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Stigma Cultures in Healthcare Scale – Qualitative Findings in an Emergency Department Setting

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ABSTRACT

One in five Canadians will experience a mental illness. Stigma poses a significant barrier for those with mental illness trying to access treatment. The Exploring Mental health Barriers in Emergency Rooms (EMBER) study aims to better understand stigma experienced by those with mental health (MH) and addiction concerns in emergency department (ED) settings. For this stage of the study, participants were asked to complete a survey detailing their visit to an ED in a hospital in Southern Alberta. Two scales were used to measure the presence of structural stigma in the ED: the Stigma Cultures in Healthcare Scale (SCHS) and an adapted version of the Structural Stigma in Mental Health Care Scale (SSMHCS). Results showed differential treatment experienced by those with MH concerns as well as highlighting areas to improve the experience of patients with MH concerns.

Keywords: mental health; mental illness; stigma; structural stigma; healthcare

Background

Emergency departments (EDs) play a crucial role in providing immediate and life-saving care to individuals in times of medical crisis. Unfortunately, the ED can be a stigmatizing place for patients who present with a mental illness. Pescosolido and Martin (2015) describe stigma as the bias and unfair treatment associated with conditions, situations, or locations that are socially labeled as undervalued. Notably, stigma has many forms, including interpersonal, intrapersonal, and structural (Cook et al., 2014; Smith et al., 2022). Interpersonal or public stigma refers to prejudice and discrimination that someone, such as a healthcare provider, may hold towards a person with mental illness (Corrigan et al., 2014; Thornicroft et al., 2022). Intrapersonal stigma refers to "negative beliefs about the self, which are largely based on shame, the acceptance of mental illness stereotypes, a sense of alienation from others, and consequent low mood" (Henderson et al., 2014, p. 468). While interpersonal and intrapersonal stigma contribute significantly to the overall stigmatization of patients, growing research indicates that it is imperative to recognize the significance of structural or organizational stigma as well (Sukhera, & Knaak, 2022).

The Significance of Structural Stigma

Structural stigma within healthcare refers to policies and procedures that create inequities for individuals facing mental health (MH) and substance use challenges (Livingston, 2020; Thornicroft et al., 2022). Although addiction and mental illness are both distinct and complex challenges, they are related and may influence one another. For the purposes of this study, addiction and mental illness are categorized under MH concerns. Previous research has demonstrated that individuals with mental illness who encounter stigma in the healthcare setting, receive suboptimal care, independent of the specifics of their diagnoses (Dockery et al., 2015, Henderson & Gronholm, 2018). Due to anticipated poor treatment, patients experiencing mental illness may delay

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seeking treatment, often to the point of requiring crisis interventions (Biancarelli et al., 2019). Despite the evidence related to the negative impacts of stigma, it continues to be an underfunded area of research (Henderson & Gronholm, 2018), which may in itself be interpreted as structural stigma.

Research identified how structural stigma towards mental illness has other long-term consequences. Hatzenbuehler et al. (2013) classified structural stigma as a fundamental cause of health inequality. Yang et al. (2014) described "how societal-level processes disadvantage access to mental health treatment for certain groups" (p.85) and consequently increased healthcare spending. Ross and Goldner (2009) noted that structural stigma in some instances compromised patient and provider safety. This unsafe work environment could be caused by deficiencies in resources including MH care providers and services, and a lack of training leaving providers hesitant to connect with patients, resulting in delayed treatment. Overall, the lack of funding and the false belief that sufficient efforts have already been made to address stigma, have resulted in a lack of prioritization in stigma research (Henderson & Gronholm, 2018).

The majority of research that does exist related to mental illness stigma focuses on interpersonal stigma or the stigma between healthcare providers and patients, rather than structural stigma (Rao et al., 2019). However, because levels of stigma are interconnected and structural stigma may reinforce intrapersonal and interpersonal stigma (Greene et al., 2018), attention to structural stigma is essential. As an example, Henderson et al. (2014) found that structural stigma may govern the effectiveness of interventions aimed at reducing interpersonal stigma in the healthcare setting. Hammarlund et al. (2018) showed that where institutions had stigmatizing policies in place, they influenced healthcare providers' behaviours in a manner that perpetuated stigma. Pescosolido et al. (2019) demonstrated that people who associate mental illness with violence are more likely to endorse public stigma by supporting stigmatizing policies, which could result in involuntary hospitalization for those experiencing mental illness. Interpersonal stigma also has been shown to perpetuate self-stigma and harm amongst MH patients (Mitten et al., 2016).

Structural Stigma and Intersectionality

Difficulty accessing MH resources may be magnified by intersectionality. For instance, Pachankis et al. (2021) determined that structural stigma can perpetuate negative MH outcomes in sexual minority men, individuals who identify as gay, bisexual, or engage in same-sex sexual behaviors. This trend can be attributed to sexual minorities internalizing negative societal beliefs about themselves and experiencing social isolation due to lack of dependable sources of support (Pachankis et al., 2021), which was found to predict negative health outcomes (Hatzenbuehler, 2016). Dockery et al. (2015) discovered that gender plays a part in access to treatment, showing that female service users and caregivers were substantially more likely to report stigma as part of their treatment experiences. Additionally, structural stigma combined with racially discriminatory policies has led to poorer MH outcomes for racialized populations, i.e., those not part of the white majority population (Kapadia, 2023). Conversations surrounding mental illness stigma also tend to paint ethnic and minority populations as groups who hold strong stigma towards mental illness, rather than exclusively as a stigmatized group, which may influence policy (Kapadia, 2023). Altogether, marginalized populations are disproportionately affected by structural stigma, further exacerbating health inequality and barriers to accessing care and support.

Structural Stigma as a Widespread Issue

Structural stigma associated with MH is an expansive concern that requires the attention of stakeholders worldwide. In the United Kingdom, Killaspy (2017, as cited in Henderson & Gronholm, 2018) reported that psychiatric services were often located in distant and inaccessible areas. Patients in the United States who used community-based MH resources, such as mental health clinics, described the treatment centers as more welcoming and respectful, while allowing them to develop better relationships with staff than in traditional hospital settings (Biancarelli et al., 2019). Henderson and Gronholm (2018) found that many of those with mental illness in the United Kingdom did not qualify and therefore could not gain access to many community-based programs, such as home-care and other health promotion initiatives.

Patients in Western countries found that waitlists and difficulty navigating resources posed additional challenges (MacDonald et al., 2021). Furthermore, those with dual diagnoses of mental illnesses and other illnesses experience even more difficulty accessing treatment due to the fragmentation of services (Dixon et al., 2016; Lomax et al., 2022). Healthcare providers in Brazil felt that policy-makers did not prioritize MH care to the same extent as general healthcare (Guimarães & Pedersen, 2022). In the United States, where healthcare is private, despite the implementation of both the Affordable Care Act and the Mental Health Parity and Addiction Equity Act, MH insurance benefits remain constrained in comparison to physical health (PH) benefits (Zhu et al., 2017). Nevertheless, access to insurance in the United States is heavily influenced by the type of employment an individual holds, which is, in turn,

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shaped by their intersectional identity (Lindstrom et al., 2023).

Structural Stigma within Institutional Contexts

Many researchers have pointed out the need for training to acquire skills to support people with MH concerns (Corrigan et al., 2014; Henderson, et al., 2014; Livingston, 2020). However, structural stigma undermines institutional prioritization of relevant training for healthcare practitioners (Perry et al., 2020). Another researcher underscored the importance of educational institutions providing training for healthcare professionals (Guimarães & Pedersen, 2022). Further, da Silva et al. (2020) found that careers in MH were devalued, thereby discouraging students from pursuing MH specializations. Such attitudes may contribute to a shortage of MH care providers (McGinty et al., 2018).

Workplace culture can be influenced by structural stigma as well. Ricciardelli et al. (2017) found that public safety personnel, such as paramedics, correctional service workers, and police officers in Canada, face obstacles when attempting to take leave from work due to their own MH concerns and were seen as "milking the system" (p. 266). Stigma that discourages individuals from disclosing their MH concerns is not exclusive to this demographic. In fact, medical students and physicians reported fear of discrimination when disclosing their own MH concerns (Haque et al., 2021). Haque et al. revealed that medical schools and licensing boards lacked transparency regarding their disability and confidentiality policies; thus, students and staff feared the consequences of disclosing their illness.

Workplace culture may also affect patient experiences and care. In one study, Sercu and Bracke (2017) discovered that the roles, language use, and treatment approach of psychiatric nurses and psychiatrists differed. Nurses used less formal medical language than psychiatrists, who adhered to psychiatric medical language. Yet, there was no organizational framework to help integrate the two professions. Further, van Boekel et al. (2013) determined that the uncollaborative work environment in healthcare settings hindered patients' active engagement in their treatment plans. Moreover, organizational cultures perpetuate mental illness stigma by permitting the use of stereotyping labels on patients' charts, such as "drug seeking …disruptive and difficult" (Perry et al., 2020, p. 6).

Structural Stigma in the ED

Some structural stigma experiences have been found to be exclusive to the ED. Youth admitted to a psychiatric ward in Canada described their experiences in the ED as more stigmatizing and isolating than those in the hospital's psychiatric unit (Mitten et al., 2016). More generally, patients with suicidal ideation admitted to the ED experienced the unit as overwhelming, while also worrying about the loss of confidentiality due to the layout and lack of privacy of the unit (Guzmán et al., 2020). In some circumstances, EDs refused to admit patients with mental illness or substance use (Lopez et al., 2021; Pescosolido & Martin, 2015). Overall, emergency rooms were deemed an inappropriate setting for MH patients by clinicians (Perry et al., 2020).

Sukhera et al. (2018) found that emergency room physicians reported the presence of a "hidden curriculum" in which healthcare staff were pressured to provide care in an efficient manner, hampering their ability to properly engage with patients presenting with mental illness (p. 592). One physician admitted to assigning MH patients to medical residents, so they could personally avoid caring for them (Sukhera et al., 2018). Presumably, the residents are less equipped than the more experienced physicians to assess and treat such patients, further diminishing quality of care for MH patients. The ED where Sukhera et al. conducted their study required practitioners to fill out a "violence sheet" for all patients presenting with mental illness (p. 593). These researchers revealed that healthcare providers resisted change in the ED environment due to structural and cultural factors; however, after receiving implicit bias training, they were more welcoming of change in the ED setting. Persistent ED culture could be related to an unwavering faith in the "hegemonic biomedical model" (Fontão et al., 2018, p. 2203), which is an approach that focuses on diagnoses and medication while undervaluing holistic and mental health perspectives. As such, the ED, an environment with documented stigmatizing practices of patients with mental illness, presents as an ideal setting for researchers to investigate specific areas for growth in handling MH concerns.

The Exploring Mental Health Barriers in Emergency Rooms (EMBER) Project

The Exploring Mental health Barriers in Emergency Rooms (EMBER) study, funded by the Calgary Health Foundation, is a five-year study that aims to better support patients and families visiting the ED for MH concerns. The aim is to examine and help address mental illness stigma in the ED at the following levels: interpersonal, intrapersonal, and structural. To achieve this objective, the study is examining mental illness-related stigma and discrimination from the perspectives of patients, families and professional staff, and using these findings to provide recommendations and interventions for improvement (Smith et al., 2022).

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Methods

Given these objectives, the EMBER team partnered with the Mental Health Commission of Canada (MHCC) to pilot their new Stigma Cultures in Healthcare Scale (SCHS), and questions from the Structural Stigma in Mental Health Care Scale (SSMHCS). Although previous phases of the study included patients, families, and staff, for this stage, structural stigma was assessed from the perspective of ED patients alone at one hospital in Southern Alberta. This comprehensive survey will provide a way to evaluate the impacts of structural stigma and improvements to mental health care in the ED on patient experiences over time. This study has been approved by the Conjoint Health Research Ethics Board (REB20-1639).

Recruitment Methods

Emergency room volunteers, psychiatric staff, and research associates used posters and postcards to recruit patients to complete a survey at various MH facilities, community agencies, and inpatient units at different hospitals in Southern Alberta. Eligibility criteria included having visited the ED at a specific hospital in Southern Alberta in the past year, being at least 18 years of age, and being able to express oneself comfortably in English. Consent was provided by all participants. Participants received a five-dollar gift card honorarium upon completion of the survey.

To recruit participants in our research project, multiple different approaches were used. Postcards with QR codes to complete the survey were distributed in the ED waiting room and psychiatric area. A research team member directly distribute cards in MH units, answered any questions, and helped participants fill out the survey using a tablet. Participants were encouraged to share the opportunity with others. The Emergency Room Outreach team also contacted discharged patients to let them know about the study. Recruitment posters were displayed in ED waiting areas, hospitals, and community MH agencies. These efforts aimed to ensure broad participation in the study.

Measures

The survey consisted of the SCHS developed by the MHCC, which is a unidimensional scale, consisting of 23 questions (Stuart & Knaak, 2023a). In addition, eight questions from the SSMHCS scale were included–seven items pertaining to coercive care, and one item pertaining to the quality of the physical space (Stuart & Knaak, 2023b). Note that the SSMHCS comprises two factors: a factor for coercive care and a factor patient-centered care. The patient-centered care items were not included in this pilot as most items were felt to be adequately captured through the questions in the SCHS. The one exception was in regard to the physical space of the ED, which is why this item was included. While the scales were merged into a single survey for ease of respondent completion, they remained as two separate scales for the purposes of analysis and reporting. The EMBER study was the first to pilot these scales in an actual healthcare setting, with the goal of capturing the experiences of patients in the ED and better understanding potential implementation challenges. The questions used a four-point Likert scale, with options ranging from strongly agree to strongly disagree, with no neutral option. Participants also had the option to select “don’t know,” “not applicable,” or “prefer not to answer.” Responses indicating “I don’t know,” “prefer not to answer,” “not applicable,” or that were missing from the survey were omitted. Total mean scores were computed for the two scales, with higher scores indicating an overall less positive experience/higher levels of stigma.

At the beginning of the survey, participants were asked to identify if they had visited the ED for concerns related to MH, PH, or both, and answered a series of demographic questions (age, sex, gender, ethnicity, and type of MH concern if applicable). For eight of the 31 items, participants were invited to provide written explanations for their responses, as a way to get additional details and context about participants’ experiences. The survey concluded by inviting participants to provide any additional comments they wished to share.

Data Analysis

Results were analyzed using the software NVivo for qualitative data and Statistical Package for the Social Sciences (SPSS) for quantitative data. The Braun and Clark (2006) six step method was used for qualitative analysis, consisting of: familiarizing oneself with the data, generating initial codes, searching for potential themes, reviewing and refining them, defining and naming the themes, and producing the report.

Results

Quantitative Results

A two-part survey was completed by 69 participants (See Table 1). The first part of the survey consisted of 23 items (SCHS) and the value for Cronbach’s Alpha for the survey was $\alpha = .95$. The second part of the survey consisted of seven items (SSMHCS – coercive care), and the value for Cronbach’s Alpha for the survey $\alpha = .88$. The eighth item about physical environment was not included in the quantitative analysis as it was originally part of a different subscale of the SSMHCS.

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Table 1

Survey Participant Demographics

May 31 – Aug 11 2023	*N*
Completed Survey	**69**
MH	27
PH	27
Both	15
Gender	
Woman	37
Man	29
Agender	1
Not listed/Prefer not to answer	2
Sex	
Female	36
Male	31
Intersex	1
Prefer not the answer	1
Ethnicity	
Indigenous	3
Visible Minority	18
White	45
Not listed/Prefer not to answer	3
Age	
Mean	38
Maximum	77
Minimum	18

Statistical Analysis

An independent samples *t*-test was performed to compare the effect of the reason for visit on the total score of the SCHS (23 questions) and the SSMHCS coercive care questions (seven questions). Participants who sought care for mental health concerns, or physical health and mental health concerns were grouped together and compared to those who sought care for solely physical health concerns. *t*-tests were performed for each scale. There was a statistically significant difference between groups on the SCHS, $t(67)=2.01$, $p=.048$. There was also a significant difference on the SSMHCS coercive care questions between MH/Both and PH patients, $t(66)=4.35$, $p<.001$ (See Table 2).

A *t*-test analysis was also conducted to test the difference in mean scores between sex assigned at birth and between genders. No significant differences were noted in the total average mean amongst specific demographics such as race and gender using a .05 significance level.

Qualitative Results

For eight of the 31 scale items, participants (*N*=69) were invited to provide written explanations for responses that were negative, "strongly disagree" or "disagree," to get additional details and context about participants' experiences.

The qualitative data were coded using NVivo 12 software, leading to the identification of several distinct themes. These themes included wait times, the dismissal of MH concerns and patient feedback, the physical environment, community resources, family members, inconsistency in the quality of care, staff attitudes, encroachment of protective services, and comparisons drawn with other EDs.

Wait Times

Delays in service were a prevalent issue independent of the reason for the visit, but particularly evident for individuals seeking care at the Emergency Department (ED) with MH-related needs. The subject of extended waiting periods emerged as a consistent pattern within this context. Those arriving at the ED with MH concerns frequently experienced prolonged wait times before receiving the necessary attention and treatment. Long wait times could be a result of structural stigma due to organizations not allocating enough resources to provide timely MH care.

Table 2

T-tests between Groups using Total Scores

	Group	*N*	Mean	Std. Deviation	p-value
SCHS	MH or MH and PH	41	58.10	15.99	.048
	PH only	28	50.02	16.98	
SSMHCS	MH or MH and PH	40	17.88	6.04	<.001*
	PH only	28	12.15	4.15	

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> "While the medical needs were met, I felt I was seen last in the group of those in triage." – MH/PH patient

> "I was in the ER for approx. 48 hours after attempting to take my life before being put in the mental health unit." – MH/PH patient

Dismissal of MH Concerns and Patient Feedback

Patients frequently encountered a distressing and disheartening pattern–a pervasive tendency among healthcare providers to overlook and downplay their legitimate MH concerns. This pattern could reflect underlying structural stigma cultivating interpersonal stigma.

> "I've never been treated like such a waste of space in my life. It was horrible and dehumanizing and traumatic on every level." – MH/PH patient

> "I felt that because the staff knew I was experiencing alcohol withdrawal symptoms, they didn't treat me with respect." – MH patient

> "I was being mocked for my actions, the way I tried to be heard. I had to almost beg for a cup of water." – MH/PH patient

> "I was looking for support and resources. I wasn't even listened to." – MH patient

> "I was simply reaching out for help, and I was pushed aside and treated like a criminal when I wasn't and never have been." – MH patient

> "I made a formal complaint to the patient feedback line about this whole experience, and no one ever followed up with me. Nothing was done." – MH/PH patient

Physical Environment

Several comments were made by both MH and PH participants about the physical layout of the emergency department, including the rooms described as "prison cells" and overcrowded waiting rooms. Participants also felt that seemingly no efforts had been made to improve the environment for patients. This theme highlights the organization's lack of focus on creating therapeutic environments for MH patients, which may be fostered by structural stigma.

> "Filthy… scratched up walls, badly torn and weathered furnishings, terrible recreation items…" – PH patient

> "I felt that being in the emergency room only exacerbated my state of psychosis, and I didn't start to properly recover until I was out." – MH patient

> "It felt cold and unwelcoming." – MH patient

> "I was here in 2003 and not much has changed!" – PH patient

Community Resources and Family Members

Participants expressed coming to the ED as a last resort because they exhausted all attempts to find assistance within their local communities. Frustrated by the lack of available support, they described a profound feeling of isolation and helplessness that ultimately drove them to seek help in the ED environment. This finding reveals a shortage of community mental health resources outside the ED, reflecting structural stigma.

> "I didn't have any resources in the community as my psychologist was off that week … the new psychiatrist that I was seeing had sent me to the ER in the first place." – MH/PH patient

Both MH and PH participants' desire to have their family members by their side (for support during medical interventions or decision-making) was consistently met with disregard and neglect. Despite expressing the vital role their loved ones played in their emotional well-being, their pleas went unheeded, leaving them to navigate challenging and unfamiliar situations alone, intensifying their feelings of vulnerability and isolation. The denial of familial support for participants reflects structural stigma, stemming from factors including a lack of clear policies allowing or encouraging family involvement.

> "I was not respected as my wishes to have a family member there to support me when I was confused and not fully conscious." – MH/PH patient

> "One of my needs was to have a family member there with me as I was unable to communicate effectively on my own upon presenting to the ER. They would not allow my family member to stay with me and only let them in after 3 hours." – MH/PH patient

Inconsistency in Quality of Care

Participants who had prior multiple admissions to the ED for MH concerns expressed frustration regarding the inconsistent quality of care that they received. This observation could be the consequence of a lack of standardized MH training, driven by structural stigma, leading to interpersonal stigma.

> "What's alarming to me is the incredible inconsistency in quality of care for mental health." – MH/PH patient

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> "At times I was treated very well and at times no one would check in on me for 6+ hours." – MH patient

Staff Attitudes

The inconsistent care for MH participants could be further attributed to healthcare provider attitudes. Participants described how some healthcare providers demonstrated qualities of compassion, authenticity, and a grasp of trauma-informed care principles, while others exhibited persistent stigmatizing attitudes. This finding also highlights the potential lack of standardized MH training, encouraging interpersonal stigma.

> "Some doctors and nurses seem to genuinely care, and others become extremely abrasive as soon as substance use is mentioned." – MH/PH patient

> "There was no respect or understanding or empathy from anyone in that visit, except the very first psych nurse that I interacted with." – MH/PH patient

> "The psych nurse believed me and gave me a glimmer of hope but the psychiatrists I interacted with told me that I was attention seeking and wasting their time." – MH/PH patient

> "Most of the negative interactions I experienced were from a singular nurse." - MH patient

Encroachment of Protective Services

A prevailing sense of unease was evoked by the presence of security personnel. Already grappling with the complexities of their MH concerns, some participants found themselves further stigmatized by the security personnel. This could be influenced by the stereotype that MH patients are violent. This observation underscores the absence of standardized mental health training.

> "There was a male guard outside my cell who sat and stared at me all night. I couldn't sleep because I was scared." – MH patient

> "The security constantly walking by and or posted outside my door, made me feel absolutely disrespected!!!" – MH patient

> "There was a lot of security at all times who had intimidating attitudes." – MH/PH patient

Comparison Drawn to Other EDs

Several participants drew parallels between their encounters at the selected ED research location and their experiences at various other primary care facilities for MH concerns. Within the narratives shared, participants rated the overall treatment they received as worse than those encountered at alternative sites, or classified all their encounters in the ED as negative. This highlights the presence of structural stigma resulting from the lack of standardized MH care across facilities.

> "I went to various ERs in 2022 from [May] until September 7…and was treated horribly every single time." – MH/PH patient

> "Emergency Psych at [research site] should have a physical layout like [a different hospital in Southern Alberta] where it has its own dedicated space with its dedicated nurses instead of sharing with the rest of emerge." – MH patient

> "They need to send all their staff to the [a different hospital in Southern Alberta] to see how it should be done. [I] presented there with the same concerns, was treated with care and respect by the nurses, doctors and psych emergency team [and] received a bed in CSU within 24 hours." – MH patient

Discussion

Our findings showed statistically significant results for both the SCHS and the SSMHCS, where patients visiting for MH or MH and PH concerns experienced more stigma than those visiting solely for PH concerns. Our findings emphasized concerns surrounding the extended wait periods endured by MH patients in comparison to other patients, when seeking essential treatment. Our results concerning wait times were consistent with findings from Dockery et al. (2015) who also found long wait times to be a significant barrier for those with mental illness seeking treatment. Consistent with other research, MH patients found themselves being dismissed and receiving substandard care because of their presenting concern (Biancarelli et al., 2019; Sheehan et al., 2017). Patients felt that they were not taken seriously, resulting in lower chances of having their needs addressed which was also recorded in Biancarelli et al.'s (2019) study. Furthermore, when patients in our current study tried to complain about the suboptimal treatment they were being provided, it was met with further dismissal.

Our results also highlighted the lack of autonomy provided to patients presenting with MH concerns. Neither their rights nor treatment plans were explained, which is contrary to the needs of these patients (Dixon et al., 2016). In comparison to those patients who presented with PH needs, patients with MH-related issues were not encouraged to participate in their own care. On the contrary, they were more likely to report being made to feel that their condition

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was their fault, even though some participants presented to ED as a last resort, after not being able to receive care within the community.

Resonating with findings from other studies, there was a higher likelihood of MH patients reporting instances of hearing derogatory language (Government of Canada, 2019). In general, they also found the space to be less comforting; notably the presence of security was said to be more intimidating. Similar to the findings of Guzmán et al. (2020), the physical environment of both the waiting room and hospital rooms themselves were described by many participants as severely untherapeutic. In particular, the MH rooms were described as despairing. Furthermore, when MH patients tried to bring in family members to support them, it was met with more resistance than for other patients.

On the flip side, not all encounters of MH patients were negative. However, numerous participants underscored the irregularity in the quality of MH care they received as a problem. In our findings as well as those of others, the attitudes of healthcare providers seemingly played a big role in how participants rated their quality of care and level of stigma experienced (Clarke et al., 2015). Certain participants compared the quality of care received at various local hospitals, rating care higher at other locations, while some participants described care to be poor at all locations.

Overall, treatment differences (i.e., wait times, dismissal, exclusion, and environment, etc.) between MH and PH groups may be the result of a variety of factors, such as inadequate staff or resource constraints. However, we believe such factors could be the result of structural stigma. The findings of this study largely paralleled those from the qualitative focus groups and interviews conducted in Phase One of the EMBER Study, which aimed to understand the key issues related to mental illness and substance use-related stigma in the ED (Smith et al. 2024).

Finally, to alleviate the stigma that people with mental illnesses encounter in the emergency department, our results suggested that a redesign of the department's organizational structure may be required. This redesign can be accomplished using strategies such as integrating MH specialists into emergency care teams, encouraging interdisciplinary teamwork, and implementing focused training programs for healthcare personnel to improve their understanding of MH. Furthermore, keeping in mind trauma-informed design principles for physical spaces as well as creating more efficient procedures for psychological evaluations, may foster a more encouraging atmosphere. With these changes, the ED can move toward a model of care that not only addresses people's urgent medical needs, but also promotes a kind and stigma-free approach to MH.

Limitations

A limitation of the current data is a nonrepresentative sample size; therefore, we were unable to compare stigma experiences with other populations. However, adhering to the same recruitment methods in the future will allow for a more representative analysis, enabling us to make such comparisons in the future. Data collection is still ongoing, and updated data analysis will be provided in the future. Both PH and MH qualitative responses in the survey tended to lean towards a negative tone, as qualitative options were only available for strong disagreements or disagreements with the presented statements.

Conclusion

Overall, our findings supported the presence of structural stigma, a culture that allows stigmatizing treatment of patients with mental illness and/or addictions to continue despite evidence of its existence. Interventions must address structural stigma to change ED culture and dismantle all manifestations of stigma. Structural changes to the emergency room culture and environment, such as renovating the layout and specific staff education for MH have potential to make a big difference on the stigma perceived by MH patients.

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