
	Professional	Professional experience (education/training/experiences)
	Organizational	Influences from organizational policy, culture, mission etc.
	Environmental	Political, economic and social influences
	Community	Influences from the local community culture
	Media	Influences from media messaging
Resource Allocation	Decision making	Individuals and processes involved in decision making
	Funding	Funding sources for various programs within agencies
	Power	Who holds power and influence over resource allocation
Policy	Creation	How policy is created
	Beliefs	Personal beliefs of agency staff reflected in policy creation
	Implementation	Policy implementation process

	Evaluation	How policies are assessed and evaluated
	Compliance	Staff compliance with agency policy
	Subversion	Staff subversion of agency policy
Integration	Purpose	Why integration occurred
	Meaning	What integration means
	How	How integration takes place
	Actors	Actors in the integration process
	Facilitation	Factors facilitating the implementation process
	Impediment	Factors impeding the implementation process
	Conflict	Intra-agency conflict regarding integration
	Outcomes	Integration impact on outcomes for patients
Participants	Position	Role in agency
	Qualifications	Academic/professional qualifications
	Experience	Life-long professional experience
	Tenure	Length of time with agency
	Gender	Gender (M/F)
Organization	Demographics	Demographic characteristics of the FQHC
	Culture	Culture of the organization, including different cultures of different groups within the organization
	Compensation	Pay and other benefits for agency staff
	Money	Funding sources
	Goals	Goals of the FQHC
	Mission	Mission of the FQHC
	Function	How the FQHC functions
	Outreach	Outreach to the community.
	Changes	Changes in the function of the center since gaining FQHC status
Board of Directors	Composition	Membership of the board
	Responsibility	Purpose of the boards
	Interaction	Interaction with staff
	Role	Role in policy development

	Representative	Is the board 51% patient representative
Staffing	Leadership	Leadership role in agency
	Staff	Staff role and function
	Communication	Staff communications
	Dynamics	Intra-agency relationships and staff dynamics
	Autonomy	Level of staff autonomy
	Discretion	Level of staff discretion
	Pressure	Pressures of job
	Influence	Agency influence on job performance
	Turnover	Staff turnover
	Layoffs	Staff layoffs/redundancies/firings
Stigma	Patients	Ascribed to patients/society
	Workers	Ascribed to staff
	CHC	Ascribed to FQHC
	Systems	Stigmatizing/non-stigmatizing beliefs
	Institution	Institutional stigma
	Reproduction	Means of reproducing stigma within the agency

APPENDIX G.

PREVALENCE OF MENTAL ILLNESS AMONG ADULTS IN US, 2012

Illness/Disorder	**% of Population**	**# of Population (Millions)**
Major Depressive Disorder	6.7	21.0
Dysthymic Disorder	1.5	4.71
Bipolar Disorder	2.6	8.16
Suicide	0.1	0.31
Schizophrenia	1.1	3.5
Any Anxiety Disorder	18.1	56.73
Panic Disorder	2.7	8.5
Obsessive-Compulsive Disorder	1.0	3.1
Post-Traumatic Stress Disorder	3.5	11.0
Generalized Anxiety Disorder	3.1	9.7
Phobias	6.8	21.35
Eating Disorders	4.4	13.8
Attention Deficit Hyperactivity Disorder	4.1	12.87
Antisocial Personality Disorder	1.0	3.13
Avoidant Personality Disorder	5.2	16.32
Borderline Personality Disorder	1.6	5.02

Data source: National Institute of Mental Health (b) (2012). Available: http://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-adults.shtml

REFERENCE LIST

Abrams, D., Hogg, M. A., & Marques, J. M. (2005). *Social psychology of inclusion and exclusion*. New York: Psychology Press.

Agency for Healthcare Research and Quality. (2013). National Healthcare Disparities Report.Available: http://www.ahrq.gov/research/findings/nhqrdr/nhdr13/2013nhdr.pdf

Alexander, L and Wilson, K (2010). *Understanding primary and behavioral healthcare integration.* Mental Health America

Allen, S. D., Neal, A., Christopher, C., & Richard, H. B. (June 06, 2009). A conceptual model for behavioral health and primary care integration: emerging challenges and strategies for improving international mental health services. *International Journal of Mental Health*, 38, 1, 100-112.

Allport, G. W. (1954). *The nature of prejudice*. Cambridge, MA: Addison-Wesley.

American Bar Association (2012). *Appeals court overturns judge who ordered sterilization for schizophrenic pregnant woman*. Available http://www.abajournal.com/news/article/appeals_court_overturns_judge

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders: DSM-IV-TR*. Washington, DC: American Psychiatric Association.

American Psychological Association (2015). *Health disparities & mental/behavioral health workforce*. Available: http://www.apa.org/about/gr/issues/workforce/disparity.aspx

Arboleda-Flórez, J., & Sartorius, N. (2008). *Understanding the stigma of mental illness: Theory and interventions*. Chichester, England: John Wiley & Sons

Armour, P. K. (1981). *The cycles of social reform: Mental health policy making in the United States, England, and Sweden*. Washington, D.C: University Press of America

Athos, A. G., & Coffey, R. E. (1968). *Behavior in organizations: A multidimensional view.* Englewood Cliffs, N.J: Prentice-Hall.

Barnes A. (2008). Race and hospital diagnoses of schizophrenia and mood disorders. *Social Work*. 53 (1), 77-83.

Barry, C. L., Frank, R. G., & McGuire, T. G. (2006). The costs of mental health parity: still an impediment? *Health Affairs* (Project Hope), 25, 3.)

Berger, P. L., & Luckmann, T. (1967). *The social construction of reality: A treatise in the sociology of knowledge.* Garden City, N.Y: Doubleday

Berndt, E. R. (2004). Changes in the costs of treating mental health disorders: an overview of recent research findings. *Pharmacoeconomics*, 2237-50.

Blount, A. (January 01, 2003). Integrated primary care: organizing the evidence. *Families Systems & Health*, 21, 2, 121.

Blount, A. and Olmedo, M. (2011). *Introduction to effective behavioral health in primary care*. Center for Integrated Health Solutions. Available: http://www.integration.samhsa.gov/June_1_Webinar.pdf

Bodenheimer, T., & Grumbach, K. (2009). *Understanding health policy: A clinical approach*. New York: McGraw-Hill Medical.

Bowman, J. (1987). Attitudes toward disabled persons: social distance and work competence. *Journal of Rehabilitation*, 53(1).

Brief, A. P., & Weiss, H. M. (January 01, 2002). Organizational behavior: affect in the workplace. *Annual Review of Psychology*, 53, 279-307.

Brolin, M, Quinn, A, Sirkin, J, Horgan, C, Park, J, Easterday, J and Levit. K. (2012). *Financing of behavioral health services within federally qualified health centers.* Institute for Behavioral Health, Brandeis University and Truven Health Analytics, Washington DC. Available: http://wfww.integration.samhsa.gov/Financing_BH_Services_at_FQHCs_Final_7_32.pdf

Brunelle, J., & Porter, R. (January 01, 2013). Integrating care helps reduce stigma. *Health Progres*s (Saint Louis, Mo.), 94, 2.)

Bryan, W. V. (2002). *Sociopolitical aspects of disabilities*. Springfield, IL: Charles C. Thomas, Publisher, Ltd.

Burke, P., & Parker, J. (2007). *Social work and disadvantage: Addressing the roots of stigma through association.* London: Jessica Kingsley Publishers.

Burris, S. (January 01, 2006). Stigma and the law. *Lancet*, 367, 9509, 529-31.

Caplan, P. J., & Cosgrove, L. (2004). *Bias in psychiatric diagnosis*. Lanham: Jason Aronson.

Centers for Disease Control and Prevention. (2012). *Fast stats. Mental health.* Available: http://www.cdc.gov/nchs/fastats/mental.htm

Christensen, R. K., Szmer, J., & Stritch, J. M. (May 23, 2012). Race and gender bias in three administrative contexts: impact on work assignments in state supreme courts. *Journal of Public Administration Research and Theory,* 3.)

Clarke, N. E., & Crewe, N. M. (March 08, 2001). Stakeholder attitudes toward ADA Title I: Development of an indirect measurement method. *Rehabilitation Counseling Bulletin, 43,* 2, 58-65.

Cohen, N. L., & Galea, S. (2011). *Population mental health: Evidence, policy, and public health practice*. Abingdon, Oxon, England: Routledge.

Collins, C., Hewson, D.L., Munger, R., and Wade, T. (2010). *Evolving models of behavioral health integration in primary care.* New York, NY: Milbank Memorial Fund.

Colton, C.W., & Manderscheid, R.W. (2006) Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. *Preventing Chronic Disease, Public Health Research, Practice and Policy.* Available:http://www.cdc.gov.ezproxy.lib.umb.edu/pcd/issues/2006/apr/05_0180 html

Community Care (November 1999). *Estates of Mind*. London

Cook, B. L., McGuire, T., & Miranda, J. (January 01, 2007). Measuring trends in mental healthcare disparities 2000 – 2004. *Psychiatric Services* (Washington D.C) 58, 12, 1533 – 40

Cooper-Patrick, L., Gallo, J. J., Powe, N. R., Steinwachs, D. M., Eaton, W. W., and Ford, D. E. (1999). Mental health service utilization by African Americans and whites: the Baltimore epidemiologic catchment area follow-up. *Medical Care.* 37 (10).

Corey, G., Corey, M and Callanan, P. (2003). *Issues and ethics in the helping professions*. Sixth Edition. Pacific Grove, CA: Brooks Cole

Corrigan, P (ed.) (2006). *On the stigma of mental illness. Practical strategies for research and social change*. Washington D.C.: American Psychological Association

Corrigan, P. W. (January 01, 2007). How clinical diagnosis might exacerbate the stigma of mental illness. *Social Work*, 52, 1, 31-39.

Corrigan, P. W., & Shapiro, J. R. (January 01, 2010). Measuring the impact of programs that challenge the public stigma of mental illness. *Clinical Psychology Review*, 30, 8, 907-922.

Covey, H. C. (1998). *Social perceptions of people with disabilities in history*. "Chapter 1: The Changing Social Contexts of Disability" Springfield, Ill: Charles C. Thomas.

Cunningham, P. J. (May 01, 2009). Beyond parity: Primary care physicians' perspectives on access to mental health care. *Health Affairs*, 28, 3.)

deLeon, P., and deLeon, L. (2002). "What ever happened to policy implementation? An alternative approach." *Journal of Public Administration Research and Theory*: J Part. 12.4 (2002): 467-492.

Department of Health and Human Services. (2013). Federally Qualified Health Centers. Available: http://www.cms.gov/Outreach-and-Education/Medicare-Learning Network MLN/MLNProducts/downloads/fqhcfactsheet.pdf

Dowling, J., & Pfeffer, J. (January 01, 1975). Organizational legitimacy: Social values and organizational behavior. *Pacific Sociological Review*, 18, 1, 122-136.

Druss, B and Walker E. (2011). *Mental disorders and medical comorbidity. The synthesis project.* Robert Woods Johnson Foundation. Available: http://www.thenationalcouncil.org/galleries/business practice%20files/Druss_021011%20policysynthesis%20mentalhealth%20 report.pdf

Durant, R. F. (2010). *The Oxford handbook of American bureaucracy*. Oxford: Oxford University Press.

Evans, A. (2010). *Professional discretion in welfare services: Beyond street-level bureaucracy*. Burlington, VT: Ashgate.

Faiella, T. S. (1989). *Coming of age: Can community health centers survive in the 1990s?*. Boston, Mass: Massachusetts Rate Setting Commission.

Falk, G. (2001). *Stigma: How we treat outsiders*. Amherst, N.Y: Prometheus Books.

Fine, M., & Asch, A. (1988). Disability beyond stigma: Social interaction, discrimination, and activism. *Journal of Social Issues*, 44(1), 3-21.

Fink, A. (2009). *How to conduct surveys: A step-by-step guide*. Los Angeles: SAGE.

Flood, A B, Scott, W R, Ewy, W, & Forrest, W H. (1982). Effectiveness in professional organizations: the impact of surgeons and surgical staff organizations on the quality of care in hospitals. *Health Services Research* 17:4 (Winter 1982).

Foldy, E. G., & Buckley, T. R. (January 01, 2010). Re-creating street-level practice: The role of routines, work groups, and team learning. *Journal of Public Administration and Research Theory*, 20, 1, 23-52.

Frank, R. G., & Gaynor, M. (1994). Organizational failure and transfers in the public sector: Evidence from an experiment in the financing of mental health care. *Journal of Human Resources*, 29(1), 108-125.

Frank, R. G., & Glied, S. (2006). *Better but not well: Mental health policy in the United States since 1950*. Baltimore: Johns Hopkins University Press.

Frank, R. G., Goldman, H. H., & Hogan, M. (January 01, 2003). Medicaid and mental health: be careful what you ask for. *Health Affairs*. (Project Hope), 22, 1.

Fraser, N. and L. Gordon (1994). A genealogy of dependency: Tracing a keyword of the U.S. welfare state. *Signs* **19**(2): 309-336.

Gliem, Joseph A., & Gliem, R. R. (2003). *Calculating, interpreting, and reporting Cronbach's Alpha reliability coefficient for Likert-type scales.* Midwest Research-to-Practice Conference in Adult, Continuing, and Community Education.

Goffman, E. (1984). *Stigma. Notes on the Management of Spoiled Identity*, Third Edition, Harmondsworth, Penguin.

Goffman, E. (2010). *Relations in public: Microstudies of the public order*. New Brunswick, N.J: Transaction Publishers.

Gold, L. H., & Shuman, D. W. (2009). *Evaluating mental health disability in the workplace: Model, process, and analysis*. New York: Springer.

Goldberg, D. P., & Huxley, P. (1980). *Mental illness in the community: The pathway to psychiatric care*. London: Tavistock Publications.

Goldman, H. H., Buck, J. A., Thompson, K., & American Psychiatric Association. (2009). *Transforming mental health services: Implementing the federal agenda for change*. Arlington, VA: American Psychiatric Association.

Green, B. (January 01, 2000). Attitudes towards mental illness in medical students. *Medical Education*, 34, 3, 166-7.

Greene, J. A. (April 01, 1999). Zero Tolerance: A Case Study of Police Policies and Practices in New York City. *Crime & Delinquency*, 45, 2, 171-187.

Grob, G. N. (1973). *Mental institutions in America*. New York, The Free Press.

Grob, G. N., (1991). *From asylum to community*. Princeton: Princeton University Press

Grob, G. N., (1994). *The mad among us. A history of the care of America's mentally ill.* New York: The Free Press

Grob, G. N. (2000). *Mental health policy in 20th-Century America.* Rutgers, The State University of New Jersey http://mentalhealth.samhsa.gov/publications/allpubs/SMA01 3537/chapter2.asp

Hall, R. H. (2002). *Organizations: Structures, processes, and outcomes*. Upper Saddle River, N.J: Prentice Hall.

Handel, M. J. (2003). *The sociology of organizations: Classic, contemporary, and critical readings*. Thousand Oaks: Sage Publications.

Harrison, Y. D., & Murray, V. (September 06, 2012). Perspectives on the leadership of chairs of nonprofit organization boards of directors: A grounded theory mixed method study. *Nonprofit Management and Leadership*, 22, 4, 411-437.

Harter, J. K., Killham, E. A., Agrawal, S., Schmidt, F. L., & Asplund, J. W. (July 01, 2010). Causal impact of employee work perceptions on the bottom line of organizations. *Perspectives on Psychological Science*, 5, 4, 378-389.

Hartley, J. (January 01, 2014). Some thoughts on Likert-type scales. *International Journal of Clinical and Health Psychology*, 14, 1, 83-86.

Health Connector (2010, November). *Report to the Massachusetts Legislature*. Implementation of health care reform, Fiscal Year 2010.

Healthit.gov (2015). Basics of Health IT. Available: http://www.healthit.gov/patients families/basics-health-it

Heatherton, T. F. (2000). *The Social Psychology of Stigma.* New York: Guilford Press.

Heflinger, C. A., & Hinshaw, S. P. (January 01, 2010). Stigma in child and adolescent mental health services research: understanding professional and institutional stigmatization of youth with mental health problems and their families. *Administration and Policy in Mental Health*, 37, 1-2.

Hermann, D. H. J. (1997). *Mental health and disability law in a nutshell.* St. Paul, Minn.: West Pub. Co

Hinshaw, S. P., & Stier, A. (May 19, 2008). Stigma as related to mental disorders. *Annual Review of Clinical Psychology*, 4, 367-393.

Hogan, S. J., & Coote, L. V. (August 01, 2014). Organizational culture, innovation, and performance: A test of Schein's model. *Journal of Business Research*, 67, 8, 1609 1621.

Horvitz-Lennon, M., Frank, R. G., Thompson, W., Baik, S. H., Alegría, M., Rosenheck, R. A., & Normand, S. L. (January 01, 2009). Investigation of racial and ethnic disparities in service utilization among homeless adults with severe mental illnesses. *Psychiatric Services* (Washington, D.C.), 60, 8, 1032-8.

Health Resources and Services Administration (HRSA). (2014). *2013 Health center profile*. Available: http://hrsa.gov/uds/datacenter.aspx?q=d&year=2013

Ingoglia, C. and Roth, L. (2012). *Health Homes: What healthcare's "one stop shopping" models mean for behavioral health.* SAMHSA-HRSA Center for Integrated Health Solutions. Available: http://www.integration.samhsa.gov/about-us/esolutions newsletter/december-2012-esolutions-health-homes

Ingram, H. Schneider, A. and DeLeon, P. (2007). Social Construction and Policy Design in Sabatier, P. A. (Ed.) (2007). *Theories of the policy process*. Boulder, Colo: Westview Press.

Institute of Medicine (U.S.). (2006). *Improving the quality of health care for mental and substance-use conditions.* Washington, D.C: National Academy Press.

Isett, K., Morrissey, J., & Topping, S. (January 01, 2007). Systems ideologies and street level bureaucrats: Policy change and perceptions of quality in a behavioral health care system. *Human Resources Abstracts*, 42, 1, 217.

Jacobs, L. R. (January 01, 1992). Institutions and culture: Health policy and public opinion in the U.S. and Britain. World Politics: *Quarterly Journal of International Relations*, 44, 2, 179-209.

Jamison, K. R. (February 11, 2006). The many stigmas of mental illness. *The Lancet,* 367, 9509, 533-534.

Jaskyte, K. (September 06, 2012). Boards of directors and innovation in nonprofit organizations. *Nonprofit Management and Leadership*, 22, 4, 439-459.

Jewell, C., & Glaser, B. (April 01, 2007). Toward a general analytic framework: Organizationalsettings, policy goals, and street-level behavior. *Sage Public Administration Abstracts*, 34, 1.

Johnsen, M. C., Morrissey, J. P., Calloway, M. O., Fried, B. J., Blank, M., & Starrett, B. E. (January 01, 1997). Rural mental health leaders' perceptions of stigma and community issues. *The Journal of Rural Health: Official Journal of the American Rural Health Association and the National Rural Health Care Association*, 13, 1, 59-70.

Joniak, E. (January 01, 2005). Exclusionary practices and the delegitimization of client voice. *American Behavioral Scientist*, 48, 8, 961-988.

Kaiser Family Foundation. (December 2011). *Health care expenditures per capita by state of residence, 2009*. Available: http://www.statehealthfacts.org/comparemaptable.jsp?ind=596&cat=5

Knight, K. E. (January 01, 2011). Federally Qualified Health Centers minimize the impact of loss of frequency and independence of movement in older adult patients through access to transportation services. *Journal of Aging Research*, 2011

Kobau, R., Chapman, D., Diiorio, C., & Delvecchio, P. (April 01, 2010). Attitudes about mental illness and its treatment: Validation of a generic scale for public health surveillance ofmental illness associated stigma. *Community Mental Health Journal*, 46, 2, 164-176.

Kogut, B. M. (2008). *Knowledge, options, and institutions*. Oxford: Oxford University Press

Kreitner, R., Kinicki, A., & Buelens, M. (2001). *Organizational behaviour*. London: McGraw Hill.

Landsberg, G. & Smiley, A., (2001). *Forensic mental health. Working with offenders with mental illness.* Kingston, Civic Research Institute.

Lane, V. R., & Scott, S. G. (November 01, 2007). The neural network model of organizational identification. *Organizational Behavior and Human Decision Processes,* 104, 2, 175-192.

Lang, A. J. (January 01, 2003). Brief intervention for co-occurring anxiety and depression in primary care: a pilot study. *International Journal of Psychiatry in Medicine*, 33, 2, 141 54.

Lauber, C., Nordt, C., Braunschweig, C., & Rössler, W. (January 01, 2006). Do mental health professionals stigmatize their patients? *Acta Psychiatrica Scandinavica. Supplementum*, 429, 51-9.

Laumann, E. O., & Knoke, D. (1987). *The organizational state: Social choice in national policy domains.* Madison, Wis: University of Wisconsin Press.

Lawrie, S. M. (January 01, 1999). Attitudes of the general population to psychiatric and physical illness. *Psychiatric Bulletin*, 23, 11, 671.

Lee, R. M. (1999). *Doing research on sensitive topics*. London: Sage.

Lefkowitz, B. (2007). *Community health centers: A movement and the people who made it happen.* New Brunswick, N.J: Rutgers University Press.

Lewis, J. A., & Lewis, J. A. (2001). *Management of human service programs*. Belmont, CA: Brooks/Cole.

Linhorst, D. M. (2006). *Empowering people with severe mental illness: A practical guide*. New York, N.Y: Oxford University Press

Linhorst, D. M., Eckert, A., & Hamilton, G. (January 01, 2005). Promoting participation in organizational decision making by clients with severe mental illness. *Social Work*, 50, 1, 21-30.

Link, B. G., & Phelan, J. C. (January 01, 2001). Conceptualizing Stigma. *Annual Review of Sociology*, 27, 363-385.

Lipsky, M. (1980). *Street-level bureaucracy: Dilemmas of the individual in public services*. New York: Russell Sage Foundation.

Little, V, Maxey, B and Mannan, M (2012). *Behavioral health in a primary care setting Keys to Success.* The National Council. Available:http://www.thenationalcouncil.org/galleries/resources services%20files/Warm%20Handoffs.pdf

Lofland, J., & Lofland, L. H. (1995). *Analyzing social settings: A guide to qualitative observation and analysis*. Belmont: Wadsworth.

Lundin, M. (November 01, 2007). When does cooperation improve public policy implementation? *The Policy Studies Journal*, 35, 4, 629-652.

Mackenzie, C., Gekoski, W., & Knox, V. (June 01, 2007). Age, gender, and the underutilization of mental health services: The influence of help-seeking attitudes. *Abstracts in Social Gerontology,* 50, 2.

Magaletta, P., Diamond, P., Faust, E., Daggett, D., & Camp, S. (2009). Estimating the mental illness component of service need in corrections. Results from the mental health prevalence project. *Criminal Justice and Behavior Journal*. 36(3), 229-244.

Majchrzak, A. (1984). *Methods for policy research.* Beverly Hills: Sage.

Manderscheid, R. (2006). *The quiet tragedy of premature death among mental health consumers. N*ational Council News. Available: http://www.thenationalcouncil.org/galleries/NCMagazine gallery/ncnews_sept06.pdf

Markowitz, F., Angell, B., & Greenberg, J. (January 01, 2011). Stigma, reflected appraisals, and recovery outcomes in mental illness. *Social Psychology Quarterly,* 74, 2, 144-165.

Marshall, C., & Rossman, G. B. (2006). *Designing qualitative research*. London: SAGE

Massachusetts Department of Public Health (2012). *Behavioral health integration initiative*. Available: http://www.massleague.org/Calendar/LeagueEvents/BehavioralHealthSummit/MPHBehavioralHealthIntegrationInitiative-Auerbach.pdf

Mauer, B. J., & Druss, B. G. (January 01, 2010). Mind and body reunited: improving care at the behavioral and primary healthcare interface. *The Journal of Behavioral Health Services & Research*, 37, 4, 529-42.

Mauksch, L. B., Tucker, S. M., Katon, W. J., Russo, J., Cameron, J., Walker, E., & Spitzer, R. (January 01, 2001). Mental illness, functional impairment, and patient preference for collaborative care in an uninsured, primary care population. *The Journal of Family Practice*, 50, 1, 41-7.

Maynard-Moody, S., & Musheno, M. C. (2003). *Cops, teachers, counselors: Stories from the frontlines of public service.* Ann Arbor: University of Michigan Press.

McSween, J. (January 01, 2002). The role of group interest, identity, and stigma in determining mental health policy preferences. *Journal of Health Politics, Policy and Law*, 27, 5, 773-800.

Mechanic, D., & Rochefort, D. A. (January 01, 1990). Deinstitutionalization: An appraisal of reform. *Annual Review of Sociology*, 16, 301-327.

Meyer, R. G. (1992). *Abnormal behavior and the criminal justice system*. New York; Toronto; New York, Lexington Books; Maxwell Macmillan Canada; Maxwell Macmillan International.

Meyers, M.K and Vorsanger, S. “Street-Level bureaucrats and the implementation of public policy”; in Peters, B. G., & Pierre, J. (2003). *Handbook of public administration*. London: Sage Publications.

Meyers, M. K., Riccucci, N. M., & Lurie, I. (April 01, 2001). Achieving Goal Congruence in Complex Environments: The Case of Welfare Reform. *Journal of Public Administration Research and Theory*: J-Part, 11, 2, 165-201.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook.* Thousand Oaks: Sage Publications.

Miller, B. F., Mendenhall, T. J., & Malik, A. D. (January 01, 2009). Integrated primary care: an inclusive three-world view through process metrics and empirical discrimination. *Journal of Clinical Psychology in Medical Settings*, 16, 1, 21-30.

Miller, J.E. and Prewitt E. (2012). *Reclaiming lost decades: the role of state behavioral health agencies in accelerating the integration of behavioral healthcare and primary care to improve the health of people with serious mental illness.* The National Association of State Mental Health Program Directors. Available: http://www.nasmhpd.org/docs/publications/docs/2012/Reclaiming%20Lost%20Decades 20Full%20Report.pdf.

Minnesota Psychiatric Society (2011). *Detailed history of mental health.* http://www.mnpsychsoc.org/. Accessed December 9, 2011

Mowbray, C. T., & Holter, M. C. (2002). Mental health and mental illness: Out of the closet?. *Social Service Review*, 76(1), 135-179.

Myers, M. D. (October, 2009). Qualitative research in information systems, *MIS Quarterly* (21:2), Available: http://www.misq.org/discovery/MISQD_isworld/.

Myrtle, R. C. (January 01, 1983). A managerial view of policy implementation. *American Review of Public Administration,* 17, 1.)

National Alliance for the Mentally Ill Massachusetts (NAMI). (2004). *The state of mental health services in Massachusetts: The impact of inadequate funding.* Woburn, Mass: NAMI of Massachusetts.

National Alliance on Mental Illness. (2011). *State mental health cuts: A national crisis: a report by the National Alliance on Mental Illness.* S.l.: National Alliance on Mental Illness. Available: http://www.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=26233

National Association of Community Health Centers (2012). *About our health centers*. Available: http://www.nachc.com/about-our-health-centers.cfm

National Association of Community Health Centers (2013). *Clinical issues. Behavioral health.* Available: http://www.nachc.com/BehavioralHealth.cfm

National Conference of State Legislators (2011). *State balance budget requirements*. Available: http://www.ncsl.org/default.aspx?tabid=12660.

National Conference of State Legislators (2015). *State laws and actions challenging certain health reforms.* Available: http://www.ncsl.org/research/health/state laws-and-actions-challenging-ppaca.aspx

National Institute of Mental Health (2012). *Use of mental health service and treatment among adults*. Available http://www.nimh.nih.gov/statistics/3USE_MT_ADULT.shtml

Newhill, C. E., & Harris, D. (January 01, 2007). African American consumers' perceptions of racial disparities in mental health services. *Social Work in Public Health*, 23, 2-3.

O'Brien, E. E. (2008). *The politics of identity: Solidarity building among America's working poor*. Albany: State University of New York Press.

O'Day, B., & Killeen, M. (January 01, 2002). Does U.S. federal policy support employment and recovery for people with psychiatric disabilities? *Behavioral Sciences & the Law*, 20, 6, 559-83.

Ospina, S., & Foldy, E. (April 01, 2010). Building bridges from the margins: The work of leadership in social change organizations. *The Leadership Quarterly*, 21, 2, 292 307.

Palpant, R. G., Steimnitz, R., Bornemann, T. H., & Hawkins, K. (January 01, 2006). The Carter Center Mental Health Program: addressing the public health crisis in the field of mental health through policy change and stigma reduction. *Preventing Chronic Disease*, 3, 2.

Peek C.J. and the National Integration Academy Council. (2013). Lexicon for behavioral health and primary care integration: Concepts and definitions developed by expert consensus. *AHRQ Publication No.13-IP001-EF*. Rockville, MD: Agency for Healthcare Research and Quality. Available: http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf.

Peters, B. G., & Pierre, J. (2003). *Handbook of public administration*. London: Sage Publications.

Pincus, H.A. (2013). *A quality management system for mental health professionals*. Institute of Medicine. Available: http://www.iom.edu/~/media/Files/Activity%20Files/MentalHealth/TRICAREMentalHealth/Pincus.pdf

Possemato, K. (January 01, 2011). The current state of intervention research for posttraumatic stress disorder within the primary care setting. *Journal of Clinical Psychology in Medical Settings*, 18, 3, 268-280.

Pressman, J. L., & Wildavsky, A. (1984). *Implementation: How great expectations in Washington are dashed in Oakland*. Berkeley, Calif: University of California Press.

Primary Care Behavioral Health: MH Care Redesign. (2008). *Access community health*. Madison, WI. Available: http://www.youtube.com/watch?feature=player_detailpage&v=t0MsDjlTQfo

Prottas, J. M. (1981). *People-processing: The street-level bureaucrat in public service bureaucracies*. Lexington, Mass: Lexington Books.

Quigley, A. (2007). *Mental health*. Detroit: Greenhaven Press.

Rack, P. (1982). *Race, culture and mental disorder.* New York: Tavistock Publications

Redhead, S.C., Colello, K.J., Heisler, E.J., Lister, S.A., Sarata, A.K. (September 2, 2010). *Discretionary funding in the Patient Protection and Affordable Care Act (PPACA).* Congressional Research Service. Available: https://www.aamc.org/download/146012/data/crs_report_on_aca_discretionary_pogram.pdf

Riccucci, N. M. (January 01, 2005). Street-level bureaucrats and intrastate variation in the implementation of Temporary Assistance for Needy Families policies. *Journal of Public Administration Research and Theory*, 15, 1, 89-111.

Richard, G. F. H. H. G. M. H. (2003). Medicaid And mental health: Be careful what you ask for. *Health Affairs, 22,* 101

Robichau, R. W., & Lynn, J. L. E. (January 01, 2009). The implementation of public policy: Still the missing link. *Policy Studies Journal* Urbana Then Carbondale-, 37, 1, 21-36.

Rochefort, D. A., Harrington, C., (2002). *Good news, bad news, and points of view: An analysis of mental health coverage in Boston's two major newspapers*. Community-Based Research Initiative, College of Arts and Sciences, Northeastern University. Boston, Mass.

Rousseau, D. M. (June 01, 1989). Psychological and implied contracts in organizations. *Employee Responsibilities and Rights Journal*, 2, 2, 121-139.

Roy-Byrne, P., Veitengruber, J. P., Bystritsky, A., Edlund, M. J., Sullivan, G., Craske, M. G., Welch, S. S., & Stein, M. B. (January 01, 2009). Brief intervention for anxiety in primary care patients. *Journal of the American Board of Family Medicine*: Jabfm, 22, 2.)

Sabatier, P., A. (1986)."Top-down and bottom-up approaches to implementation Research: A critical analysis and suggested synthesis." *Journal of Public Policy*. 6.1 (1986): 21-48.

Sabatier, P. A. (2007). *Theories of the policy process*. Boulder, Colo: Westview Press.

Sabatier, P., & Mazmanian, D. (January 01, 1980). The implementation of public policy: A framework of analysis. *Policy Studies Journal,* 8, 4, 538-560.

Salkever, D. S., Sorkin, A. L., & Ettner, S. L. (2000). *The economics of disability*. Stamford, Conn: JAI Press.

SAMHSA-HRSA Center for Integrated Health Solutions. (2012). *Webinar integration models: Lessons from the behavioral health field.* Available: http://www.integration.samhsa.gov/about-us/webinars.

SAMHSA-HRSA Center for Integrated Health Solutions. (2013). Available: http://www.samhsa.gov/data/national-behavioral-health-quality-framework

SAMHSA-HRSA Center for Integrated Health Solutions. (2015). Available: http://www.integration.samhsa.gov/

Satcher, D., & Higginbotham, E. J. (2008). The public health approach to eliminating disparities in health. *American Journal of Public Health*, 98, 9, 8-11.

Schein, E. H. (1980). *Organizational psychology*. Englewood Cliffs, N.J: Prentice-Hall.

Schneider, A. & Ingram, H. (1993). Social construction of target populations: Implications for politics and policy. *American Political Science Review*. 87

Schutt, R. K., & Goldfinger, S. M. (2011). *Homelessness, housing, and mental illness*. Cambridge, Mass: Harvard University Press.

Segal, S. (January 01, 2009). A beautiful math: John Nash, game theory, and the modern quest for a code of nature by Tom Siegfried. *The Mathematical Intelligencer*, 31.

Shield, T., Campbell, S., Rogers, A., Worrall, A., Chew-Graham, C., & Gask, L. (January 01, 2003). Quality indicators for primary care mental health services. *Quality & Safety in Health Care*, 12, 2, 100-6.

Sirey, J. A., Bruce, M. L., Alexopoulos, G. S., Perlick, D. A., Raue, P., Friedman, S. J., & Meyers, B. S. (2001). Perceived stigma as a predictor of treatment discontinuation in young and older outpatients with depression. *American Journal of Psychiatry*, 158, 479 481.

Slate, R. N., & Johnson, W.W., (2008). *The criminalization of mental illness. crisis and opportunity for the justice system*. Durham: Carolina Academic Press

Smaldone, A., & Cullen-Drill, M. (January 01, 2010). Mental health parity legislation: understanding the pros and cons: find out how two recently enacted federal laws have the potential to strengthen-or possibly even limit-mental health care access, cost, and quality. *Journal of Psychosocial Nursing and Mental Health Services*, 48, 9, 26-34.

Smedley, B. D., Stith, A. Y., Nelson, A. R., & Institute of Medicine (U.S.). (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, D.C: National Academy Press.

Smith, W.D., Burlew, A.K., Mosley, M.H., Whitney, W.M. (1978). *Minority Issues in Mental Health.* Reading, MA: Addison-Wesley Publishing Company

Steinmo, S. & Watts, J. (1995). "It's the Institutions Stupid! Why comprehensive national health insurance always fails in America." *Journal of Health Politics, Policy and Law. 20* (2): 329-72. Available: http://jhppl.dukejournals.org/cgi/reprint/20/2/329

Stuber, J., & Schlesinger, M. (August 01, 2006). Sources of stigma for means-tested government programs. *Social Science & Medicine*, 63, 4, 933-945.

Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (October 6, 2011). *The NSDUH Report: State Estimates of Adult Mental Illness.* Rockville, MD. Available: http://oas.samhsa.gov/2k11/078/WEB_SR_078.htm

Surgeon General. US Public Health Service (2011). Overview of Mental Health Services. Available: http://www.surgeongeneral.gov/library/mentalhealth/chapter2/sec7.html. Accessed: December 9, 2011.

Trochim, W. M. K., & Donnelly, J. P. (2008). *Research methods knowledge base.* Mason, Ohio: Atomic Dog/Cengage Learning.

Upshur, C. (January 01, 2005). Crossing the divide: Primary care and mental health integration. *Administration and Policy in Mental Health*, 32, 4, 341-355.

U.S. Department of Health and Human Services. (December, 2014). *Health information privacy.* Available: http://www.hhs.gov/ocr/privacy/index.html

US Department of Health and Human Services (September 2014). *Health center program governance*. Available: http://bphc.hrsa.gov/policiesregulations/policies/pin201401.pdf

US Government Printing Office (2009). *The American Recovery and Reinvestment Act*. Available: http://www.gpo.gov/fdsys/pkg/BILLS-111hr1enr/pdf/BILLS 111hr1enr.pdf

US Government Printing Office (a) (2011). *The Patient Protection and Affordable Care Act*. Available: www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW 111publ148.pdf,

US Government Printing Office. (b) (2011). *The Balanced Budget Act*. Available: http://www.gpo.gov/fdsys/pkg/PLAW-105publ33/html/PLAW-105publ33.htm

Vinzant, J. C., & Crothers, L. (1998). *Street-level leadership: Discretion and legitimacy in frontline public service.* Washington, D.C: Georgetown University Press.

Weiss, R. S. (1994*). Learning from strangers: The art and method of qualitative interview studies.* New York: Free Press.

Wells, R., Morrissey, J. P., Lee, I.-H., & Radford, A. (August 01, 2010). Trends in behavioral health care service provision by community health centers, 1998-2007. *Psychiatric Services, 61, 8, 759-764.*

Werner, A. (2004). *A guide to implementation research*. Washington, D.C: Urban Institute Press.

Whitaker, R. (2010). *Anatomy of an epidemic: Magic bullets, psychiatric drugs, and the astonishing rise of mental illness in America*. New York: Crown Publishers.

Whitford, A. B. (March 01, 2007). Decentralized policy implementation. *Political Research Quarterly*, 60, 1, 17-30.

Williams, M. E. (2007). *Mental illness*. Detroit: Greenhaven Press.

Wilson, J. Q. (1989). *Bureaucracy: What government agencies do and why they do it.* New York: Basic Books.

Woltmann, E., Grogan-Kaylor, A., Perron, B., Georges, H., Kilbourne, A. M., & Bauer, M. S. (January 01, 2012). Comparative effectiveness of collaborative chronic care models for mental health conditions across primary, specialty, and behavioral health care settings: systematic review and meta-analysis. *The American Journal of Psychiatry*, 169, 8, 790- 804.

Wonnacott, T. H., & Wonnacott, R. J. (1990). *Introductory statistics*. New York: Wiley.

Wright, B. (January 01, 2013). Who governs federally qualified health centers? *Journal of Health Politics, Policy and Law*, 38, 1, 27-55.

Wright, B., & Martin, G. P. (January 01, 2014). Mission, margin, and the role of consumer governance in decision-making at community health centers. *Journal of Health Care for the Poor and Underserved*, 25, 2, 930-47.

Wright, D. B. (January 01, 2012). Consumer governance and the provision of enabling services that facilitate access to care at community health centers. *Medical Care*, 50, 8, 668-75.

Yin, Robert K. (2003). *Case study research. Design and methods, Third Edition*. Thousand Oaks, CA: Sage Publications.

Zaiontz C. (2014) *Real statistics using excel*. Available: www.real-statistics.com