WHERE IS THE CLIENT IN CLIENT-CENTERED CARE? CENTERING THE EXPERIENCES OF INTEGRATED CARE AMONG BLACK AND HISPANIC WOMEN OF LOW-INCOME AND ECONOMICALLY MARGINALIZED BACKGROUNDS TO BETTER PROMOTE WELLNESS

by

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ABSTRACT

ANNALISE J. TOLLEY. Where is the Client in Client-Centered Care? Centering the Experiences of Integrated Care among Black and Hispanic Women of Low-Income and Economically Marginalized Backgrounds to Better Promote Wellness.
(Under the direction of DR. VICTORIA C. SCOTT)

While integrated care in public health settings may be important to promote health equity and to advance health outcomes within low-income and economically marginalized (LIEM) populations, implementation has not been well documented. And few studies have examined clients' integrated care experiences using qualitative or mixed-methods designs. This study sheds light on implementation considerations for integrated care in public health settings from the client perspective via two research questions: RQ1) How do Black and Hispanic women of LIEM backgrounds experience integrated behavioral health care in public health settings? RQ2) What natural supports do clients access to promote their wellness, and how might these be incorporated into integrated care models?

These research questions were explored using a mixed-methods design that integrated survey responses (n = 126) with in-depth interviews (n = 8) among ethnically and racially diverse women of LIEM backgrounds served by the public health department. Data analyses included descriptive and inferential statistics as well as interpretive phenomenological analysis IPA.

RQ1 results indicated clients across the public health department reported high satisfaction with overall and behavioral health-specific services and high perception of providers' cultural responsiveness. To better understand the experiences across screening, handoff, and consultation, IPA was conducted. While perceptions of a depression screener in public health were varied, honest responses were a matter of personal agency and were influenced by factors such as high mental health need, limited access to mental health services, being asked the questions at the right time, and being comfortable with the provider. After screening positive for depressive symptoms and being referred for a behavioral health consultation, two women reported “slipping through the cracks,” and multiple women described a desire for a warmer handoff. During the behavioral health consultation, women reported feeling “hopeful” that their health system sought to understand them holistically and tailored their services. Pregnant women in the sample especially appreciated behavioral health services during pregnancy, which made managing depression even more difficult. Follow-up interviews (n = 7) revealed that the majority of women did not ultimately make it to mental health services due to factors such as limited time, depressive symptoms, and communication mishaps.

RQ2 results indicated that women reported most frequently using supportive relationships (e.g., scheduled time with social circle) and relaxation activities (e.g., listening to music) to promote their wellness. Results indicated variability in natural supports access by race and ethnicity. In addition, results indicated that women reported being more likely to use and trust mental health services that incorporate their natural wellness supports.

The study findings indicated that client satisfaction is just one part of the client experience and is heavily influenced by care expectations. Over-reliance on client satisfaction quality improvement measures in health settings may be difficult to interpret. Results also highlighted the importance of person-centered care in shaping a high-quality integrated care experience. While there are several researcher-derived person-centered integrated care models, this study illustrated person-centered care from the clients’ perspectives. In their eyes, person-centered care (which is embedded within culturally-responsive health systems) is signaled by perceived abilities to a) seek to holistically understand the client and b) act

appropriately based on that understanding. Follow-up interviews revealed that clients who did not ultimately make it to mental health services continued to suffer from depressive symptoms, and that additional systemic support (such as follow up or on-site therapists) is required to ensure high-quality and equitable care.

This study underscored the importance of natural supports in promoting wellness among Black and Hispanic women. However, it also revealed that natural supports without health system support may be insufficient (and, in some cases, exacerbate mental health symptoms) among women living with mental health symptoms. Results also highlighted an opportunity to maximize utility and increase trust of mental health services: integrated care may incorporate natural wellness supports to better serve the whole person.

Given the in-depth interviews conducted, complemented by the survey, this study deepened an understanding of the integrated care client experience by amplifying client voices. Clients critiqued their experience and imagined how their integrated care experience could better meet their needs, thus their recommendations for practice improvement are discussed. In addition, the setting of this study–the public health department–sheds light on the generalizability of integrated care findings in new practice settings. Finally, this study illuminates the need for *person*-centered (rather than client-centered care) and illustrates how it may manifest in real-world settings.

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DEDICATIONS

I dedicate this thesis to my family. Thank you to my loving parents for supporting the theatre kid turned scientist. Your encouragement to take the road less traveled by has shaped my worldview and, consequently, my identity as an applied researcher. Thanks also to my older brother, who I've always deemed the "smart one." Your hard work and dedication to learning inspired me to apply myself in ways I never thought possible. I'm perennially grateful that I'm not the first born. I love you all immensely.

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CHAPTER 1: INTRODUCTION

1.1 Literature Review

Women, Black and Hispanic individuals, and individuals from low-income and economically marginalized (LIEM) backgrounds are often more likely to experience depression than men, white individuals, and those not from LIEM backgrounds (Banks & Kohn-Wood, 2002; Brody et al., 2018; Cook et al., 2017). When gender, race, and socioeconomic status intersect, the likelihood of experiencing depression increases further. For example, between 2013-2016, the average prevalence of depression among U.S. adults was 8.1% (Brody et al., 2018). However, when disaggregated by sex, women were almost twice as likely to experience depression as compared to their male counterparts (10.4% compared to 5.5%). The prevalence of depression was even higher among women with lower incomes, with almost 20% of women below the federal poverty line experiencing depression (Brody et al., 2018).

While Brody et. al's (2018) report did not consider the intersection of race and ethnicity, income, and depression, there are disproportionate numbers of Black and Hispanic individuals from LIEM backgrounds experiencing depression due to historical, structural, and social barriers that limit asset acquisition (Creamer et al., 2022; Ettman et al., 2020). Therefore, it is likely that LIEM status accounts for higher depression rates among Black and Hispanic populations as compared to white populations. A study by Ettman and colleagues (2020) found that non-Hispanic Black and Hispanic people had 1.8 greater odds of depression than non-Hispanic white people in the U.S. and that these greater odds were primarily explained by lack of assets.

In addition to the higher risk of depression faced by many Black and Hispanic women across the lifespan, these women are more likely to suffer from depression that is chronic and highly debilitating than their counterparts (Bailey et al., 2019). However, despite having the greatest need, they often face structural and psychological barriers to care (Bailey et al., 2019; Vyas et al., 2020), which likely contribute to higher rates of underutilization of mental health services among Black and Hispanic populations as compared to their white counterparts (Terlizzi & Schiller, 2022). Underutilization may also be exacerbated by LIEM status. For example, a study on a multiethnic cohort of perinatal Medicaid participants found that broadly, low-income and perinatal women were less likely to initiate mental health care for their postpartum depression (9%), but rates of initiation were particularly low for Black (4%) and Hispanic women (5%) (Kozhimannil et al., 2011).

1.1.1 Barriers to Mental Health Services

Underdiagnosis

To provide mental health services to women experiencing depression, their symptoms must be recognized. However, there are substantial differences in diagnosis based on race and ethnicity. A study conducted by Blue Cross Blue Shield determined that individuals in Black and Hispanic communities are underdiagnosed for major depression, respectively by 31% and 39% as compared to white communities (Blue Cross Blue Shield, 2022). These findings corroborate previous research by Stockdale and colleagues (2008). Using National Ambulatory Medical Care Study data to investigate diagnostic differences in depression based on race and ethnicity, their results indicated that Black and Hispanic individuals were underdiagnosed in primary care settings as compared to their white counterparts (Stockdale et al., 2008). One factor that likely contributes to the underdiagnosis of depression in communities of color includes the ethnocentric diagnostic methods pervasive in mental health settings in the U.S. (Bredström, 2019) despite different symptomatology across various races, ethnicities, and cultures (Assari & Lankarani, 2016; Bailey et al., 2019; Chentsova-Dutton et al., 2014; Karasz, 2005; Perez et al., 2022). These studies emphasize the need to consider how current diagnostic methods are stymieing the identification of Black and Hispanic women in need of mental health services, thus creating another significant barrier to receiving care.

Stigma

Stigma is often reported as a psychological barrier that contributes to the underutilization of mental health services among Black and Hispanic populations. In one study, perinatal Latina women reported dismissing symptoms of postpartum depression as a “Western Phenomenon” that would pass (Sampson et al., 2018a). Other studies have found that overcoming mental health stigma is a significant challenge for Black women seeking treatment for postpartum depression and that Black women who endorse the Strong Black Woman (SBW) Schema are more likely to experience depressive symptomatology due to self-silencing (Abrams et al., 2019; Bodnar-Deren et al., 2017; Givens et al., 2007). In sum, stigma is an additional barrier to both initiating and continuing care.

Inaccessibility of Mental Health Services

Reducing structural barriers to care may be one pathway toward counteracting psychological barriers in a client’s ongoing cost-benefit analysis to receiving care. Low-income individuals, who (due to social injustice) are disproportionately Black, Hispanic, and female in the U.S., experience more difficulty accessing mental health services despite having the greatest need (Wood et al., 2018). They face geographical, structural, historical, and social inequities–including lack of transportation, resource-constrained health systems, lack of insurance coverage, and limited mental health providers, all of which are more common in communities with greater populations of Black and Hispanic people (Caraballo et al., 2022; Cook et al., 2017; VanderWielen et al., 2015). For example, a study by VanderWielen and colleagues (2015) found that for every 10% increase in the Black population and 10% increase in the Hispanic population in a neighborhood, primary care centers were 6.5% and 8.5% (respectively) less likely to have geographically accessible behavioral health services. The geographical inaccessibility of behavioral health services was also exacerbated in communities with higher proportions of the population reporting being uninsured (VanderWielen et al., 2015).

Lower Quality Care

Even when accessible, mental health services provided to Black and Hispanic women from LIEM backgrounds are often inadequate. Research indicates that low-income, Black, and Hispanic populations receive lower quality health care than their higher-income and white counterparts (Anderson et al., 2009; Fiscella & Sanders, 2016; McGuire & Miranda, 2008; Robert Wood Johnson Foundation, 2014; E. Wang et al., 2021). This is true for general and mental healthcare (McGuire & Miranda, 2008; Stockdale et al., 2008). For example, in primary care settings, Black and Hispanic clients are less likely than white clients to be referred to resources and counseling services and less likely to be prescribed medication for depression, even when controlling for the physician-provided diagnosis (Stockdale et al., 2008).

Care is also inadequate if a provider or clinic is unable to cultivate a safe, equitable environment for clients to receive culturally-responsive services. Black and Hispanic women frequently experience discrimination in healthcare. A quarter of Latina women report being discriminated against due to their ethnicity when going to a doctor or health clinic, which is more frequently experienced than Latino men (Robert Wood Johnson Foundation et al., 2017). Black women also report medical mistrust due to stereotype threats and negative personal experiences with doctors, such as the doctor’s perceived reluctance to touch them due to their skin color (Gary et al., 2021). In addition, many Latina women fear seeking services due to their immigration status or fear of repeated institutional betrayal (McGarry et al., 2009; O'Mahen & Flynn, 2008; Sampson et al., 2018). These results indicate that many medical settings are not adequately conveying their status as a safe place and/or are not living up to their responsibility to provide high-quality, culturally-responsive care to all clients.

1.1.2 Alternative Services and Settings to Improve Mental Health Access and Utilization

In light of these barriers to high-quality, culturally-responsive care, the literature demonstrates that many Black and Hispanic women have developed natural supports to promote their wellness. For this study, non-medical practices, resources, and communities (e.g., religiosity, spirituality, prayer, familial support) that promote one's well-being are referred to as "natural supports." On average, Black and Hispanic women tend to utilize distinct supports to promote their mental wellness that include non-medical coping mechanisms (Abrams et al., 2019; Blue Cross Blue Shield, 2022; O'Mahen & Flynn, 2008; E. C. Ward et al., 2009). While practices differ, the comfort and accessibility provided by these supports (in stark juxtaposition to inadequate services in many medical settings) may explain why many Black and Hispanic women underutilize mental health services (Ai et al., 2012; Kozhimannil et al., 2011; Matthews & Hughes, 2001; Woods-Giscombe et al., 2016). For example, pre-existing protective factors such as resilience, strong family network, and religiosity have dissuaded some Hispanic women from obtaining mental health providers for their symptoms of postpartum depression (Callister et al., 2011). Additional studies report that Black participants communicated leaning primarily on support networks (i.e., friends, family), religious faith, and prayer, and only secondarily sought treatment from mental health professionals (Newhill & Harris, 2007; Ward et al., 2009; Ward & Heidrich, 2009).

While these natural supports are salient to promote wellness in the absence of high-quality, accessible mental health care, they may be insufficient. Therefore, in order to maximize the wellness-promoting impact of mental health services, interventions should leverage natural supports that exist in communities *and* address barriers to care. The simultaneous value and limitation of natural supports are captured in the following interview from a study on Black women's beliefs, coping behaviors, and barriers to mental health services conducted by Ward and Heidrich (2009):

> I was never able to get professional help, so I had to fight my way through. It can be a good thing in a way, but for most people, it's not good because everybody needs help. If they don't get some type of help, anything could happen. They could hurt themselves in a lot of ways, like committing suicide, and that's what professional help is out there for—to prevent that from happening. So I advise anybody, if they have a problem that can elevate, get help right away. Don't wait until something bad happens, or something tragic happens. (p. 10)

One mechanism to integrate natural supports and mental health services may be to build the natural supports that clients are already using in non-medical settings (e.g. family, religious congregation) into their official healthcare plans. This approach may reduce stigma in care-seeking behavior and better meet clients' needs in a culturally responsive manner but, to the author's knowledge, has yet to be studied.

1.1.3 Revolutionizing Healthcare: Integrated Care

Mental health care as it currently exists (in the context of diagnostic measures, stigma, accessibility, and quality of care) is not meeting the needs of those most in need. Therefore, we need to revolutionize the way we think about providing care. Only by changing the way that our healthcare systems operate will we be able to offer Black and Hispanic women of LIEM backgrounds additional support to optimize their wellness.

Integrated care emerges as an evidence-based approach to providing accessible, high quality, and culturally-responsive care. Unlike traditional, segmented models of care, integrated care aims to treat the whole person using coordinated services that can improve both mental and physical health outcomes (Bagalman et al., 2022; Butler et al., 2011; Curtis & Christian, 2012). According to the Agency for Healthcare Research and Quality, integrated care refers to a collaboration between primary care and behavioral health clinicians who work together to provide systematic, cost-effective, and client-centered care (Peek & National Integration Academy Council, 2013).

Defining Features of Integrated Care

Integrated care has defining features that make it different from the typical operations of the U.S. healthcare system, which tends to silo different services (Hajek, 2013; Sherry et al., 2016), invest more frequently in curative over preventive medicine (Jacques & Noël, 2022; Maciosek et al., 2010; F. Wang, 2018), and promote either protocol-driven or profit-driven care (Crowley et al., 2021; McKinlay & Stoeckle, 1988; Schroeder, 2003). Three of integrated care's defining features–holistic care and wellness, cultural responsiveness, and client-centered care–may be especially important to meet the mental health needs of Black and Hispanic women from LIEM backgrounds.

Holistic Care and Wellness. Integrated care seeks to provide holistic care that can improve overall client wellness. Wellness is defined as a "way of life oriented toward optimal health and well-being, in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community" and has been increasingly recognized as a cornerstone of health (Myers et al., 2004). The World Health Organization's definition of health–"a state of complete physical, mental and social well-being" (*Health and Well-Being*, n.d.)–embodies the spirit of wellness. This paradigm shift from health as a mere absence of disease or infirmity to one of wellness, requires health researchers to develop interventions that treat the whole person, not the disease.

When health services shift focus from the disease to the person, idiographic wellness promotion strategies become exceedingly important (Hayes, 2004). Therefore, speaking to integrated care clients about what natural supports (e.g. practices, resources, communities to support wellness) they currently employ is beneficial. By identifying these supports, they can be harnessed for health promotion and health equity efforts (Hayes, 2004). Thus, the identification and incorporation of natural supports into integrated care efforts should be investigated. This strategy may improve the utilization of services and enhance clients' perceptions of services as culturally-responsive.

Culturally-Responsive Care. Because integrated care efforts target holistic wellness and because wellness concerns individual and group differences, providing culturally-responsive care (which can better meet heterogeneous needs) is a defining feature of many integrated care models (Holden et al., 2014; Illes et al., 2015; Wrenn et al., 2017). According to Illes and colleagues (2015), culturally-responsive care is "the capacity to provide patient-centered care to patients despite differences in race/ethnicity, language, worldview, health beliefs, sexual orientation, religion, and a host of other individual, family, and social variables."[1] In short,

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[1] Cultural responsiveness is *conceptually* tantamount to cultural competence and cultural humility: a stance taken toward differences and a sensibility cultivated from life-long learning and unlearning (American Evaluation Association, 2011). However, cultural competence *in practice* has been critiqued for losing sight of its identity and instead becoming a checkbox whereby practitioners of the hegemonic group learn how to interact with "others" from the nondominant group. This misunderstanding of cultural competence has been critiqued for contributing to stereotyping. Cultural responsiveness is often used in the integrated care literature as opposed to cultural competence or humility. The word "responsive" itself seems to conjure up the original meaning of cultural

culturally responsive care values diversity and prioritizes adapting care to meet the unique needs of each client. It does not mean that clients should be labeled with identifiers by their providers; instead, it means that services should be personalized to ensure a high standard of care regardless of clients' cultural differences. When additional resources, referrals, and treatment options can accommodate the heterogeneous needs of clients, care may be perceived as more culturally responsive. In instances where culturally responsive care builds trust between the client and the provider, client experiences and outcomes are expected to improve (Cuevas et al., 2019; Pugh et al., 2021; Youssef et al., 2020). However, evidence demonstrating that culturally-responsive care improves client health outcomes is limited (McGregor et al., 2019), which is likely due to ineffective implementation (Hagiwara et al., 2020). Regardless, there is a plethora of evidence that a *lack* of culturally responsive care can lead to negative healthcare experiences (Mehra et al., 2020; Nguyen et al., 2022; Shepherd et al., 2018). Even with equivocal evidence related to outcomes, aiming to provide culturally-responsive care is likely to make clients feel seen and affirmed by their provider and healthcare services, particularly in instances of racially and ethnically discordant medical interactions (Penner et al., 2013).

Based on the theoretical and moral value of culturally-responsive care, many hypothetical models and considerations exist for culturally-responsive integrated care (Holden et al., 2014; Illes et al., 2015; Wrenn et al., 2017). However, very few studies ask clients whether their *actual* integrated care experiences were culturally responsive (De Los Santos, 2020; Wrenn et al., 2017). Because Black and Hispanic women often experience lower quality mental health care with a lack of culturally-responsive care as a documented factor (Holden et al., 2014; Newhill &

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competence: practitioners should demonstrate the humility to center their client and then adapt their services to the needs of the client.

Harris, 2007), concerted efforts should be made to understand these women's integrated care experiences and amplify their voices.

Client-Centered Care. In order to promote wellness and provide culturally-responsive care, it is necessary to center the client. Client-centered care empowers the client to be a stakeholder in their own treatment plan and tasks the provider to "know the patient as a person, in addition to accurately diagnosing their disease" (Epstein, 2000). Client-centered care is important to clients and can improve healthcare utilization and health outcomes (Doyle et al., 2013; Mastellos et al., 2014; Youssef et al., 2020). In addition, acknowledging, respecting, educating and empowering clients is intrinsically justice-oriented (Epstein & Steet, 2011). The intrinsic and practical value of client-centered care is likely why it has become pervasive in medical settings, including integrated care initiatives.

There are again many *hypothetical* client-centered models for integrated care (Berntsen et al., 2018; Framework on Integrated, People-Centered Health Services, 2016; Youssef et al., 2020), but in application, very few studies center feedback from clients about what factors could transform their integrated care experience. At the heart of client-centeredness is empowerment, but if clients are not given the chance to evaluate their own integrated care experiences, they are likely to be repeatedly subjected to care experiences that may not meet their needs. A study by Stoop and colleagues (2020) demonstrates the value of asking clients directly to assess their care. Across 13 integrated care sites in Europe, both service providers and clients reported whether service activities positively influenced person-centeredness. Results indicated a discrepancy between the service provider and client answers. Where providers believed that most activities had a positive influence, clients indicated that many activities did not have the intended impact (Stoop et al., 2020). Therefore, it is necessary to ask clients directly for their integrated care insights, as researchers and providers may have a different perspective of the ideal client experience as compared to clients.

This admonishment has been echoed amongst integrated care thought-leaders via editorials in the International Journal of Integrated Care. Augst (2022) forebodes: "integration without personalisation is useless at best, and dangerous at worst. We will only achieve the outcomes we claim to pursue through our integration efforts, if we start by asking people and communities what it is that matters to them." Goodwin and colleagues (2022) call for a major shift in care, whereby integrated care teams actively challenge power imbalances and promote autonomy in healthcare decision-making. They draw readers' attention to the handful of client-centered integrated care special issues that seem devoid of observations in practice (Goodwin et al., 2022).

Knowledge Gaps in the Integrated Care Literature

Few studies assess the effectiveness of integrated care through client-reported outcome and experience measures (Bandurska, 2023). This gap in the literature is further exacerbated when considering methodology. A systematic review conducted by Youssef and colleagues (2019) identified only 12 studies internationally that used mixed or qualitative methods to capture clients' perspectives of their integrated care experience. In the absence of mixed-methods and qualitative studies in the integrated care arena, clients continue to feel unheard despite the intent of many integrated care initiatives to be client-centered and culturally responsive.

Of the 12 international studies identified as using mixed or qualitative methods to capture clients' perspectives of their integrated care experience, only two U.S. studies sought to understand the integrated care experience of LIEM samples (Mead et al., 2014; Sheff et al., 2017), and only one U.S. study recruited a majority Black sample (Wrenn et al., 2017). An underrepresentation of people of color in integrated care studies has also been demonstrated in randomized controlled trial (RCT) studies on the efficacy of integrated care. A systematic review of integrated care studies between 2000-2015 revealed only seven RCTs with a majority of the sample representing people of color (Martinez et al., 2019). Of the studies, three demonstrated improved outcomes for people of color, but the small sample size indicates a serious limitation to the generalizability of integrated care mental health benefits and illuminates the need for additional research on samples from racially and ethnically diverse backgrounds. A summary of the relevant gaps in the integrated care literature is presented in Table 1.

Table 1

Summary Table of the Gaps in the Integrated Care Literature

	Content Area in Integrated Care Literature			
Paper	Patient-Reported Outcome/Experience Measures	Malady Assessed	Methodology	Sample
Bandurska et al., 2023	x	x		
Youssef et al., 2019	x		x	x
Martinez et al., 2019				x
Summary of Gaps in the Literature	Despite client-centered care being a defining feature of IC, few studies have actually asked clients to evaluate their IC experience	Of the 73 IC studies in the last 10-years that sought to evaluate IC via PROMs and PREMs, only 10 focused on IC initiatives treating depression	As of 2019, only 12 studies world-wide have used mixed or qualitative methods to ask the client to assess their IC experience	Despite the potential mental health benefit that IC provides for marginalized populations, few studies center these clients' experiences. Between 2000-2015, only 7 RCT had a majority BIPOC sample. Of the mixed and qualitative methods studies, only two U.S. studies recruited a primarily LIEM population

Note. Across the three papers core to the integrated care literature landscape germane to this study, four content areas were examined: patient-reported outcomes, malady assessed, methodology, and sample. This table summarizes the focus of each study and reflects gaps in the literature.

Integrated Care and Public Health

Integrated care was first conceptualized as behavioral health service delivery in primary care settings (Lewis & Myhra, 2017; Peek & National Integration Academy Council, 2013). However, due to the success of the approach, models of integrated care are being adapted to other health and human service settings in the U.S., including behavioral health clinics (Cahn et al., 2022; Errichetti et al., 2020; Ward & Druss, 2017), school-based health centers (Bains & Diallo, 2016; Jaure, 2022), and public health clinics (Coffman et al., 2020; Klawetter et al., 2021).

Public health clinics are key locations to integrate mental health services and may be uniquely suited to meet the mental health needs of populations with limited access to services. First, the demographics served by many public health clinics reflect those most in need of services but facing the greatest barriers to care, such as Black and Hispanic women from LIEM backgrounds. Public health clinics offer cost-effective and accessible care to the community to serve those who are without insurance, are underinsured, have Medicaid, or have Medicare. Locally, almost 50% of the population served by the health department identifies as Black, and almost 25% of the population identifies as Hispanic/Latinx.[2] Therefore, public health clinics may be optimal settings to meet the mental health needs of this population through integrated care.

Second, public health as a field is compatible with integrated care due to a shared emphasis on prevention and wellness. Unlike tertiary care models in the U.S., which seek to manage disease only after it has manifested, public health models center prevention and health

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[2] Based on data provided from the local public health department’s Senior Health Program Manager. Data is based on demographics of patients served in associated clinics between 2018-2021.

promotion. Therefore, public health clinics may be propitious sites for integrated care for the same reasons that primary care settings are. Further, an emphasis on prevention may better serve Black and Hispanic women of LIEM backgrounds. In a qualitative study by Newhill and Harris (2007), Black participants spoke about the "reactive rather than proactive" nature of mental health systems as a leading barrier to mental health care. Many reported the feeling of degrading themselves to "prove" they were mentally ill enough for treatment. A preventive approach to mental illness would help to mitigate this barrier.

Finally, public health clinics may uniquely meet the mental needs of the target population because of the field's focus on reducing health disparities by addressing social determinants of health. Social determinants of health are upstream factors often deemed the "root cause" of negative health outcomes. Identifying the upstream factors of mental health can provide alternative health promotion methods that a) may be viewed more favorably by the target population and b) may be more helpful for the target population. For example, taking medication may be viewed unfavorably by Black and Hispanic women as compared to white women (Cooper et al., 2003; Fernandez y Garcia et al., 2011; Givens et al., 2007; O'Mahen & Flynn, 2008; Sonik et al., 2020), yet medication is often the biggest defense against mental illness offered by primary care centers (Maust et al., 2017; Robinson et al., 2005). Public health clinics can take a different approach to behavioral health services by addressing social determinants of health (e.g., financial, physical, and social assets), which have been demonstrated to be related to the greater odds of depression among Black and Hispanic individuals before controlling for assets (Ettman et al., 2020).

Literature on Integrated Care and Public Health. Research investigating integrated behavioral health and public health services is scarce and requires greater examination. There appear to be very few published studies that describe integrated behavioral health services in public health clinics. A rapid systematic review of person-centered integrated care with a public health approach yielded no U.S. studies published between 2018-2020 (Burdett et al., 2021; Noor et al., 2023). While it is likely that integrated care in public health clinics is more frequent than what is reflected in the literature (Alkhomsan et al., 2023), this gap has significant implications for practice. Without the ability to study and learn from others, the implementation of new integrated care initiatives into public health clinics still feels largely uncharted and is prone to implementation challenges.

To the knowledge of the author, there are very few studies in the U.S. that specifically explore behavioral health services in Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) clinics (Coffman et al., 2020; Glaze et al., 2023; Klawetter et al., 2021; Scott et al., 2024). These studies reflect the existence of two known integrated behavioral health programs in WIC: one in Colorado and one locally, in North Carolina.

1.2 Integrated Care at the Local Public Health Department

Locally, a study conducted by Coffman and colleagues (2020) found that women served by the public health department WIC clinics screened positive for depressive symptoms in postpartum at a rate almost twice that of the national average (24% as compared to 14%; Coffman et al., 2020). This study precipitated what is now known as the Holistic Opportunity Program for Everyone (H.O.P.E.). H.O.P.E. provides infrastructure for WIC and Family Planning clinics to integrate mental health services into public health service delivery. H.O.P.E. has three key features: screening for depressive symptoms, consultation with a behavioral health provider, and referrals to community resources.

First, eligible clients are screened for depressive symptoms during their routine care visits using the Patient Health Questionnaire. Second, clients who indicate the presence of depressive symptoms (or who are identified using clinical judgment) are referred to the behavioral health provider for additional support. The behavioral health consultation is intended to identify the root cause of the client's depressive symptoms from a social determinants of health lens. Consultative services include active listening, helping clients apply to public services, and identifying community resources tailored to the client's needs. Third, clients are referred to community resources based on the consultation. These referrals may include low-cost therapy clinics, affordable child support options, breastfeeding consultations for new mothers, etc. The majority of clients are Black women and Hispanic women, all of whom are from LIEM backgrounds to qualify for services.

H.O.P.E. is in its third year of implementation. Presently, no studies have examined whether H.O.P.E. services provided have met clients' mental health needs. Learning about the experiences of H.O.P.E. clients can amplify the voices of Black and Hispanic women from LIEM backgrounds and drive program improvement in a way that promotes culturally responsive, client-centered care and advances clients' holistic wellness.

1.3 Current Study

This exploratory and descriptive mixed-methods study addressed the following gaps in the literature while simultaneously amplifying the voices of Black and Hispanic women from LIEM backgrounds.

1) Very few studies world-wide have sought to understand clients' integrated care experience using qualitative or mixed-methods designs, fewer have focused on the experiences of marginalized populations. This study used mixed-methods to better understand the integrated

care experience of Black and Hispanic women of LIEM backgrounds with a specific focus on culturally-responsive care.

2) Integrated care has traditionally been conceptualized as mental health services in primary care settings, but pioneer initiatives are piloting integrated care in public health settings. While it is likely that integrated care in public health clinics is more frequent than what is reflected in the literature, this gap has significant implications for practice. Thus, this study explored the client experience of integrated care in public health clinics.

3) Integrated care aims to promote holistic wellness, be client-centered, and be culturally responsive, but it has yet to fulfill this promise. To move toward client-driven care, it is important to personalize care, which may include asking clients what they need to promote their wellness, both inside the system (e.g., improvements to services offered) and outside the system (e.g., natural supports). This study invited clients to think critically about their care experience and to report what natural supports they are currently harnessing to promote their wellness outside of what exists in the public health department.

This study is guided by the following research questions:

RQ1) How do Black and Hispanic women from LIEM backgrounds experience behavioral health services in public health settings? The scope of this question included the experiences with the screener, the referral to the behavioral health provider, the consultation with the behavioral health provider, and the community resource referral agencies.

RQ2) What natural supports (i.e., communities, resources, and practices in non-medical settings) are women from LIEM backgrounds accessing to promote their wellness? The scope of this question also probed for insights related to integrating natural supports into behavioral health service delivery.

CHAPTER 2: POSITIONALITY STATEMENT

I am a community psychologist in training. Thus, values of social justice, empowerment, systems-change, and respect for diversity are core to my personal and professional life. As an applied researcher, I believe that the questions we are capable of asking, the methods to operationalize these questions, and the conclusions drawn are all bounded by our worldview. Thus, reflexivity and awareness of my own positionalities are critical, particularly for this study, which is imbued with critical theory (and thus the hope that results can drive more equitable systems change). There are a few particular positionalities that I believe I must reflect, as they both explicitly and implicitly affect my research design.

My education, socioeconomic status, and racial and ethnic identity are incongruent with many of the participants in my study, thus I tend to be more of an “outsider” in this research (as a white woman in graduate school raised in an upper-middle class family). Thus, I worry that my different life experiences may influence my interpretation of the data in a way that is not representative of my participants' lived truth. To increase accountability for and transparency in amplifying the voices of the “insiders, ” I believe strongly in the salience of participatory and idiographic methods.

In addition, I had not previously thought of my political commitments as a necessary part of my reflexivity practice until reading Ezzy (2002):

> Research always involves politics, and political issues. Research affects social policy, to varying degrees. Research also has political consequences for participants, and this is linked to considerations of rigor and ethics in research practice. (p. 53)

As a research assistant for H.O.P.E., I aim to collaboratively develop procedures and policies that support integrated care implementation, thus my research questions are heavily informed by my desire and position to influence organizational policy at the health department. In addition, I have a vested interest in the success of this program and the desire to see it benefit the clients served.

CHAPTER 3: METHODOLOGICAL ORIENTATION

The research questions of this study were answered using a mixed-methods design. Mixed-methods research was originally conceptualized as any study that involved at least one quantitative and one qualitative method to answer a research question (Greene et al., 1989), but over time the definition has evolved to instead conceptualize mixed methods research as a methodological orientation that blends both methodological approaches to inquiry throughout all stages of the scientific process (Tashakkori & Teddlie, 1998). Greene (2007, p. 200) has referred to mixed methods as “multiple ways of seeing” the social world.

Mixed-methods researchers must make two primary decisions regarding the integration of their methods: priority and sequence (Morgan, 1998). Priority refers to whether the primary paradigm of interest is quantitative, qualitative, or equal. This study was primarily qualitative but used quantitative methods to expand the utility and meaning of the results. Sequence refers to the sequence of quantitative and qualitative methods across methodological stages. This study employed a convergent design, whereby quantitative and qualitative data were collected concurrently. The quantitative analysis and qualitative analysis took place separately and results were integrated during interpretation.

3.1 Philosophy of Science

A priori consideration of philosophy of science (i.e., ontology, epistemology, axiology) is especially important for mixed methods researchers to ensure that quantitative and qualitative methods are integrated thoughtfully. Historically, quantitative research is assumed to be positivist while qualitative research is assumed to be phenomenological. Incompatibilists argue that the underlying epistemologies of quantitative and qualitative research are so different that they cannot be combined (Beach & Kaas, 2020). Mixed-methods researchers reject this dichotomy between quantitative and qualitative research and believe that in tandem, these methods can address complex research problems with sophistication and rigor (Bryman, 1984; Creswell & Plano Clark, 2017). However, epistemological consistency must be demonstrated throughout each stage of the scientific process (Bryman, 1984). The first step to ensuring consistency is to explicitly define the epistemology of the researcher and to frame procedures within this philosophy of science (Creswell & Plano Clark, 2017).

Epistemology: Social Constructivism

This study is situated within a social constructivist paradigm, meaning that multiple realities exist and are constructed by integrating social, cultural, and historical contexts (Bloomberg & Volpe, 2019; Creswell & Plano Clark, 2017). The central assumption of this philosophy of science is that individuals construct their realities and develop subjective meaning from personal experience, thus inquiry is "value-bound" (Bloomberg & Volpe, 2019). The researcher aims to put themselves in their participants' shoes to understand these values and multiple realities. This is in contrast to the postpositivist approach, by which there is one "true," value-free reality that can be identified through cause and effect (Bloomberg & Volpe, 2019; Creswell & Plano Clark, 2017).

Theoretical Orientation: Critical Phenomenology

There are various methodological "genres or traditions" that direct research design and methods (i.e., case study, ethnography, phenomenology, grounded theory, narrative inquiry, action research, and critical genres). This study uses phenomenology, developed by Edmund Husserl (Pietkiewicz & Smith, 2014). Phenomenology seeks to describe the meaning of a particular phenomenon and identify the "essence" of it (Bloomberg & Volpe, 2019; Starks &

Trinidad, 2007). The assumption of phenomenology is that the truth of the experience is "subjective and knowable only through embodied perception" (Starks & Trinidad, 2007).

Phenomenological research questions are intentionally broad for the following reasons. First, the more specific the research question, the more that the researcher's own bias limits the description of the experience. Open questions without formulated hypotheses promote inductive data collection and analysis, meaning that researchers build up to more generalizable theories of the essence of an experience without reification, a critique of postpositivism (Creswell & Plano Clark, 2017; Pietkiewicz & Smith, 2014). Second, this approach honors the participants' lived experiences by granting them the openness to describe their experience in a way that is consistent with their own worldview.

Two perspectives guide phenomenological research: eidetic and hermeneutical (Pietkiewicz & Smith, 2014). In the traditional, eidetic approach, researchers concern themselves only with description of phenomena. However, the hermeneutical approach (chosen for this study) elevates interpretation, arguing that in order to appropriately describe the research participants' experience, the researcher must comprehend their mindset in order to accurately translate their message:

> The concept is based on Hermes, the Greek mythological god of boundaries and of those who cross them, who is said to have translated the gods' messages for humans. To do so successfully, he had to understand both the language and the mind-set of the gods (so as to communicate the intended message). (Given, 2008)

Phenomenology became prominent in the health psychology discipline with the emergence of Interpretative Phenomenological Analysis (IPA; Smith, 1996, 2011; Yardley & Ussher, 1997). IPA was developed as a methodological approach to answer complex research questions within the field of health psychology, such as “how do gay men think about sex and sexuality” and “what forms of social support are helpful to people in pain” (Warwick et al., 2004; Yardley & Ussher, 1997). IPA is therefore suited to answer the RQ1 of the current study: “how do women from low-income and economically marginalized (LIEM) backgrounds experience behavioral health services in public health settings”?

There is scholarly debate around the practice of imbuing phenomenology with critical theory to create a philosophy of science known as critical phenomenology (Guenther, 2019; Mohr, 2014; Oksala, 2023). According to Guenther (2019), unlike classic phenomenology, critical phenomenology illuminates the “quasi-transcendental social structures that make our experience of the world possible and meaningful” for the purpose of social critique and liberation (p. 15). By seeing the essence of experience as influenced by the sociohistorical context in which perception is generated, Guenther deviates from the idea of one transcendental, shared consciousness that can be uncovered by bracketing away sociohistorical context. Instead, she pulls on Audre Lord’s poetry and describes the “quality of light” that “cannot be understood apart from one’s social location in a specific historical lifeworld” (p. 14). In plain terms, we become fluent in the language of our social world. To separate phenomenology from the existence of the social world would risk the interpretation and the utility of findings for social change.

This study employs a critical phenomenology, and the goal of this research is to produce meaningful social change. In this case, meaningful social change would manifest as improving the quality of care through the narratives of women belonging to racially marginalized groups with a history of oppression by healthcare systems. Therefore, aligned with Guenther (2019), I see a key part of the qualitative data analysis as “pulling up traces of a history that is not quite or no longer there— that has been rubbed out or consigned to invisibility— but still shapes the emergence of meaning" (p. 15).

3.2 Integrating Phenomenology and Quantitative Methods

Mixed methods are defined not by the existence of qualitative and quantitative methods in a study, but instead by the integration of these methods to leverage the strengths of each and protect against the limitations of each. For example, quantitative methods are often lauded as objective and generalizable, but are often critiqued for simplifying complex experiences through aggregation. Qualitative methods, on the other hand, tend to encourage the researcher to view social problems through the eyes of the participant. This is useful for providing a rich, nuanced narrative and unanticipated findings, but is often critiqued for having limited generalizability and being unsystematic. Integrating these methods can therefore leverage strengths and mitigate weaknesses.

Integrating phenomenological and quantitative methods has only recently been conceptualized (Mayoh & Onwuegbuzie, 2014), but there is justification to combine these methods and precedence to do so in health sciences and psychology. Mayoh and Onwuegbuzie (2014) argue that although unorthodox, phenomenological and quantitative research can be reconciled in a mixed-methods study and that phenomenology is uniquely suited to be compatible with more deductive, quantitative methods. Recent research by Martiny and colleagues (2021) supports this view. They emphasize that while phenomenology centers on the first-person narrative, it does not aim to develop a subjective account of a phenomenon. Instead, the field seeks to understand the interdependence between the reality of an experience and the subjectivity of consciousness.

Although mixed methods phenomenological research is still in development, there is evidence of an increase in its application, particularly in health sciences. A systematic review process was conducted in 2014 by Mayoh and Onwuegbuzie to identify mixed methods phenomenological research across 16 databases. They identified 24 empirical articles that met their inclusion criteria between 2003-2012, 70% of which were conducted within the field of health research for five different purposes: grounding (i.e., grounding quantitative data in the lived experience of participants), framing (i.e., using the strength of one methodological component to compensate for the limitations of another), orientating (i.e., utilitarian use of the alternative methodology to better focus phenomenology on a particular sample or relevant phenomenon), confirming (i.e., cross validating results from different methods measuring the same phenomenon), layering (i.e., multi-layered analysis in order to paint a clear picture of the phenomenon).[3]

Finally, while scant, mixed-methods, phenomenological research has made its way into the field of psychology (Mayoh & Onwuegbuzie, 2014; Martiny et al., 2021). Martiny and colleagues outline examples of mixed methods phenomenological research in health psychology and include suggestions and considerations to ensure methodological rigor.

3.3 Justification for Mixed Methods

This study is defined as mixed-methods, phenomenological research that is qualitative dominant, meaning that it relies on social constructivism while simultaneously recognizing the value of quantitative data to increase nuance and generalizability (Johnson et al., 2007). This approach was chosen based on the aims of the study: to better understand the integrated care

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[3] These five purposes are related to the five rationales of mixed methods as defined by Greene and colleagues (1989); however, they are adapted to mixed methods phenomenological research.

experience of women from marginalized backgrounds *and* to provide client-centered recommendations to improve their experience.

Centering the perspective of these women's interviews provided a rich understanding of their experiences. In addition, to move past exploration and toward description, this study used a survey as an alternative method that increased the utility of the results. Specifically, the survey a) provided a larger sample size than the interview, thus increasing generalizability and b) asks specific questions about constructs that emerged from the literature as central to positive integrated care experiences. By layering IPA results with the survey results, this mixed methods study produced powerful, client-centered narratives complemented by survey data that can guide recommendations for integrated care practice change.

CHAPTER 4: RESEARCH DESIGN

4.1 Ethical Approval

This study was approved by the Institutional Review Board of University of North Carolina at Charlotte (IRB Protocol #23-0238).

4.2 Setting

This study was conducted entirely online using Zoom and Qualtrics. Zoom is a virtual video platform and was used to conduct the interviews. Qualtrics is an online survey platform and was used to develop and administer the surveys.

4.3 Survey

4.3.1 Participants

Eligibility for survey participation included the following criteria: 18 and older; female; client at one of the five local public health department clinics that implement H.O.P.E.; received one or more H.O.P.E. services; can read, write, and speak in English or Spanish; any race or ethnicity. Exclusion criteria include anyone who does not identify as a woman because research questions are concerned with the experiences of women, consistent with the target population for H.O.P.E. services.

Recruitment

Recruitment for the study took place in the following formats: in-person by public health providers, through email and phone communication by the behavioral health provider (BHP), and in-person by research team members. All recruitment materials were available in both English and Spanish. Recruitment materials were translated by a translator employed by the public health department. They were then back translated by a bilingual student to ensure appropriate translation.

In-Person by Public Health Provider. After a visit that included H.O.P.E. service delivery, the provider (physician assistant, medical assistant, registered nurse, nurse practitioner, or nutritionist) provided the client with a printed flyer with a scannable QR code. The provider was given a script with suggested language to ensure that they are responsible only for distributing recruitment material and that any questions related to the specifics of the research would be directed to members of the research team. The QR code on the recruitment material directed patients to the survey. This recruitment strategy had minimal success.

Email/Phone by BHP. The BHP included a link to the survey in her email signature.. Thus, as part of routine email communication, clients saw the opportunity. In addition, using her discretion, the BHP communicated the opportunity to participate in the survey to clients with whom she spoke over the phone. For interested clients, the BHP connected them directly with the primary researcher via phone or email.

In-Person by Research Team. Members of the UNCC research team supported recruitment in-person by setting up a table in the clinic waiting rooms and asking clients if they were interested in participating. If they were, they were checked for eligibility, provided with the flyer, and prompted to scan the QR code. If they did not have the ability to take the survey using a smartphone, paper copies were provided (and later documented electronically by the researcher). Bilingual students were identified to support in-person recruitment among Spanish-speaking clients. In-person recruitment was the most successful modality and accounts for the majority of the sample.

Sampling

The study includes a non-probability, convenience sample of 126 survey respondents. Respondent demographics are available in the results section (Table 3).

4.3.2 Measures

All survey measures and questions were translated into Spanish by a professional translator employed by the public health department. Items were then back translated by a bilingual student, who provided additional changes to ensure a rigorous translation.

Screener Questions

To assess if clients were eligible for the survey, they were first asked screener questions related to age, gender, and H.O.P.E. services received.

Age. Potential participants were asked, “Are you 18 or older?” They could respond with “yes” or “no.” Those who selected no saw the following message: “Thank you for your interest in participating in this research study. At this time, you do not qualify for participation. You may exit this survey by closing this screen.”

Gender. Potential participants who were 18 or older were presented with the next question: “Which gender do you most identify with?” Clients who did not select “woman” saw the following: “Thank you for your interest in participating in this research study. At this time, you do not qualify for participation. You may exit this survey by closing this screen.”

Services Received. A final screening question was administered to the women of age: “Which of the following services did you receive? Please check all that apply.” Responses included: “My provider asked me questions about how I’ve been feeling recently, such as have I been feeling down, stressed, unhappy, hopeless, or depressed;” “My provider told me that I screened positive for depression and recommended that I talk to the social worker/behavioral health provider on staff;” “I met with the social worker/Behavioral Health in-person or on the phone;” and “none of the above.” Clients who selected “none of the above” saw the following:

"Thank you for your interest in participating in this research study. At this time, you do not qualify for participation. You may exit this survey by closing this screen."

Client Satisfaction

Two items assessed client satisfaction. One question is specific to H.O.P.E. services, and the other question is about the overall satisfaction with services. Respectively, the questions read: "Based on the services you checked above, how satisfied or dissatisfied are you with the mental wellness services that you received?"; "How satisfied or dissatisfied were you with the overall services you received while at the clinic?" Answers ranged on a 7-point Likert-type scale from strongly dissatisfied to strongly satisfied.

Demographics

Age. Participants were asked to indicate their age with the following: "Which range reflects your current age?" Answer choices included "18-24," "25-34," "35-44," "45-54," "55-64," and "65+."

Ethnicity. Ethnicity was assessed with the following "Do you identify as Hispanic/Latinx?" Respondents could answer yes or no.

Race. Race was assessed by prompting respondents to select all that apply to the following "Which of the following best describes your race?" The options included can be found in Appendix A and are consistent with the current racial categories recorded in the electronic medical records at the public health department.

Clinic of Services. The participants were asked where they received services with the following *"Which clinic did you access to receive services?"* The responses included the five public health department clinics participating in H.O.P.E.

Clients' Perceptions of Providers' Cultural Responsiveness

To assess clients' perceptions of cultural responsiveness, the Clients' Perceptions of Providers' Cultural Competency Instrument was used (Pacquiao et al., 2021). This scale centers the client experience rather than relying on the self-report of providers. The development of this scale was inspired by the work of Freire (1973) and rooted in values of community psychology, such as reflexivity, humility, empowerment, and centering the voices of marginalized individuals (Elias et al., 2015). The authors define cultural competence as "health care that empowers and respects individuals, families, and communities." They declare that "culturally competent care is experienced and perceived by the care recipient (individuals, families, and communities); thus evaluation of this care is best done by those who have direct experience with the care."

Pacquiao and colleagues (2021) drew items from emic care values identified by 23 distinct cultural groups and established content validity. Once care constructs were developed and compared to the work of other authors, they were quantitatively tested to assess construct and criterion validity and deemed appropriate. Questions are asked about the "provider(s)", thus clients are asked to answer these questions one time considering all of the providers they have seen associated with H.O.P.E. services (from screening, to referral, to consultation).

The final scale includes three constructs–promotes supportive and meaningful interactions, promotes connection with others, acts on behalf of others–and 22 items (omnibus α = .89; Pacquiao et al., 2021). Respectively, sample items include: "I was understood and comforted after speaking with my provider(s)"; "My provider understood my needs"; "I was connected with resources available in my community."

Partial scales were used for each construct to reduce response burden. Items included in the partial scales were chosen by considering the following: eigenvalues and relevance to the research questions. For example, the original subscale for the construct "acts on behalf of others" includes four total questions, but only two were included in this study. One question was chosen because it is the item with the highest factor loading (re: “Other people I consider important participated in my care”, eigenvalue = .91; Pacquiao et al., 2021). The other item was chosen because the information provided is most pertinent to the study. For example, the item “I was connected with resources (e.g. health information, support, services, etc.) available in my community” (eigenvalue = .63; Pacquiao et al., 2021) speaks directly to one of the services offered by H.O.P.E.: referral to community resources. Further details about scale items are included in Appendix A.

Natural Supports to Promote Wellness

To identify natural supports related to wellness that women already have in place, the Mindful Self-Care Scale was used (Cook-Cottone & Guyker, 2018). The Mindful Self-Care Scale (omnibus α = .89) is a psychometrically validated instrument that asks respondents to report the frequency of their behavior in the last week with the following guidelines: never (0 days), rarely (1 day) sometimes (2 to 3 days), often (4 to 5 days), and regularly (6 to 7 days) (Cook-Cottone & Guyker, 2018). It has six subscales that emerged from factor analysis. To reduce response burden, subscales were not used if they did not seem to provide meaningful data to improve behavioral health interventions in the current setting. For example, the Supportive Structure subscale includes items related to a healthy balance between work and rest. This was excluded because work-life balance is outside of the scope of the work done at the public health department clinics by behavioral health providers.

The Supportive Relationships (5-item; α = .86) and Mindful Relaxation (6-item; α = .77) subscales were used in their entirety. Sample questions include “I spent time with people who are good to me (e.g., support, encourage, and believe in me,” and “I did something creative to relax (e.g., drew, played instrument, wrote creatively, sang, organized),” respectively. Three of eight items were included from the Physical Care Scale: the items relating to exercising daily, taking part in physical activities (including dance and sports), and taking part in yoga or other mind/body practices. The other items are related to nutrition. These items were excluded because this study seeks to identify natural supports that may inform new care recommendations offered by the behavioral health providers. Nutritional recommendations are outside of the purview of the behavioral health providers in WIC settings because nutritional supports are provided by the nutritionists.

Incorporating Natural Supports into Mental Health Services. The survey included two additional questions to probe the value of integrating natural supports into behavioral health service delivery. “If my care included more of the resources, communities, and practices I indicated above, I would be more likely to <u>trust</u> the mental wellness services offered” and “if my care included more of the resources, communities, and practices I indicated above, I would be more likely to <u>use</u> the mental wellness services offered.” Answers on a 5-point Likert scale ranged from “strongly disagree” to “strongly agree.”

4.3.3 Procedure

The study was conducted online using Qualtrics. After eligibility was established, participants were prompted to provide consent for participation in the survey study. To maintain confidentiality, a signature was waived. The survey took most respondents between 5-10 minutes to complete. Eligible respondents were only permitted to take the survey once.

After all questions were answered, participants were asked to enter their contact information to receive the gift card. They saw the following thank you message:

> Thank you for your participation. The primary researcher will email you your electronic $10 Amazon gift card in the next 72 hours. To ensure you receive your gift card, please enter in the following information, which will not be shared with anyone beyond the primary researcher. When data collection closes, data will be deidentified.

Finally, participants were asked to indicate if they would like to be contacted with more information about serving on a patient advisory board if the opportunity became available. In-person recruits received their gift card immediately. For those who completed the survey independently, the primary researcher aimed to distribute the gift card within 72 hours.

Data Management

Data was kept confidential. Participants had the option to provide their name and email address to receive an electronic gift card for their participation. However, identifying information was removed after the data were downloaded.

For those who indicated that they would like to be contacted regarding information about serving on a client advisory board should the opportunity become available, their contact information was stored for a future study in a password-protected file on the UNC Charlotte Google Drive. If their information is not used within two years, it will be permanently deleted.

4.3.4 Data Analysis

The survey data were downloaded from Qualtrics into Microsoft Excel. Descriptive and inferential statistics were calculated in Excel. To report on sample characteristics, frequencies were calculated to convert into a percentage of the sample for the following demographics: language of survey response, age, race, ethnicity, site of services, services received.

For Likert-type questions, the mean, standard deviation, and range were calculated and, when applicable, calculated for the aggregate subscale scores (e.g., all items pertaining to the

Mindful Self-Care subscale of "relaxation" were aggregated to calculate the aggregate mean, standard deviation).

Yes/no questions were coded as 1/0, respectively. For each subscale (e.g., Promotes Supportive and Meaningful Interactions within the Clients' Perceptions of Providers' Cultural Competency Scale) the yes answers were summed and the average and standard deviation were calculated. The same procedure was performed for the overall CPPCC scale. The overall CPCC scores were calculated for the total sample and scores were compared between the leading racial and ethnic groups represented in the sample (i.e., Hispanic, Black, white).

To determine if there was a significant difference in how respondents rated satisfaction of H.O.P.E. services versus overall services, a two-way, paired t-test was conducted. In addition, to describe the shared variance in scores, a Pearson's Correlation was conducted. This process was also performed on the subset of survey respondents who reported receiving a consult with the behavioral health provider ($n = 28$).

The same procedure was performed to determine if there was a significant difference in how respondents rated whether integration of natural supports into their care would increase "use" versus "trust" of services. This process was also performed on the subset of survey respondents who reported receiving a consult with the behavioral health provider ($n = 28$).

Finally, as an exploratory descriptive statistic, a Pearson's correlation between satisfaction with services and perceived cultural competency was conducted.

4.4 Interview

4.4.1 Participants

Interview eligibility criteria were more narrow than those of the survey. Participants indicated that they a) consulted with the behavioral health provider and b) identified as Black.

There were multiple reasons for narrowing the scope of the interview sample. First (according to descriptive statistics run on H.O.P.E. clients between June 2021 and October 2023) 63% clients identify as Black. Therefore, the voices of Black women and their suggestions for practice change should be amplified. Second, research supports that Black women have higher rates of perinatal depression but lower access to support (Guintivano et al., 2018; Shepherd et al., 2018; Suglia et al., 2011; Taylor, 2020; Wood et al., 2018). Because this study aims to improve the support that is offered by H.O.P.E. services, it makes sense to solicit feedback from the women most in-need of mental health support and with the most barriers to care. Third, this study explores which natural wellness supports women are using, including a cursory exploration of the feasibility of incorporating these natural supports into H.O.P.E. Research shows that Black women have unique barriers to seeking treatment (Bodnar-Deren et al., 2017; Givens et al., 2007; O'Mahen & Flynn, 2008) and unique practices to support their wellness as compared to other racial and ethnic groups (Amankwaa, 2003; Sampson et al., 2018). Therefore, the survey asked all women about the natural supports they access, and the interview sought to co-imagine what it may look like to integrate culturally responsive natural supports into H.O.P.E. that reflect the preferences of Black women, the majority of the clientele.

Sampling

Using purposive sampling, a sample of eight Black women were recruited for the interview in accordance with the standards of Interpretive Phenomenological Analysis (IPA) and recommendations for doctoral-level student studies (Pietkiewicz & Smith, 2014; Smith et al., 2009; Smith & Osborn, 2007). This resulted in a smaller, more homogenous group for whom the research question was germane. A smaller sample size not only increases the quality of phenomenological methods, as found in a systematic review conducted by Bartholomew and colleagues (2021), but also allows for the voices of the participants to be adequately presented in results (Smith, 2011).

This purposive homogeneous sampling followed the guidance of IPA founder Jonathan Smith (Smith et al., 2022). Importantly, Smith cautioned that this sampling method should not be misunderstood as seeing group-members as monolithic: “Quite the contrary, by making the group as uniform as possible according to more obvious social factors, or other theoretical factors relevant to the study, one can then examine in detail other forms of variability within the group" (Smith et al., 2022, p. 44).

Recruitment

Eligible interview participants were identified one of two ways: by the survey or by the behavioral health provider.

Survey. Women who took the survey and indicated that they consulted with the behavioral health provider and identified as Black received an additional prompt at the end of their survey: “Based on your survey responses, you may be eligible to participate in a virtual, 60-minute interview for an additional $50. Would you like to be contacted to learn more?” Participants who selected “yes” were prompted to enter their phone number. The primary researcher first attempted to contact them through the email address provided. In instances where the email was unfruitful, the prospective participant was contacted via phone. The primary researcher worked with participants to identify an interview time.

Behavioral health provider. The behavioral health provider also assisted with interview recruitment. In her email signature, an interview interest link was included with the text: “Receive $50 Amazon gift card for interview. If you identify as a Black/African American woman, you are eligible. Please click here.” The link directed clients to provide their contact information, who were then contacted by the primary researcher. Based on the provider's own capacity and clinical discretion, some clients were also asked directly at the end of their consultation if they were interested in sharing more about their experience via an interview. In these instances, clients who expressed interest were connected with the primary researcher via the behavioral health provider by email or phone.

4.4.2 Procedure

Primary Interview

Once the participants were scheduled for an interview, they were emailed an informed consent form through DocuSign. This consent form (Appendix F) informed participants that their responses would remain confidential and would not influence the care that they receive at the public health department in any way. They were also informed that they were still entitled to compensation if they declined to answer any specific interview questions. After consent was received, the interview was conducted using a semi-structured interview guide (Appendix C). Before beginning, the interviewer asked the participant for explicit consent to record the interview, which was used to create an audio file for transcription purposes. The duration of the interviews ranged from 50-90 minutes and were conducted by the primary researcher on Zoom.

A semi-structured interview allows researchers and participants to engage in dialogue and to explore topics as they emerge (Lindlof & Taylor, 2017; Morse & Richards, 2002). In addition, it allows interviewers to ask questions out of order to ensure that the conversation flows naturally (Morse & Richards, 2002). There were a total of nine core questions with additional probing questions if necessary to prompt deeper answers. For example, one question reads, "Can you tell me more about your visit with [BHP's name]?" If not addressed in the initial response, follow-up questions include "what did you gain" and "what suggestions do you have for improvement?"

Consistent with the social constructivist approach, the semi-structured interview can evolve throughout the process to ensure that research questions are addressed and domains of inquiry are adequately explored (Creswell & Plano Clark, 2017). The interview guide was designed to assess the following domains: 1) experience with the screening process; 2) experience with the referral process; 3) experience with the behavioral health provider; 4) experience accessing resources provided by the behavioral health provider; 5) integrating natural supports to promote wellness, and 6) barriers to care. Respectively, sample questions include the following: “How did it make you feel to be asked mental health questions while receiving services?”; “Based on your responses to how you’ve been feeling, your provider may have recommended that you talk to the social worker/behavioral health provider on staff. How did the conversation go?”; “In three words, how would you describe your experience with the social worker (behavioral health provider)?”; “Were you able to access the community resources that you were referred to? What did you gain?”; “Based on the practices, resources, and communities you just described, how would you recommend incorporating these practices into your treatment plan?”; “What is the biggest barrier to accessing mental health care in your community?” After the interview was completed, the researcher confirmed the participant’s email on file and distributed an electronic $50 amazon gift card.

Follow-Up Interview

To augment the depth of the data and to increase the reliability of the data, follow-up interviews were conducted with participants based on participant interest and availability. They were compensated with an additional $10 Amazon gift card. The follow-up interview was unstructured, though it lightly followed an outline: the researcher listened back to the participant’s original interviews, wrote down the services that they were referred to, and met with clients to meet the following objectives: a) to determine if the clients accessed the services they were referred to; b) to discuss the factors that contributed to their accessing or not accessing the services; c) to ask if, now that time had elapsed, they thought that speaking with the behavioral health provider was beneficial.

Member Checks

After preliminary qualitative analysis was finished, interview participants were invited to participate in a process known as member checks. Member checks invite participants to check that the personal experiential themes adequately describe their experiences (Kloos et al., 2021). Member checking took place via a 20-minute one-on-one zoom session.

Participants who elected to provide additional feedback on the codes through the member check process were compensated with a $10 amazon gift card for a total possible compensation of $70 ($50 from the interview, $10 from the follow-up interview, $10 from member check). If in addition to the interviews and member check they participated in the survey, their total compensation amounted to $80. These gift cards were distributed by way of email.

Data Management

After the individual interview concluded, Zoom exported the recording to the primary researcher’s computer as two separate files: an audio file (m4a) and a video file (mp4). The video file was deleted and the audio file was used for transcription. Audio recordings were saved in the university’s password-protected Zoom account.

A separate, password-protected master list that links the participant name to the participant ID was stored in the university Google Drive. Sample quotes were reported with pseudonyms.

A separate, password-protected file including the participants' contact information was used to schedule interviews, provide the gift card over email, and to invite participants for a member check. After the study is concluded, this information will be permanently deleted.

4.4.3 Data Analysis

The audio files were transcribed verbatim using Otter.ai. After the initial transcription, the primary researcher listened again to the interview recording to audit the transcription quality and make necessary adjustments. Any identifiable information was redacted from the interview transcriptions.

To analyze the data, Interpretive Phenomenological Analysis (IPA) was used according to Smith and colleagues (2022) seven-step, systematic approach: 1) read and re-read; 2) exploratory noting; 3) experiential statements; 4) connections across experiential statements; 5) personal experiential themes; 6) steps 1-5 for subsequent cases; 7) group experiential themes.

Step one includes reading and re-reading one case at a time. This step requires the researcher to slow down while getting familiar with the data. During this step, the primary researcher kept track of initial reflections in a journal that may be relevant to the greater sense-making but should not be in the analysis. The reflections tended to be more process-oriented. For example, in the first interview, before asking about the participant's experience with the behavioral health provider, the researcher said, "Oh, I love her; she's great." This could have influenced the participant's willingness to share critiques of the behavioral health provider.

Step two consists of exploratory noting, whereby the researcher remains open-minded and adds notes about what is interesting and emerging. During this phase, the comments are closely rooted to the text and tend to be more descriptive. The researcher keeps an eye towards that which matters to the participant and their sensemaking of the lifeworld and makes preliminary interpretive noting (e.g., noting tone shifts, emotional words, abstract concepts). While this is not prescribed by Smith and colleagues (2022), the primary researcher of this study used in vivo coding (i.e., the participant's own words) wherever possible to retain participant voice and to ensure interpretation did not stray too far from the original text. In addition, the researcher kept an eye towards disproving preconceived notions, uncovering complex truths, and recognizing contradictions during this step. While developing exploratory notes, the researcher kept the research questions in mind, which shaped the terminology in some of the exploratory notes. For example, one participant noted "my therapist says in order for you to continue to heal, it has to be consistent. And I'm missing the consistency." The associated exploratory note was "both client and therapist worried about barriers to continuity of care." "Consistency" was translated to "continuity of care" in accordance with key integrated care terminology.

Step three involves constructing experiential statements. The goal of this step is to reduce the volume of the exploratory comments made in step two while still maintaining the complexity of the narrative. During this step, the researcher moves away from the participant's own description and closer to interpretation. This is why the primary researcher included in vivo codes, so that when developing experiential statements, interpretation was still shaped by the participant's own words. However, at this stage, the primary researcher's own experience with the lifeworld begins to play a role in analysis (re: 'the you').

> However, 'the you' here is closely involved with the lived experiences of the participant – and the resulting analysis will be a product of both of your collaborative efforts. (Smith et al., 2022, p. 87)

This step leads to more polished and analytical statements than are produced in step two.

Step four requires the researcher to search for connections across experiential statements and then to map how the statements fit together. Not all statements are included. There are different approaches to this step, some more tactile than others. The primary researcher opted for the electronic version proposed by Smith and colleagues (2022), whereby she copy and pasted the experiential statements into a blank word document and scrambled them up. Then, using intuition, experiential statements that are similar were grouped together. This step is more inductive than other analytic techniques, which may begin by identifying emergent themes and then choosing instances in the text that match these themes. By allowing the experiential statements to guide the researcher before "naming" the categories, this gives all experiential statements equal weight.

Step five requires naming the clusters, which may include both main themes and subthemes. These themes are known as personal experiential themes (PETs) in IPA. PETs are different from experiential statements in that themes transcend any particular section in the narrative.

Step six repeats steps one through five on subsequent cases.

Step seven tasks the researcher with creating Group Experiential Themes (GETs) by looking across the PETs. At this stage, both similarities and differences are identified.

> Remember, within IPA we are not trying to present a kind of 'group norm' or 'average' of the experience we are investigating. Instead, within cross-case analysis, we are trying to highlight the shared and unique features of the experience across the contributing participants. We want to understand and explore points of convergence and divergence at the level of the contributing cases (Smith et al., 2022, p. 100).

While the researcher does not attempt to aggregate the experiences at the cost of honoring individual differences, they do search for shared elements of the experience across participants. The GETs speak more to the "essence" of the experience, whereby the PETs that illustrate the GET highlighted how this essence may manifest differently between participants.

4.5 Data Analysis Integration

The quantitative and qualitative methods outlined above were analyzed separately and then integrated to develop a shared interpretation of the data. This integration led to richer answers to the research questions (Table 2). For example, the first research question pertains to the experience of Black and Hispanic women from LIEM backgrounds. The interview was semi-structured, so (unlike the survey) clients have the time and space to construct their experience with the researcher and bring up any themes without being limited by the worldview of the researcher. These interviews aided in the construction of a nuanced, "thick" description of the client experience. However, interviews also have their limitations, such as smaller sample sizes with a larger breadth of emergent insights. The purpose of this study is not only to understand the client experience and to amplify client voices, but also to make recommendations that can improve the future client experience with H.O.P.E. Therefore, it is also beneficial to solicit the clients' perceptions of particular components of their care experience, which is made possible with the survey in this study. For example, asking specifically about clients' perceptions of culturally-responsive care.

Table 2

Summary Table: How Methods Were Integrated

Research Question	Constructs to Measure	Data Collection Approach	Sample Question
How do women from LIEM backgrounds experience behavioral health services in public health settings?	1. Client Experience with a) screening, b) referral, c) consultation with BHP	Interview a) screening (Core *n* = 1; F/u *n* = 2) b) referral (Core *n* = 1; F/u *n* = 1) c) consultation (Core *n* = 3; F/u *n* = 3)	"In three words, how would you describe your experience with the social worker/ behavioral health provider?" (re: consultation question)
	2. Client Satisfaction	Survey (*n* = 2) a) general satisfaction b) satisfaction with H.O.P.E.-specific services	"Based on the services you checked above, how satisfied or dissatisfied are you with the mental wellness services that you received?"
	3. Perception of Cultural Responsiveness	Clients' Perception of Providers' Cultural Competency (Pacquiao et al., 2020) (*n* = 14)	"I received care that fit my beliefs, work, and family"
What natural supports (i.e., communities, resources, and practices in non-medical settings) are women from LIEM backgrounds accessing to promote their wellness?	1. Natural supports	Mindful Self-Care Scale (Cook-Cottone & Guyker, 2013) (*n* = 14)	"I did something creative to relax (e.g., drew, played an instrument, wrote creatively, sang, organized)."
		Interview (*n* = 1)	"What do you do to keep yourself well?"
	2. Potential value of integrating natural supports into the care plan?	Survey (*n* = 2)	"If my care included more of the resources, communities, and practices I indicated above, I would be more likely to trust the mental wellness services offered."
		Interview (Core *n* = 1; F/u *n* = 1)	"How would you recommend incorporating these practices, resources, and communities into your treatment plan? (f/u) How might your recommendations improve your overall healthcare experience?"

4.6 Quality and Rigor

Several methodological elements were incorporated to enhance the study's integrity. The appropriate criteria to evaluate mixed-methods research is variable and difficult to determine (Onwuegbuzie & Johnson, 2006). Some argue that mixed-methods research needs its own criteria while others advocate for assessing the quantitative components of the study for internal and external validity and the qualitative components for credibility, dependability, confirmability, and transferability. O'Cathain and colleagues (2008) deviated from this granular approach by proposing the Good Reporting of a Mixed Methods Study (GRAMMS) method to assess the broad quality of mixed methods research in health services. There are six items in GRAMMS: 1) justify the use of mixed methods; 2) describe the mixed-methods design; 3) detail the sampling, data collection, and analysis; 4) explicate the integration of quantitative and qualitative methods; 5) address limitations; 6) provide insights. How this study addresses items one through four is detailed in the introduction and methods sections. Five and six are detailed in the discussion section.

In addition to using GRAMMS, this study used distinct methodological criteria to ensure the trustworthiness of IPA (Smith, 2011). The four criteria are as follows: 1) the researcher must subscribe to all theoretical principles of IPA: phenomenological (i.e., determine the unique essence of a phenomenon from the perspectives of the individuals), hermeneutic (i.e., interpret perspectives as appropriate to ensure the essence is translated into the description), and idiographic (i.e., explore every single case before producing generalizations) (Pietkiewicz & Smith, 2014; Smith, 2011); 2) methods must be transparently reported; 3) analysis must be sufficiently coherent and interesting; 4) there is sufficient sampling to show density of evidence for each theme, meaning that there must be at least three participants for each theme (Smith, 2011).

1) This study demonstrates its commitment to phenomenology with its first research question, which seeks to determine the essence of experiencing behavioral health services in public health settings among women of marginalized backgrounds.

The interviews were translated verbatim; however, to ensure that the analysis was hermeneutic, the primary researcher made note of not only what participants *said*, but also interpreted what was *meant.* To ensure trustworthiness, the researcher kept detailed notes of all seven steps of IPA, which allowed for auditing as necessary. In addition, the primary researcher used a common analytical practice known as "bracketing," whereby the researcher aims to make explicit their own perceptions so as to divorce themselves from them and increase the validity of the study (Chan et al., 2015; Moustakas, 1994). Finally, the purpose of interpreting responses is to translate the essence of the phenomenon appropriately. By employing member checks, whereby participants were invited to confirm that codes do reflect the essence of their experience, this increased the credibility of the study.

To ensure that the study was idiographic, analysis was conducted on each interviewee separately before making any comparisons between interviews. In addition, quantitative analysis was conducted separately to ensure that it does not influence the interpretation of the interviews.

2) To ensure transparency, methods were reported using the guidance of GRAMMS.

3) To ensure that results were compelling and coherent, the seven-step, systematic approach proposed by Smith and colleagues (2022) was used. In addition, to meet standards of rigor, an IPA expert was asked to closely review the pilot Personal Experiential Themes developed for participant one. Feedback was provided and the analysis was completed again

from scratch to ensure it was up to par. The revision was approved and the researcher completed the analyses for the remaining seven participants. Finally, after the Group Experiential Themes were developed, the IPA expert again reviewed and provided feedback.

4) To ensure adequate density of data for Group Experiential Themes, the study recruited eight women. All of the Group Experiential Themes are supported by data from at least three participants.

This study also employed a survey. When drawing conclusions from survey data, ensuring that constructs are well operationalized was key. The constructs in this study (i.e. client satisfaction, cultural competency, and wellness practices) are measured using pre-existing scales with evidence that supports their reliability and validity.

To improve external validity, or the degree to which the results can be generalized to the larger population of interest, the survey sample pooled more H.O.P.E. clients than those participating in the interview. In addition, women were recruited from multiple sites to improve external validity. Unfortunately, due to external factors (i.e., site construction), recruitment was limited largely to one geographic location. However, women from both WIC and Family Planning clinics are represented in the study, thus improving the generalization of these results across public health clinic settings.

CHAPTER 5: RESULTS

5.1 Respondent Characteristics

The survey was distributed between May 2023 through January 2024. One hundred and thirty four women began the survey, with 128 finishing it (96% completion rate). Two respondents were deleted in a listwise fashion due to respondent errors. One respondent answered twice, so only the first response was retained. The other respondent answered A for every question and finished far quicker than the average response time. Since it was assumed that she did not read each question, undermining the validity of the data, she was removed.

The majority of respondents were aged 25-34, were non-Hispanic, were Black, and received services at Northwest public health clinics[4] (Table 3). The racial and ethnic demographics of the sample in the study closely reflect the racial and ethnic demographics of H.O.P.E. clients served across the public health department. From demographic data provided by the public health department between June of 2021 and October of 2023, 25% of all H.O.P.E. clients identified as Hispanic (compared to 31% in this study); 63% identified as Black (compared to 63% in this study); 13% were Spanish speaking (compared to 12% in this study).

To be eligible for the survey, clients had to report receiving at least one H.O.P.E. service. The majority of the sample (71%) received only the depressive symptoms screener, while 28% indicated receiving multiple H.O.P.E. services. Twenty two percent indicated they had a consultation with the behavioral health provider.

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[4] There is an overrepresentation of clients receiving services at the Northwest public health clinics external factors that precluded on-site recruitment at the other locations

Table 3

Characteristics of Survey Respondents (n = 126)

Characteristics	***n* (%)**
Age	
18-24	32 (25%)
25-34	65 (52%)
35-44	19 (15%)
45-54	6 (5%)
55+	4 (3%)
Race	
Asian	1 (<1%)
Black/AA	79 (63%)
Native Hawaiian	0 (0%)
Native Indian	1 (<1%)
White	17 (14%)
Multiracial	8 (6%)
Other	13 (10%)
Prefer not to say	7 (6%)
Language	
Spanish	15 (12%)
English	111 (88%)
Ethnicity	
Hispanic	39 (31%)
Non-Hispanic	87 (69%)
Site	
NW WIC Only	62 (49%)
SE WIC Only	2 (2%)
CLT East WIC Only	2 (2%)
NW Clinic A Only	42 (33%)
SE Clinic Only	9 (7%)
Multiple Sites	9 (7%)
Services Received	
Screener Only	90 (71%)
Multiple Services	35 (28%)
Behavioral Health Consult	28 (22%)

A total of eight women participated in the interviews. All of the women identified as Black and were between the ages of 19 to late 30s. Half of the women received WIC services (and pregnant at the time of encounter) and half received Clinic services. Demographics characteristics are summarized in Table 4. Seven women participated in the follow up interview, with four women participating in member checking.

Table 4

Characteristics of Interview Respondents (N = 8)

Pseudonym	Race	Gender	Age	Services Received
Jade	Black	Woman	30	Clinic A
Diamond	Black	Woman	32	Clinic A
Justinia	Black	Woman	20	WIC
Noelle	Black	Woman	25	WIC
Nina	Black	Woman	33	WIC
Sandra	Black	Woman	Late 30s	WIC
Daphanie	Black	Woman	27	Clinic A
Mabel	Black	Woman	19	Clinic A

5.2 Research Question 1

The first research question was the following: How do Black and Hispanic women from LIEM backgrounds experience behavioral health services in public health settings? The scope of this question included experiences with the screener, the referral to the behavioral health provider, the consultation with the behavioral health provider, and the community resource referral agencies. Both quantitative and qualitative data were integrated to answer this question (Table 5).

Table 5

Integrated Data for RQ1

Research Question	Constructs	Data	Interpretation
How do women from LIEM backgrounds experience behavioral health services in public health settings?	1. Client Satisfaction	Survey	QUAN-qual
	2. Perception of Cultural Responsiveness	Survey	QUAN-qual
	3. Client Experience with a) screening, b) referral, c) consultation with behavioral health provider	Interview	QUAL
	4. Client Experience with community resource referral agencies	Follow-up Interview	QUAL

Note. In mixed-methods research it is standard to identify the priority data for interpretation (quantitative, qualitative, or equal). Capital letters indicate priority and lowercase letters indicate secondary emphasis.

5.2.1 Client Satisfaction

Survey. In aggregate, respondents reported high satisfaction with both public health services generally ($\bar{x}$ = 4.48, SD = .76) and H.O.P.E.-specific services ($\bar{x}$ = 4.36, SD = .94) on a one to five Likert-type scale. The satisfaction scores were moderately correlated (r = .65). However, they were significantly different when tested with a two-way, paired sample t-test (α = .10, p = .052). This may suggest that clients are able to distinguish between general public health services and H.O.P.E.-specific services. A subsample was constructed of the women who reported receiving a consult with the behavioral health provider (n = 28). These women also reported high satisfaction with both public health services generally ($\bar{x}$ = 4.18, SD = 1.09) and H.O.P.E.-specific services ($\bar{x}$ = 4.11, SD = 1.10). For this subsample, scores were highly correlated (*r* = .88) and the difference between the mean scores was not statistically significant (*p* = .49).

5.2.2 Perception of Cultural Responsiveness

Survey. On average, clients reported that services were culturally responsive. Of the 14 cultural competency questions, clients endorsed "yes" an average of 13 times ($\bar{x}$ = 13.19, SD = 1.38), indicating that respondents felt positively about their care (e.g., those who they felt were important participated in their care, they felt respected by their provider, etc.). Irrespective of self-identified race and ethnicity, clients reported "yes" an average of 13 out of 14 times (Table 6).

Table 6

Cultural Competence Disaggregated by Race and Ethnicity

Demographics	***n* (%)**	**Mean (SD)**
Ethnicity		
Hispanic	39 (31%)	13.03 (1.75)
Non-Hispanic	87 (69%)	13.26 (1.18)
Race		
Black	79 (63%)	13.35 (1.06)
White	17 (14%)	12.94 (1.71)

Note. Six total racial categories were represented in the data in addition to a seventh category "other" (Table 3); 6% of respondents preferred not to respond. The table reflects the top two racial categories, with the overwhelming majority of participants identifying as Black and white.

The overall cultural competence score is an aggregate of three subscales: promotes supportive and meaningful interactions, promotes connections with others, and acts on behalf of others. On average, clients responded affirmatively that their needs were met across the three cultural competency subscales. Average scores are summarized in Table 7.

Table 7

Cultural Competence Averages by Scale (n = 126)

Scale	Mean (SD)	Total Possible Score
Promotes Supportive and Meaningful Interactions	7.77 (.63)	8
Promotes Connection with Others	3.72 (.68)	4
Acts on Behalf of Others	1.70 (.53)	2
Total CPPCC Score	13.19 (1.38)	14

Note. Clients' Perceptions of Providers' Cultural Competency (CPPCC) Instrument was used to assess cultural competency (Pacquiao et al., 2021). Respondents could answer yes or no to each question. The means represent on average how many times "yes" was endorsed. Higher scores denote greater levels of perceived provider cultural competency. The total possible score is representative of the score if participants answered affirmatively to every question.

Interview. None of the women explicitly mentioned cultural responsiveness as a key component in their H.O.P.E. care, though all women spoke to high-quality care as being relationship-oriented and person-centered. However, during the member check, participants were asked about their perceptions of cultural responsiveness and whether it was important to their care. Jade, who has a bachelor's in social work, was familiar with the concept of cultural responsiveness but recalled that in practice it seemed more like box checking demographics, which made her uncomfortable. She compared her experience being asked about demographics in care settings to her experience applying for jobs.

> I think we can take out the questions about race, about veterans; I still don't understand that. Not just in public health but on job applications… It's just questionable… like how do I really answer this? Am I really getting penalized?

While her description is not reflective of quality, culturally-responsive care, she does emphasize that when cultural competency is more about checkboxes than about "humans," it feels "fake." She said that she really wants her providers to make sure she is okay and can live her life to the fullest regardless of her race, gender, and sexual orientation. Maya iterated the intangible nature of culturally responsive care, which is rooted in connection:

> I feel like it's a connection thing. I don't really know how to explain it. Why not just see this human being as what they are? Just see this person as a person that is looking to you for help.

Maya added an additional nuance to her perception of culturally responsive care – it was not only about the connection, but also about the outcome: "are you going to give me the help that I really, really need? It's never really been about anything else."

In discussing culturally responsive care, Maya and Daphanie also touched on the intersection of racially incongruent providers and culturally responsive care. She indicated that it did not matter if her provider shared her salient identities if they were ultimately able to get her the care that she needed: "My last therapist was… an old white man…He asked me some crazy question, and I looked at him crazy. But there was still love enough in his eyes for me to answer."

In contrast, Daphanie described that she used to want a Black therapist to "understand my background;" however, her perception has changed over time. She described two experiences with non-Black providers. One treated her lived experiences like an epiphany. Frustrated, she exclaimed, “I don’t need your empathy” and described preferring providers that shared her lived experiences.

> “My next therapist I got was a [white] woman, but it was just like the connections on what we felt. Even though we weren’t the same color she understood me and where I was coming from as a bisexual woman.”

She goes on to describe being open to racially incongruent mental health providers, as long as she senses that they are trying to relate to her.

5.2.3 Client Experience

The client experience data are all derived from the interviews conducted and are summarized in Table 8. Six of eight women indicated that their screening experience was positive, with one indicating a neutral experience and another indicating that she had one positive screening experience and one negative experience. Five of eight women reported positive referral experiences, with one woman reporting a negative experience, one reporting a neutral experience, and one reporting two referral experiences–one of which was positive and one of which was a negative referral experience. Resources provided to the clients varied, though all women were provided a therapy referral to mental health services such as Mental Health of America, the HOPE Community Clinic. Three women accessed some of the provided community resources at the time of follow-up, with only two women accessing mental health resources. Participants reported a myriad of perceived barriers to mental health care, with transportation and insurance/cost being leading barriers.

Table 8

Summary H.O.P.E. Service Experience Across Participants

Pseudonym	Screening	Referral /Handoff	Consult	Resources Provided	Accessed Resources	Barriers to Care
Jade	Asked for services, in-person care (+)	Provider offered referral, BHP called same day (+)	Felt understood, "breath of fresh air" (+)	Therapy, job placement	Y	Transportation, insurance, income
Diamond	In-person PHQ2/9 (+)	Provided referral. Waited 30 days for call back (-)	By phone (0)	55+ housing, free therapy, other (not specified by client)	N	Insurance, income, low quality care
Justinia	In-person PHQ2 (+)	Provided same day call (+).	By phone (+)	Food banks, rideshare, community baby shower, perinatal nursing program, therapy	n/a[1]	Knowledge about available services
Noelle	In-person PHQ2 (0)	Provided same day call (+)	By phone (+)	Therapy, DMV support, Coven House, Infant CPR, Diaper Bank	N	Transportation, insurance, a punitive rather than preventive mindset, aging out of services, trusting a new therapist, poor quality care even when there is access
Nina	Asked for services, in-person care (+)	Provided same day call (+)	By phone (+)	Diaper bank, food pantry, formula, therapy referrals	N - therapy Y - foodbank	Aging out of supportive services, not knowing what you don't know, answering MH questions

						honestly, stigma to getting help, not having enough time, services being out of touch with client reality
Sandra	By phone PHQ2 (+)	Provided same day call (+)	By phone (+)	Counselor for whole family, diaper bank, pantry, grief counseling, youth programs for teenagers	N	Stigma, transportation, admitting you need help
Daphanie	In person; first time (-) second time (+)	First time never got called back (-) Second time provided same day call (+)	By phone (+)	Foodbank, showers, housing, job placement, household items, counselor	N	Has to prove she's serious about getting help, continuity of care, quality services, client-centered services,
Mabel	In person PHQ2/9 (+)	Somewhat nervous to accept referral but same day call (0)	By phone (+)	On Ramp Resource Center for Young Adults	Y	Cost of mental health, self-stigma accessing resources, perception that others need the resources more, waiting too long to get help, being too ill to accept help

Note. Key: (+) positive, (-) negative, (0) neutral quality of experience as reported by the client.

[1] Client did not choose to participate in a follow-up interview.

The group experiential themes (which are themes developed by looking across the personal experiential themes of each participant and endorsed by at least half of participants) are summarized in Table 9. More information about interpretive phenomenological analysis (IPA) can be found in the methods section.

Table 9

Summary of Group Experiential Themes

Theme	**Description**
Clients respond to the depressive symptoms screener on their own terms.	5/8 clients were used to mental health screeners in primary care systems, but that did not mean that they would answer honestly. 8/8 women indicated that disclosing their mental health concerns was a matter of personal agency. Some women reported that they disclosed because they were overtaken by emotion while other women used a cost-benefit analysis.
Clients' experiences surpassed their low expectations for quality care.	8/8 women reported having no or low expectations for their care. Reasons varied (e.g., stigmas towards the public health department, distrust of government agencies, negative prior experiences with healthcare and welfare systems). 5/8 women organically expressed that H.O.P.E. services had exceeded their expectations.
Clients are slipping through the service cracks and would benefit from more hands-on support. *Subtheme:* Between screening and consult *Subtheme:* Between referral and access to community resources	H.O.P.E. offers three services: 1) screener, 2) consult with behavioral health provider, 3) referral to community resources. The fourth domain of H.O.P.E., though beyond the purview of the public health department) is that clients will access community resources. Results indicated that 2/8 women fell through the cracks between the screener and consult. In addition, 6/8 women "slipped through the cracks" between their referral to resources and accessing resources.
High-quality integrated care requires the provider to demonstrate that they care about the individual as a human being, not a number. *Subtheme:* Personalized services are key to high-quality care *Subtheme:* No follow up may damage the client-healthcare system relationship	No clients knew their providers before receiving H.O.P.E. services. Thus all clients indicated how important rapport building was during screening. Women reported looking for signals that their provider authentically cared about them rather than merely going through the motions. When clients recounted the highlights of their consultation, they described moments that made them feel seen and heard. Personalized care and tailored resources contributed to the sense of being seen as a person and not a number. Conversely, a lack of follow up felt personal and called into question the integrity of prior services.
Integrated care can be especially important for pregnant women.	4/8 women were pregnant in the sample. 4/4 reported that pregnancy interacted with their prior mental health concerns. Thus, they appreciated H.O.P.E. services in WIC. 2/4 women reported how pregnancy led to a change in disease management (disrupting medication, increased isolation, limiting natural supports). 2/4 women reported how societal glorification of pregnancy creates an additional need for safe spaces to discuss the negatives of pregnancy without judgment.

The screener is increasingly seen as a routine part of care, but clients respond on their own terms. Five of eight clients reported that they were used to receiving a depressive symptoms screener in primary care systems. Justinia, a new mother-to-be at 20 years-old, describes: “It wasn't my first time being asked that. I think every provider that I've seen…they all tend to typically ask that. I kinda like it.” Jade, a 30 year-old woman who was receiving Clinic A services, feels similarly: “I think I'm kind of used to it, because I think all of the providers that I've been seeing lately, even outside of the clinic, like my primary when I had insurance, they do little check-in questions.”

However, not everyone shared this perception of the screener as a routine part care. Two women expressed being surprised: Diamond and Noelle. Diamond is 32 and has been going to the public health department for many years. Her past experiences have not been positive and she felt anxious that she was being judged. Noelle is a 25-year old Florida native. She recently moved to Charlotte and her visit to WIC was the first time she had been to a public health department in Charlotte. While Diamond felt the depressive symptoms screener was a pleasant surprise and put her at ease, Noelle was “shocked.” A mental health screener in primary care was inconsistent with her past healthcare experiences and the experiences her friends shared about WIC, and thus the screener was inconsistent with her expectations for care. Noelle is a very private person and struggles to trust others. Therefore, expectation setting is a key part of high quality care for her. When she received unexpected services, she felt internal tension between wanting to engage but feeling that additional services (such as supplemental iron shots and the depression screener) infringed on her closely guarded privacy.

> It felt a little weird, because I really didn't know anybody there. And I didn't expect them to ask me about my emotions and things like that… [Other people] just pretty much just

> gave me the impression that you go in, you sign your papers, they talk about the WIC benefits and how it works, and if you're approved or not. And that's pretty much it. Nobody [ever] mentioned a shot or being weighed or anything about counseling or therapy or anything.

Regardless of whether or not the women were surprised to be asked mental health questions in public health clinics, all women demonstrated that their choice to answer honestly was a matter of personal agency. Both Jade and Nina disclosed their mental health concerns even prior to receiving the screener, indicative of their own drive to get help. Nina, a 33-year old mother of six who works full-time, describes herself as "voluntarily" disclosing her mental health concerns with her provider: "I want something because these kids are driving me crazy." Jade also decided to disclose her mental health concerns before being asked the screener questions, but rather than doing so like Nina (i.e., just because it was top of mind), Jade had mentally prepared herself to go into the health department and ask for support: "I had already prepared myself: whoever it was, I was going to ask… I went with the purpose."

Sandra on the other hand, a mother in her late 30s going through a high-risk pregnancy and who has a history working in healthcare, was unsurprised to be asked mental health questions while receiving WIC services. However, she had no intention of disclosing her mental health concerns at the beginning. She made the decision to do so only at the end of the appointment based on her provider's "welcoming spirit." She appreciated being asked the questions "at the end [because] a person can say whether or not they want to answer these questions *with this person*."

Clients' experiences surpassed their low expectations for quality care. All eight women reported having no or low expectations for their care, though for different reasons.

Diamond, Jade, and Justinia indicated that their low expectations were (from their perspectives) due to their negative perceptions of the public health department and their ability to provide high-quality care. Diamond describes seeing the clientele, majority Black and Hispanic, and "instantly think[ing] negative." She walked into the waiting room, looked around and expressed, "you think the ghetto. I was thinking oh my god. Thinking they about to mix my results up with somebody else's crap." For Diamond, the clientele, the location ("I went to Beatties Ford. It's a little hood over there"), and the services as free ("I wish I could go see [another doctor] and afford to get his opinion") all signal to her that her care may be low quality.

While the other women were not as overt about their stigmas towards the health department, their biases against the department peek through. Jade reported that both her and her friends avoid the public health department: "Nobody wants to go to the health department, but you got to do what you got to do." Justinia also describes that she expected her care to be inefficient based on her perceptions of WIC services: "It was better, *way* better, than what I thought it was going to be. I was expecting it to be crowded and me to wait for a long time."

In addition to client expectations being influenced by stigmas surrounding the public health department and WIC, there was evidence that government-funded agencies are generally perceived as feckless. Among the women interviewed, this bias against government-funded agencies emerged consciously and perhaps unconsciously (e.g., two women compared negative healthcare experiences to the DMV). These biases may have influenced their expectations for care through the public health department. Sandra clearly verbalized her minimal expectations for her care as reflective of her low expectations for government entities.

> I'm a person that realized that certain expectations of certain things are just null and void. It's purposeless…Do I have expectations for my children? Yes. Expectations for these

> programs to be all that I need? No, because I'm not the only person that needs them….The only expectation that I would have of her is to do what her job was to do. Is to see what programs she could facilitate for me to utilize based on what I said my issues were, and that's about it. Anything else…it's a bonus. It looks good, it's great. It's wonderful. It may be a life changer, but from myself, because I've worked in different places. No, I don't have expectations, especially when I'm dealing with government entities. Definitely not.

Nina also expressed her distrust towards government entities and demonstrated her awareness that WIC services are government-funded. She expressed her discontent with the public health department by saying “you” because she sees the interviewer as associated with the public health department.

> You don't care about people, right?...[The] county drops the ball a lot. Because it seems like, if they had the option, they really don't care, which is fine. You don't have to. But then what do you do with all the money that you actually get from the government?

In other instances, low expectations for care at the public health department were shaped by past experiences. For example, Daphanie (a 27 year-old woman who moved to Charlotte to live with her best friend two years ago but has been unable to find work or counseling services) describes her first experience with the depressive symptoms screener at the public health department as feeling perfunctory, and she reports never receiving a callback from the behavioral health provider despite screening positive. This experience, in concert with her negative experiences with integrated care at another large, local health organization that is privately owned, shaped her expectations for her care. Multiple health systems overlooking her needs over multiple years has led her to believe that her mental health concerns will not be taken seriously.

Expecting that they will not provide her the resources, she requests the referral information herself as insurance.

> They're not understanding that you're really trying to get this help. And they just over here, like rescheduling your appointment every time they get the appointment. No, bruh. Like this is the third time…Honestly, I've been here for almost two years. I've been trying…[my provider] was like, 'so do you want them to reach out to you? Do you want to reach out to them?' I think we can do both ways. Just so they know. I'm serious. I'm serious about it.

Nina described low expectations for her integrated care when it has a community resource referral model. In her experience, resources are reactive rather than preventive.

> There's no real resources to help you with rent and different things. Because you go to crisis; crisis gives you nothing, right? So then they refer you to different programs. But those other programs will tell you, 'well, you don't live in that area, or you don't do this'…So you're telling me as a mom that my children could possibly be homeless. You don't care about that aspect."

Perhaps for her own wellbeing, she attempted to temper her expectations for change: "it's hard. It's a little frustrating. It also could be worse, right? I try not to get frustrated more."

Unlike the other women, Mabel (the youngest woman interviewed, 19) reported having no expectations beyond getting tested (the service she went to the health department to receive). Her lack of expectations for care were not due to negative experiences, but rather to an uncertainty surrounding what else the health department could offer.

Surpassing expectations. Five of the eight women explicitly said their integrated care experience at the public health department exceeded their expectations. For Jade, who felt that no one wanted to go to the “gloomy” health department, her experience with H.O.P.E. made her feel like “the good outweighs the bad… it's not such a bad experience, when you're able to get what you need.” Diamond, who had a negative experience with the public health department in the past, said “it’s definitely different from the last time I had been, and it felt a little bit better.” Noelle, a Florida native who had formed expectations around her care based on Florida clinic norms, is pleasantly surprised that the local public health department provides “resources that someone actually needs,” which is “very helpful compared to where I come from.”

Clients are “slipping through the cracks” and would benefit from more hands-on support. H.O.P.E. offers three primary activities: 1) a depressive symptoms screener, 2) a consultation with a behavioral health provider, 3) and referrals to community resources. The fourth activity (though outside of the purview of the public health department) is that clients will actually access the resources. Among the women interviewed, there is evidence of slipping through the cracks *between* activities.

Cracks between screening and consultation. After screening positive for depressive symptoms, two of the women described the handoff to the behavioral health provider (facilitation of stages 1 to 2) going awry. The first time that Daphanie screened positive, she was told she would receive a call from the behavioral health provider, but she never heard anything back. Months later, she returned to the public health department, screened positive again, accepted another referral, and finally received a callback. Diamond also described herself as slipping through the cracks after receiving a referral. While she did not need to return to the public health department, it was 30 days before she received a callback.

Both women highlighted the consequences of this error. When the interviewer asked Daphanie why she decided to keep answering the screener honestly, her response illustrated an inner tension between a need for integrated care (as a point of entry to mental health care) but an eroding faith in its ability to get her services.

> I'm not fine. I'm tired of that - I'm tired of lying to y'all. Nope. I'm bout going crazy over here. So it's like, Nah, I would never lie when they ask that question. But I do pull back on seeking help. Because it's like you keep trying. And it's not going nowhere.

For Diamond, she expressed that the delay in services was “shameful” and foreboded that the consequences could have been fatal: “they definitely should have put me with someone else immediately... I would have been, done killed myself, had the funeral, and at Heaven's gates… I don’t think I have 30 days to really just get a grip on my mental [health].”

These testimonies illuminate why half of the interviewees (Diamond, Daphanie, and Jade, Sandra) explicitly called for more on-site support as a mechanism of improvement both for their own experience and for the experience of other women. Daphanie also emphasized that on-site behavioral health services may be more timely, which is critical for women suffering from depression: “This person is asking for help, but they might by the time you talk to them again, they might change their mind.”

Cracks between the referral and accessing resources. The second place where women fell through the cracks was between the H.O.P.E. referrals and actually accessing resources, (activities 3 and 4). Only three of the eight women made it to the community resources they were referred to, with only two of those women accessing therapeutic services. The follow-up interviews elucidated that many women were unable to benefit from resources, in part, due to nebulous communication within the communication triangle of the client, the behavioral health provider, and the community resource referral agencies. For example, both Daphanie and Diamond said that they were told that they were scheduled with Mental Health America but did not know for when and never received a callback from the referral agency. Diamond describes this lapse as making her feel like “I slipped through the cracks.”

Nina saw the “miscommunication” between a community resource referral agency and the behavioral health provider first-hand. She was on the phone with the behavioral health provider while she called a local food and diaper bank on Nina’s behalf. The diaper bank said that they had diapers, but when the client went to pick them up, there were none available. As for her therapeutic resources, Nina wanted a therapist who would take her insurance. She was waiting to hear back from the behavioral health provider, who said she would do additional research to find someone in-network: “I said I'll give her a week to find a resource that takes my insurance. Because by the time the week is up, you know, I've moved on… it's no longer in my power.” At the time of the follow-up (a few months later) she had not heard back.

There were various opinions as to the degree to which the client needs to engage themselves in getting the support that they need. As evident in Nina’s previous quote, she feels like she did her part by asking for help. The remaining responsibility is in the hands of the healthcare system. In contrast, Noelle sees herself as needing to have done more:

> I'm not gonna hold [the behavioral health provider] accountable for anything. Because… you guys did your part. It's up to me to pretty much reach out to the resources and take the help that I need. But I haven't really gotten a chance to do it, because I'm holding back or something is stopping me or whatever the case may be. So I feel like she was a good connection, but it's just me, that's the issue.

Noelle’s testimony felt pained and seemed to be impacted by her depressive symptoms. She had only minimally left the house in a year, had no family or friends in Charlotte, and had recently given birth to her first child at the time of follow-up. She blamed herself for never getting connected to resources. Jade, another client and former social worker, warned of this outcome in her own interview. She discussed a need for more hands-on support when clients are depressed and in crisis. She warned that a clients' own depressive symptoms created additional "room for error" when tasked to follow up with community resource referral agencies themselves. Daphanie seemed to feel similarly and evoked a need for paternalism on the part of the healthcare system: "I feel like if this person has already told you [they need help] just do it for them; don't give them the option. And I know that that might sound wrong." Sandra agreed that more on-site support was valuable for busy moms, regardless of mental health crisis; "let's be real. It's all about convenience."

High-quality integrated care requires the provider to demonstrate that they care about the individual as a human being, not as a number. Disclosing mental health concerns requires more vulnerability than physical health concerns. In Justinia's words, "I'm not just talking about having a headache." Vulnerability is particularly difficult with "basically strangers," which creates a unique challenge for integrated care in public health settings, which tend not to have ongoing client-provider relationships. Multiple participants reported not knowing who their providers were, but knowing how they made them feel. For example, while Jade "didn't really build a relationship with the doctor" she felt that "she heard my needs." Diamond echoes this sentiment: "I forgot who my doctor was. But when I went to the back, they made me feel comfortable."

All clients described that their comfortability during the screening process was driven by the perception that their provider, though a stranger, authentically cared for them. Daphanie was the only client who was screened twice at the public health department. The first time, she sensed that the screening was quotidian and dismissive: "you really just wanted to get me in and get me out." This negative experience was underscored by the fact that she never received a callback from the behavioral health provider. In contrast, the second time she felt that her experience was much better because her provider was authentically compassionate.

> You could tell that she actually cared, even though we just met that day. You know, you can just tell. It was at a point where I ended up crying…you just sense the genuineness. And so that made it easier to be able to actually speak up.

As part of being genuine, Justinia emphasized the importance of eye contact.

> Some of them will look you in your eyes when they ask you. And some of them will just keep looking at the paper or computer, and I feel like I'm making eye contact with you and talking to you about a vulnerable moment…When we make eye contact while talking about it, it just shows me that you actually care. And you're just not [just] following routine and protocol.

Beyond the screener, the sense of authentic compassion from unknown providers continued to be important during the consultation with the behavioral health provider. Jade recounted "I was able to make a connection with someone that doesn't know me, but can relate to me and…it made me hopeful." Daphanie, who was repeatedly let down by healthcare systems, described the value of her consultation with the following sentiment, "She made me feel like I wasn't just another number. And that's something for me. That's definitely something for me, because I don't want to feel like a number. I want to feel like a human being."

Personalized services are key to high-quality care. Seven of eight women described tailored community resource referrals, which made them feel that the behavioral health provider truly had their best interest at heart. Sandra describes, "everything that I told her I needed, she sent me a referral for…It wasn't off…which means she understood what my requests were." The personalized care meant that referrals varied between clients. For example, Mabel (19) was the only woman referred to On Ramp Resource Center, a hub of resources for 16-24 year-olds which includes therapy, social workers, spiritual guide, GED support, and financial literacy training. Justinia, a young pregnant mother, was referred to community baby showers and a free program that pairs registered nurses with women throughout the duration of their pregnancy. Noelle said her behavioral health provider "went above and beyond" because not only were resources relevant to her needs, but also the resources were geographically accessible to her. Daphanie expounded on the need for personalization in high-quality care. She expressed that a major barrier to care was finding care that reflected her holistically, such as counselors who "understand you for your background, and your understanding, and culture, and everything."

The desire for personalized care was also underscored in client suggestions for program improvement. Nina, for example, indicated that her care would have been improved if services (in this case the modality of community referrals given by the behavioral health provider) were even better tailored to the realities of a busy mother.

> So you're calling me; you're telling me that you're here to help. But then you're giving me an email that I have to take the time to read and understand and take the time to actually get the time to read it. But a lot of parents that are at WIC have newborns. At what point do you have that time?

Sandra expounds on this need for personalized care but extends her consideration to the various women who receive WIC services, noting that each woman has a unique set of needs for their care: "You have to deal with women from different cultures… for a lot, [screening women in the WIC waiting rooms] would not make sense for those who have husbands who are very involved."

No follow up may damage the client-healthcare system relationship. Of the six conversations during which follow up naturally emerged (among the six women who did not make it to services), all six believed follow up would be an important part of improving their experience. From a practical sense, follow up can increase resource utilization. Without it, Nina reported feeling like "you left me with the tools, but I don't know how to use them." However, clients also hinted at the importance of follow up for the public health department's ethos.

When Nina was asked what she would change about her integrated experience, the first thing that came to mind was "just kind of check in more…Because sometimes that's just a conversation that needs to be had, you know, in the ninth inning, that you're not alone." For Nina, a check in from the health department reminds her of the value of a friend sending a "hey, just thinking of you" text message. The hypothetical value of check-ins was corroborated by Justinia's experience. Unlike the other women, Justinia had received follow-up calls from providers out of the blue: "It makes me feel like I'm not alone in that I have a lot of support… if I didn't have [the follow ups], I just don't know what I would have done."

This conception of follow up as personal (and perhaps the lack thereof as a sort of institutional betrayal) was underscored by the follow-up interviews with Daphanie, Diamond, and Sandra, all of whom did not access resources. When Daphanie was asked why follow-up in healthcare was important to her, it quickly became personal: "I done learn that I like people to care about me consistently…I tend to give people my all the whole way out. And that's what ends up hurting me the most. Because I'm giving you my all, and I'm really not getting nothing back." Jade echoed this emotionally-loaded sentiment during the member check. To her, no follow up felt like a "slap in the face."

Diamond also expressed the negative impact of never receiving a follow up after the three therapy referrals she was given failed. Despite having a positive experience immediately after her consultation, the lack of follow up (on the part of both the therapy referrals and the health department) soured her experience. During the second interview, she said to the interviewer, “I'm sick of [them] at this point.” In contrast, she expressed her gratitude to the interviewer because–unlike the actors in her integrated care–there was follow up: “I really feel that you are trying to help me, I appreciate you for reaching back out because you're the *only* one who has.”

Sandra highlighted the impact of feeling left to one’s own devices after receiving community referrals. She started to question whether the behavioral health services provided were really in the client’s best interest.

> Why are you referring to these things and not following up behind them? What's the point? Are we just doing it because this is government funding, we have kickbacks, we have different behind the scenes benefits? Or are we doing it because we're putting people in places that really care and want to see these programs change people’s lives?

Integrated care can be especially important for pregnant women. Four women in the sample received WIC services and were pregnant at the time of their interview. All of them discussed how their identity as a mother-to-be interacted with their preexisting mental health concerns. Justinia and Noelle had both been struggling with depression for many years, but this was the first time that they struggled with depression while pregnant. For both women, their pregnancy disrupted their previous strategies for wellness promotion. Justinia describes going off of her medication “cold turkey” out of fear that any medication would harm the baby’s well-being. In the absence of medication, she searched for natural supports to promote her wellness, such as walks and attending cookouts at her Grandma’s church. She reflected, “I have to give myself even more grace because I'm not only dealing with what I was dealing with before, but also added hormones." Noelle also struggled to promote her wellness in ways that had worked well in the past. She is a very creative woman and loves painting shoes. However, the fumes from the paint were not safe for the baby, so she lost an important natural support. Justinia and Sandra both discussed how societal pressures to celebrate pregnancy can compound the penchant to suffer in silence. Sandra offered:

> Not everybody is joyous about a pregnancy; it doesn't mean that they don't want the baby; doesn't mean that they don't love the baby. There's just certain fears, certain perspectives, certain things you hear. So now if you know [a provider] is there…they get a little taste of how they can have an outlet for what they're feeling during this pregnancy

She went on to explain how this conversation at WIC could be especially important to fill a nonjudgmental support gap: "[pregnant women] may not have people that they can express *certain* feelings to safely." Justinia concurred, "I feel like pregnancy can sometimes be a little glorified. Like, 'oh, your skin's gonna glow; you're gonna glow; your nails are gonna grow –look healthy.' Um yeah, like I've seen the downsides of pregnancy." She expressed her appreciation for conversations around depression and pregnancy: "It's really important to highlight mental health during pregnancy because you know, people just emphasize postpartum depression and mental health a lot… it's not just about postpartum."

5.3 Research Question 2

The second research question was: What natural supports (i.e., communities, resources, and practices in non-medical settings) are women from LIEM backgrounds accessing to promote their wellness? The scope of this question also explored insights related to integrating natural supports into behavioral health service delivery.

Table 10

Integrated Data for RQ2

Research Question	**Constructs**	**Data**	**Interpretation**
What natural supports (i.e., communities, resources, and practices in non-medical settings) are women from LIEM backgrounds accessing to promote their wellness?	1. Natural supports	Survey, interview	QUAN-qual
	2. Potential value of integrating natural supports into the care plan?	Survey, interview	QUAN-qual

Note. In mixed-methods research it is standard to identify the priority data for interpretation (quantitative, qualitative, or equal). Capital letters indicate priority and lowercase letters indicate secondary emphasis.

5.3.1 Natural Supports

Survey. Clients were asked to report the frequency of particular behaviors that were important for promoting their wellness on a Likert-type response scale of never (1) to regularly (5) (Table 11). These behaviors ranged across six domains (physical, supportive relationships, relaxation, religion, family, meditation), with the most frequently endorsed domains being social relationships and relaxation. The most frequently endorsed items were “I feel confident that people in my life would respect my choice if I said no” (x̄ = 4.08, SD = 1.08) and “I listen to relax (e.g., to music, a podcast, radio show, rainforest sounds)” (x̄ = 4.06, SD = 1.06).

Table 11

Average Utility of Various Natural Supports Among Survey Respondents

Natural Supports	**Mean (SD)**				
	Race		Ethnicity		
	White (*n* = 17)	Black (*n* = 79)	Hispanic (*n* = 39)	Non-Hispanic (*n* = 87)	Aggregate (*n* = 126)[1]
Physical	2.25	2.35	2.19	2.38	2.33 (.85)
Exercise	3.18	2.91	2.95	2.95	2.95 (1.06)
Scheduled physical activities	1.76	2.19	1.97	2.16	2.10 (1.15)
Yoga or other mind/body practice	1.83	1.95	1.64	2.03	1.91 (1.12)
Supportive Relationships	4.09	3.91	3.84	3.94	3.91 (.91)
Time with others	3.94	3.58	3.59	3.70	3.67 (1.16)
Sense of support	3.94	3.82	3.92	3.86	3.88 (1.11)
Someone who listens	4.29	4.00	3.87	4.05	3.99 (1.18)
Social circle respects “no”	4.12	4.18	3.92	4.15	4.08 (1.08)
Scheduled time with social circle	4.18	3.95	3.90	3.94	3.93 (1.00)
Relaxation	3.62	3.58	3.38	3.60	3.53 (.84)
Intellectual	4.06	3.62	3.54	3.67	3.63 (1.11)
Interpersonal	3.88	3.56	3.64	3.62	3.63 (1.18)
Creative	3.24	3.37	3.08	3.33	3.25 (1.21)
Aural	4.00	4.20	3.79	4.18	4.06 (1.06)
Images	3.29	3.52	3.23	3.52	3.43 (1.17)
Smells	3.24	3.20	3.00	3.30	3.21 (1.29)
Religion	2.76	3.37	3.12	3.28	3.23 (1.19)
Place of Worship	2.47	3.00	2.92	2.86	2.88 (1.34)
Prayer	3.06	3.75	3.31	3.69	3.57 (1.32)
Family	3.12	3.61	3.18	3.61	3.48 (1.24)
Meditation	1.94	2.76	2.56	2.72	2.67 (1.34)

Note. The activities listed within each natural supports domain are not the word-for-word of each item. To reference item wording, see Appendix A. In addition, the family and meditation domains of natural supports were captured by a single item, which is why there are no additional components listed. The Likert-type scale ranged from 1-5.

[1] The 126 participants include all respondents in the sample irrespective of self-identified race or ethnicity. The subsamples in the table are listed by race (white/Black; the two highest represented racial categories in the sample) and ethnicity (Hispanic/Non-Hispanic). The racial subsamples highlighted do not sum to 126 because there were other possible options (e.g., Native Hawaain, prefer not to disclose, multiracial). Race and ethnicity are separated in the table because race and ethnicity were two separate questions on the survey. There were participants who identified as both Black and Hispanic as well as those who identified as both white and Hispanic.

Interview. Natural supports were also discussed in the interviews. Consistent with the survey, the most frequently endorsed natural support was listening to music (reported organically by five of eight women - i.e., no specific natural supports were probed for). Diamond, a musician, described that "music helps me to decompress and express my feelings." Justinia agreed: "I love music. I will sing and dance my heart out; it makes me feel so good every time."

Five of eight women discussed using religion (specifically prayer) to promote their wellness. This is also consistent with the survey, which found that religious supports were frequently used by Black women, with prayer being a more frequent activity than seeking out a place of worship. When discussing the importance of religious natural supports, interviewees also described the limitations. Daphanie is a 27 year-old woman who has struggled to find therapeutic support throughout her life. She describes that asking for therapy as a child was taboo in her religious family:

> I remember growing up… My dad was like, ‘pray to God’…
>
> I was over here like, ‘No, I want a therapist.’
>
> They over here, ‘pray to God.’
>
> ‘No, I want therapy. What are you talking about? Listen to me. I am your child.’

Lastly, the survey indicated that physical natural supports were not frequently utilized in the sample. Only one participant described going to the gym, but three participants talked about the importance of long walks for their wellness: “I love a good walk. If I feel like crap…or if I need some sun, I'll go on a walk and I feel better.”

Natural Supports and Pregnancy

As described in greater detail within the theme “integrated care may be especially important for pregnant women,” some women in the interviews described that their pregnancy precluded them from accessing their usual natural supports, which took an additional toll on their mental health. For Noelle, a 25 year-old woman going through her first pregnancy without a network of social support, her leading natural support was to paint shoes. Unfortunately, the fumes from the paint were dangerous for the baby and she had to stop. Justinia, a 19 year-old woman experiencing an unplanned pregnancy, also described that her natural supports had been altered. While she is very social and relied on friends before her pregnancy, she recounted feeling more isolated since becoming pregnant.

> I would like to be friends with people who can understand me because when you are around people who are about your age, but you know, they're not pregnant and they don't

> have a baby or kids, they can't understand what you're going through… when you are a young mom, it can be really lonely.

However, this experience was not universal among the pregnant women in the sample. Sandra reported natural supports like church, prayer, and eating right: "these are just things that I've done prior to pregnancy. It's nothing different because I'm pregnant."

5.3.2 Potential Value of Integration

On average, respondents indicated moderate agreement with the notion that incorporating their natural supports into public health services would improve their trust in the services (x = 3.98, SD = 1.06). Respondents also indicated, on average, that incorporating their wellness practices would improve their use of the services (x = 3.91, SD = 1.02). The responses between trust and utility were highly correlated ($r = .88$) and not significantly different ($p = .12$). This may indicate that clients see trust and utility as closely related.

The interview prompts also explored what integrating natural supports into the public health department might look like for participants. While the findings were not particularly rich, perhaps due to the abstract nature of the prompt, participants did provide a few ideas. Justinia, the young mother-to-be who indicated that she loves walks to promote her wellness, suggested that the public health department create a walking group for young mothers to meet one another. She reflected that this would promote wellness for pregnant women and create connections among women who may be looking for other young mothers with whom to share the experience. Jade also suggested that the public health department facilitate group walks to meet up. She also wondered whether "the public health can be in contract like the recreational centers, and they can allow some of their clients to have access to the Wellness Centers." She reflected that since public health and exercise go hand-in-hand, she would love to see the public health department use their connections to increase the accessibility of exercise.

Noelle, a creative woman who had relocated to Charlotte during her pregnancy and was missing both community and creative outlets, suggested that natural supports be integrated into the behavioral health consultation. Specifically, she recommended that during the assessment, the behavioral health provider ask clients about extracurricular activities of interest, and upon hearing their responses, provide them with a pamphlet that has related information. Nina, a 33 year-old mother concurred: “[if they had asked], maybe they could have given me different resources. You know, for me, outside is my happy place.”

In contrast, Diamond indicated that she did not need natural supports from the public health department, she needed more in-house therapists to better promote her wellness. Sandra, who had lived in Charlotte most of her life, also agreed that she did not need natural supports incorporated into her care. Personally, she felt that “if this is something that you've been practicing, something you've been doing, [then] nine times out of 10, you're already linked to what you really need [and] the groups that you really want to be a part of.” However, she acknowledged that not everyone is as well connected as her and it may be helpful to have a menu of alternative resources offered to clients as needed.

CHAPTER 6: DISCUSSION

Though Black and Hispanic women of low-income and economically marginalized (LIEM) backgrounds bear the greatest disease burden of depression (Bailey et al., 2019; Banks & Kohn-Wood, 2002; Baumgartner et al., 2021; Brody et al., 2018; Cook et al., 2017; Creamer et al., 2022; Ettman et al., 2020), their mental health needs often continue to go unmet, in part, due to psychological (Bailey et al., 2019; Kozhimannil et al., 2011; Terlizzi & Schiller, 2022) and structural barriers to care (Anderson et al., 2009; Caraballo et al., 2022; Cook et al., 2017; Fiscella & Sanders, 2016; McGuire & Miranda, 2008; Robert Wood Johnson Foundation, 2014; Stockdale et al., 2008; VanderWielen et al., 2015; E. Wang et al., 2021). To address these salient needs and promote health equity, we must revolutionize the way we provide care. Integrated care is a person-centered, evidence-based approach which may better meet the mental health needs of Black and Hispanic women of LIEM backgrounds.

While the literature is saturated with models of integrated care (Berntsen et al., 2018; Framework on Integrated, People-Centered Health Services, 2016; Holden et al., 2014; Illes et al., 2015; Wrenn et al., 2017), these models are understudied in practice and few existing studies include the client perspective (Bandurska, 2023; Youssef et al., 2019), particularly among Black, Indigenous, People of Color and individuals who are economically marginalized (Martinez et al., 2019; Youssef et al., 2019). Consequently, integrated care thought-leaders have admonished that the revolutionary promises of integrated care are unfulfilled (Augst, 2022; Goodwin et al., 2022). This study collected both survey data (n = 126) and interview data (n = 8) from ethnically and racially diverse women receiving behavioral health services at a local public health department–with the goal to re-center the client in integrated care. The mixed-methods nature of this study produced rich, client-centered findings with action-oriented recommendations for integrated care in public health settings.

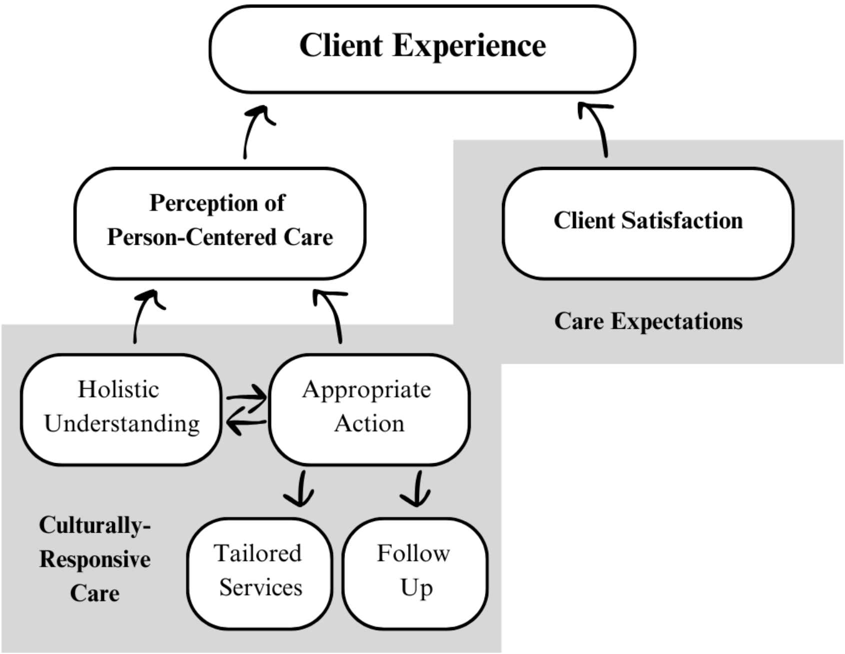
The results of this study provide four contributions to the literature. First, very few studies world-wide have attempted to understand the client experience using a qualitative or mixed-methods approach. Thus, there may be a superficial understanding of clients' integrated care experiences. Given the in-depth phenomenological interviews conducted, complemented by the survey, the richness of the data presented in this study enhances understanding of the integrated care experience. Second, while Black and Hispanic women of LIEM backgrounds may uniquely benefit from integrated behavioral health care, these clients' voices are missing from the literature. Through surveys and interviews, these women's voices were amplified not only to better understand their integrated care experiences, but also to inform client-centered program improvement. Third, integrated care is traditionally conceptualized as mental health services in primary care settings. By investigating integrated care in a public health setting, this study sheds light on the generalizability of prior integrated care findings in new settings. This investigation revealed unique implementation considerations for integrated care in public health clinics. Fourth, client-centered care is a central tenet of integrated care in a variety of hypothetical models. However, this study illuminates the need for *person*-centered care (rather than client-centered care) and illustrates how it may manifest in real-world settings.

6.1 The Integrated Care Experience (RQ1)

RQ1 explores how Black and Hispanic women of LIEM backgrounds experience behavioral health services in public health settings across three stages of care: the depressive symptoms screener, the referral to the behavioral health provider, and the consultation with the behavioral health provider. In addition, as part of the client experience (though currently outside of the scope of the health department’s purview), clients were asked to discuss whether they were connected with the community resources they were referred to and if those resources met their needs. Two components emerged as central to clients' sensemaking of their integrated care experience: client-centered care and client satisfaction (Figure 1).

Figure 1

Emergent Elements of the Integrated Care Client Experience in Public Health Settings



Note. The purpose of this figure is to illustrate two factors that emerged as part of the client experience in this study. These are not the only two factors of client experience. In addition, the dark gray boxes are the context in which the other concepts are situated. For example, client satisfaction is situated within care expectations.

6.1.1 Person-Centered Care

Person-centered care surfaced as central to a positive client experience. According to the American Association of Colleges of Nursing, person-centered care “focuses on the individual within multiple complicated contexts, including family and/or important others…[it] is holistic, individualized, just, respectful, compassionate, coordinated, evidence-based, and developmentally appropriate" (American Association of Colleges of Nursing, n.d.). It can be evaluated through questions such as "Does your PCP know you very well as a *person*, rather than as someone with a medical problem?" (Johns Hopkins, n.d.; Shi et al., 2001; Starfield, 2011). Though person-centered care is related to client-centered care, scholars contend that it is more holistic and inclusive than client-centered care (Eklund et al., 2019; Riley & Jones, 2022; Starfield, 2011). Person-centered care seeks to understand the person, the ecology in which they are embedded, and how their diagnoses interact with life course experiences. Therefore, it is more likely to include family and community systems (Dong & Gagliardi, 2023; Eklund et al., 2019); Riley & Jones, 2022).

Across both screening and consultation, clients looked for verbal and nonverbal signals that their providers holistically understood them as human beings, not as numbers. Two primary factors that shaped clients' perception of person-centeredness were a) the process by which providers sought to understand the whole person, and b) the actions taken based on that understanding. To the former (re: process), clients reported the importance of eye contact, being asked the screener questions in an empathic rather than perfunctory way, a holistic mental health assessment, and providers acknowledging client uniqueness.

In addition to evaluating the process by which their providers sought to understand them, clients assessed how their providers responded via action (Figure 1). Ultimately it was the action (or inaction) that had the biggest impact on clients' assessment of their care as person-centered. In the smallest example of appropriate action, a client reported crying during the depression screener and the meaningful action of being handed a box of tissues. In another example, a client disclosed her mental health concerns, and when her provider provided a referral to a behavioral health provider in response, she reported feeling understood and centered. Across participants, providing tailored services was the action most frequently reported as signaling person-centered care. This finding supports an integrated care experience framework developed by Youssef and colleagues (2020), who proposed that tailored services were important for clients' perceptions that their providers cared about them. In an instance from this study, one woman appreciated that she was provided bereavement services for herself *and* her children. These actions go beyond active listening and respectful engagement and demonstrate that providers will adapt to client needs, rather than the client needing to adapt to the health system. Towards client empowerment, this person-centered approach challenges traditional provider-client power hierarchies.

Not receiving follow up was the action most frequently reported as undermining a perception of person-centered care. The majority of women in need of mental health services did not get connected to them, which soured their previously positive experiences with integrated care (re: the screener, referral, and consultation). Participants described the lack of follow up as personal. The hurt associated with this inaction may be best explained by the construct of institutional betrayal. Institutional betrayal is defined as an institution's "failure to prevent or respond effectively to unexpected or negative experiences" when an individual is reliant on it to meet their needs (Smith & Freyd, 2014). Consistent with this dynamic, women reported feeling that the public health department was their primary entry point for mental health care and without it, they were likely to continue suffering in silence. Like in other studies with racially and ethnically marginalized women (Gary et al., 2021; Nguyen et al., 2022; Tamaian et al., 2017; Wang et al., 2021), participants reported that they had a history of being let down by their care, which was riddled with broken promises and "reactive rather than proactive" care (Newhill &

Harris, 2007). Feeling let down after a hopeful first encounter made some women less likely to engage with behavioral health services in the future. This is consistent with research associating institutional betrayal with healthcare avoidance and underutilization of services (Gigler et al., 2022; Monteith et al., 2021; Tamaian et al., 2017).

Culturally-Responsive Care

Cultural responsiveness is integral to person-centered care. This study revealed—from the client-perspective—how cultural responsiveness may look in practice and influence the client experience. In this study, cultural responsiveness is defined according to Pacquiao and colleagues (2021) as:

> A set of congruent behaviors (that can be learned), interest, attitudes (e.g., cultural humility, sensitivity), and policies that come together in a system, in an agency, or among professionals that enable effective work in cross-cultural settings… The ultimate goal of culturally competent care is to promote health equity… (p. 530)

This definition has two salient components. First, it asserts that culturally-responsive behavior and attitudes at the provider level can be cultivated. Cultural responsiveness at the provider-level is a life-long process of learning and unlearning that disrupts provider-client power dynamics by acknowledging that the provider is not the expert in the client’s lived experience. As a construct, cultural responsiveness exists on a continuum (rather than being dichotomous). A person is not culturally responsive or not. Second, transformative cultural responsiveness is multi-level (Abe, 2020). Health equity mandates social transformation, which requires individual *and* institutional adaptation that decenters the cultural hegemony (Torres Rivera & Comas-Díaz, 2020).

Cultural responsiveness is differentially perceived by providers and clients (Ohana & Mash, 2015; Pacquiao et al., 2021). Therefore, measures of cultural responsiveness that only capture the provider perspective create major gaps in quality improvement strategy. Client-reported survey results indicated that the integrated care provided at the public health department was perceived as culturally responsive. *And*, congruent with the notion of cultural responsiveness as a dynamic, multisystem value that requires ongoing attention, there are still opportunities to improve. Client interviews and member checks revealed how they implicitly attended to and assessed cultural responsiveness. Their stories illuminate opportunities for quality, culturally-responsive care in practice.

At the provider-level, clients shared that they could tell when their providers humbly sought to understand how their intersectional identities influenced their lived experiences versus when they a) went completely unaddressed or b) were addressed in an inauthentic, perfunctory manner. Clients had a hard time identifying particular behaviors associated with cultural responsiveness, yet an attempt at genuine "connection" despite their identities kept surfacing. This is aligned with conceptions of cultural responsiveness that emphasize "ways of being" (developed by critical reflexivity) rather than "ways of doing" (Abe, 2020; Fisher-Borne et al., 2015; Lekas et al., 2020; Stormer et al., 2019). While "ways of being" are informed by the knowledge, attitudes, and practices around differential identities, results seem to indicate that this inner work occurs in advance and "behind the scenes" in order for the client-facing interaction to come across as meaningful and authentic. This background work is particularly important when clients and providers experience cultural discordance (Hagiwara et al., 2013; Penner et al., 2013). Fortunately (and aligned with the conception of cultural responsiveness as learned), results indicated that—irrespective of provider-client identity congruence—clients can feel comfortable disclosing sensitive mental health information to providers who genuinely attempt to connect with them in their social contexts.

At the health systems-level, clients reflected elements of service delivery that could be enhanced for the purposes of culturally-responsive care. For example, the depressive symptoms screener is available in both English and in Spanish to serve the two primary languages of clients. While this is a step towards culturally responsive care, one client illustrated how this is insufficient. Even if the screener is linguistically accessible, there are other reasons it may be challenging to answer honestly, such as mental health stigmas and/or the presence of other microsystem actors. In her example, she touched on how intersectional identities (such as being a married woman in a patriarchal culture, with a husband who disapproves of mental health concerns and is watching her fill out her intake forms) may influence the uptake of behavioral health services. This example demonstrates how culturally-responsive care must extend beyond the microsystem (i.e., provider-client interaction) and into the exosystem (i.e., organizations and policies that influence the client's care experience indirectly) (Beagan, 2018; Pacquiao et al., 2021). It also demonstrates how organizational policies and procedures can preclude "effective work in cross-cultural settings" (Pacquiao et al., 2021), which frustrates the ability to provide person-centered care (re: care "within multiple complicated contexts…holistic, individualized, just, respectful, compassionate, coordinated, evidence-based, and developmentally appropriate;" American Association of Colleges of Nursing, n.d.). Therefore, culturally-responsive care, as a condition of high-quality person-centered care, is a key component of the client experience among marginalized women.

6.1.2 Client Satisfaction

In addition to person-centered care, another salient component of the client experience is client satisfaction. Client satisfaction and client experience are related, but not interchangeable (Berkowitz, 2016; Goodrich & Fitzsimons, 2019; Karam, 2017; LaVela & Gallan, 2014). Client satisfaction is a complex construct to measure in healthcare settings because it is influenced by a number of factors external to the direct services provided (Farzianpour et al., 2015; Naidu, 2009). Ferreira and colleagues (2023) described client satisfaction as "nothing but a relative concept, influenced by individual expectations and evaluations of health services' attributes." The results of this study elucidated the complexity of interpreting client satisfaction in the broader context of the client experience.

While client satisfaction with integrated care services was high on the survey, the interviews revealed that baseline expectations for care from the public health department were low. Low expectations were associated with stigmas and attitudes surrounding government agencies, "welfare services," and free care. These results suggest that client satisfaction scores may be inflated relative to low expectations. Without assessing the client experience, it is difficult to interpret client satisfaction. Though client satisfaction surveys seem to be frequently used for quality monitoring data in healthcare settings, high rates of client satisfaction may not be indicative of quality (Berkowitz, 2016; Johnston, 2013; Kupfer & Bond, 2012). These findings forebode that client satisfaction surveys as a singular measurement of the client experience is inadequate for meaningful understanding and quality improvement (implications are discussed in "Future Directions").

6.1.3 The Ecology of the Client Experience

The results of this study illustrate how the patient experience is influenced by factors across a variety of ecological levels (Bronfenbrenner, 1994). At the individual level, each client has a unique set of identities that shape the way that they interact with the world and affect their care experience. For example, one woman deemed herself an "open book." As someone comfortable talking about anything and everything, she saw the screener as a positive part of her care experience. In contrast, another woman indicated that she has a hard time trusting people. Therefore, because she was not expecting to be asked about her mental health while at WIC, she was skeptical of the mental health screener and her client experience was more neutral.

At the microsystem level are individuals and communities that have a direct influence on the client's integrated care experience, such as the provider. However, other microsystem actors like family and community members (Thiam et al., 2021; Waddington et al., 2021) need to be considered in order to truly understand the service expectations, preferences, uptake, and compliance that influence a client's experience. For example, one young woman described that when she had previously been offered integrated behavioral health services in primary care settings, her mother told her not to answer honestly. At that time, she was on her parents' insurance and they did not want to pay for therapy. This is just one example of how other microsystem actors (beyond the provider) can influence the care experience.

The mesosystem level of the client experience includes interactions between microsystem actors, such as between family members and providers. For example, many Spanish-speaking clients brought their children to the health department to translate. This informal translation practice is known as "child language brokering" (Antonini & Torresi, 2021; Cohen et al., 1999; Tse, 2002). Child language brokering seems to have a negative effect on the client experience, as children may be unable to translate medical terms correctly, and/or may struggle to deliver sensitive health information (Antonini & Torresi, 2021; Iqbal & Crafter, 2023). For conversations surrounding mental health–particularly if clients are not anticipating them in primary care or public health settings–parents may feel uncomfortable having those conversations through their children. Without accounting for mesosystem interactions that are common among clients served, integrated care services may not truly be accessible to all clients.

The exosystem level of the client experience includes actors that have an indirect effect—most often organizations and institutions. In this study, exosystem actors included the public health department, the WIC Program, the federal government, and the state government. These various institutions affect the care that microsystem actors can actually provide. For example, the federal government determines how frequently women must reapply for their WIC benefits. One participant recounted that unbeknownst to her, her benefits expired which prevented her from getting formula for her newly born twins. When she did re-enroll and go to her next appointment, her entire experience (including with integrated behavioral health services) was shrouded in frustration. Without understanding how decisions in the exosystem affect care–particularly for government backed healthcare systems–we cannot truly understand the client experience.

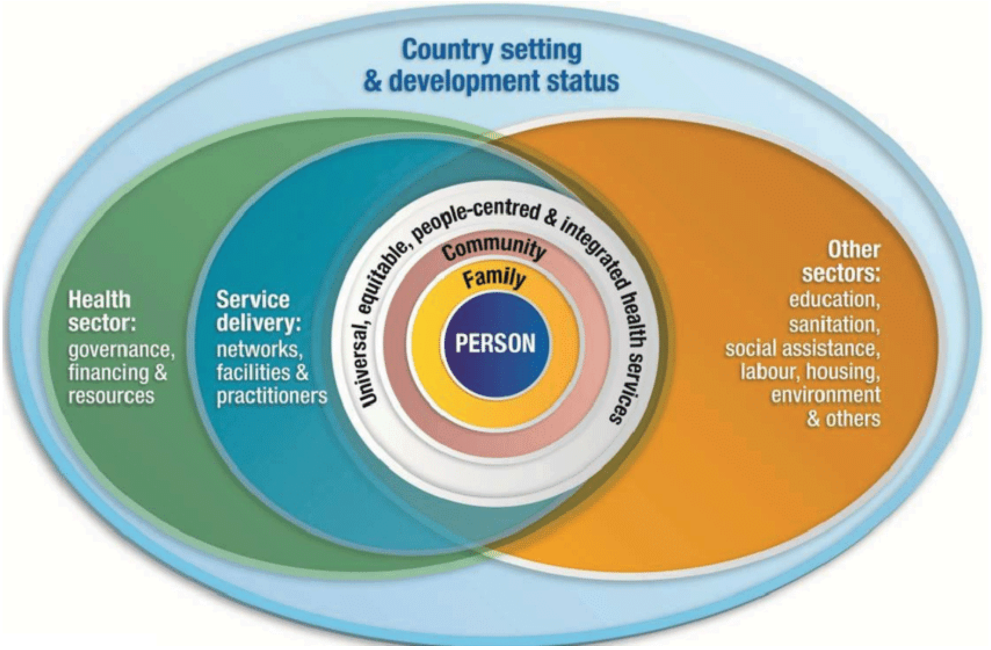
The macrosystem level of the client experience include "contextual patterns [across levels] that are underpinned by belief systems, ideology, and language" (Reifsnider et al., 2005). In healthcare, institutions, organizations, and individuals tend to mimic profit-oriented value systems (Gross, n.d.; Institute of Medicine, 1986), which subsequently influences the care experience–particularly for clients who are from LIEM backgrounds. For example, the American Psychology Association (APA) reports that 55% of mental health professionals have stopped accepting Medicaid, with the primary reason being low reimbursement (APA, 2010; Chatlani, 2023). In addition, APA reports only about 30% of psychologists report working with clients from LIEM backgrounds because of "payment issues" (Chatlani, 2023; Clay, 2020). This creates a serious barrier for LIEM clients looking to access mental health care independently or through integrated care systems. For integrated care systems that do not offer in-house therapy, this is a significant barrier to providing high-quality mental health care. For instance, in this study, the public health department relied on external referral agencies to provide direct mental health services to clients identified as in-need. There are two primary community clinics that are utilized; however, they have waitlists, a limited number of sessions, and often use students in-training rather than licensed professionals. This negatively impacted clients' self-reported experiences over time because they had less options for timely, high-quality care.

The chronosystem level describes socio-historical events that affect the integrated care experience indirectly. The impact of history is heavily interwoven with the attitudes, values, and belief systems of the macrosystem. In this study, macrosystem stigmas seem to be heavily influenced by a history of the U.S. government and its population undervaluing governmental support of women of color from LIEM backgrounds (e.g., massive cuts to public assistance under the Reagan administration justified by stereotypes such as the "welfare queen" (Nadasen, 2007; Plotnick, 1993; present-day discourse surrounding who is "worthy" of government benefits). Clients described holding stigmas against the public health department as a government agency. Based on what they know of history and what they experienced in their own lives with government agencies, they questioned whether or not the government really cared about investing in high-quality care for them. Chronosystem level factors can influence both the quality of care provided to clients as well as their perception of the care. Thus it is important to understand the client experience.

Integrated care scholars and thought leaders are increasingly embracing an ecological approach as a standard for integrated, person-centered care (Dessers et al., 2019; Halsall et al., 2018; Hunter et al., 2018; Reifsnider et al., 2005; Rosenbloom et al., 2023; Woolcott et al., 2019). The World Health Organization developed a Framework on Integrated, People-centered Health Services (2016, Figure 2) with five strategies to revolutionize care: 1) empower and engage communities, 2) strengthen governance and accountability, 3) reorient models of care, 4) coordinate services within and between sectors, 5) create an enabling environment. The thread throughout these strategies is to take a multi-level approach to care transformation that centers the client–not as a passive beneficiary of care, but as an active agent of change within health systems (WHO, 2016). Nesting the client experience within a broader integrated care ecosystem is important not only to better understand the experience, but also to promote multi-level systems change to improve care quality and promote health equity.

Figure 2

WHO Framework on Integrated, Person-Centered Health Services (2016)



Note. Figure developed by Hartmann (2020) to depict the WHO Framework on Integrated, Person-Centered Health Services (2016)

6.2 Natural Supports and Integrated Care (RQ2)

To address RQ2, we collected information about utilization of natural supports among Black and Hispanic women locally, with the goal to consider the feasibility of integrating natural supports into the behavioral health services offered by the public health department. Results underscored the importance of *both* natural supports and medical supports for optimal wellness among clients.

Research suggests that many Black and Hispanic women utilize distinct natural supports (also known as self-care practices) to promote their wellness (Abrams et al., 2019; Blue Cross Blue Shield, 2022; Callister et al., 2011; O'Mahen & Flynn, 2008; E. C. Ward et al., 2009; E. C. Ward & Heidrich, 2009) in part due to need in the absence of high-quality, accessible care (Abrams et al., 2009; Ward & Heidrich, 2009), and in part due to penchant (Callister et al., 2011; Newhill & Harris, 2007; Ward et al., 2009; Ward & Heidrich, 2009). Across six domains (physical, supportive relationships, relaxation, religion, family, meditation), the most frequently endorsed natural supports among both Hispanic and Black women were supportive relationships (e.g., time with others) and relaxation (e.g., creative activities).

Far and above any other natural support, music emerged as key to promoting the wellness of Black women. Deakings's (2023) dissertation entitled "Our Story, Our Song: Assessing and Addressing Black Women's Healthcare Experiences," explores the importance of music in Black women's healthcare experiences. He describes the historical and liberatory nature of music for African American people and proposes that music therapy may be an especially important alternative wellness practice among Black women. An emergent theme was labeled "music is life," as participants reflected that music was an effective tool for healing and coping. The inclusion of music therapy in integrated care services should be further explored as a culturally-responsive care modality.

Scholars have suggested that mindfulness-based interventions such as meditation are important options for stress management across diverse populations (Tobin et al., 2021; Waldron et al., 2018; Watson-Singleton et al., 2019; Woods-Giscombé & Gaylord, 2014); however, in this study, meditation was the lowest reported self-care practice. It is unclear whether this is associated with lack of interest in the practice or with lack of knowledge. It may be worthwhile to explore the utility of meditation and other mindfulness practices as a brief intervention for H.O.P.E. clients.

In a number of studies, religion has been proposed as an important wellness support for Black and Hispanic women (Derose et al., 2019; Lara-Cinisomo et al., 2019; Newlin et al., 2012; O'Mahen & Flynn, 2008; Schwingel & Gálvez, 2016; E. C. Ward et al., 2009). While results found that Black and Hispanic women reported high levels of religious natural supports, some women indicate that religious supports were not enough to mitigate their depressive symptoms. In addition, women reported that, at times, desiring professional help for their mental health concerns isolated them further from their social support systems, which themselves relied on religion rather than professional help and recommended turning to religion rather than a therapist.

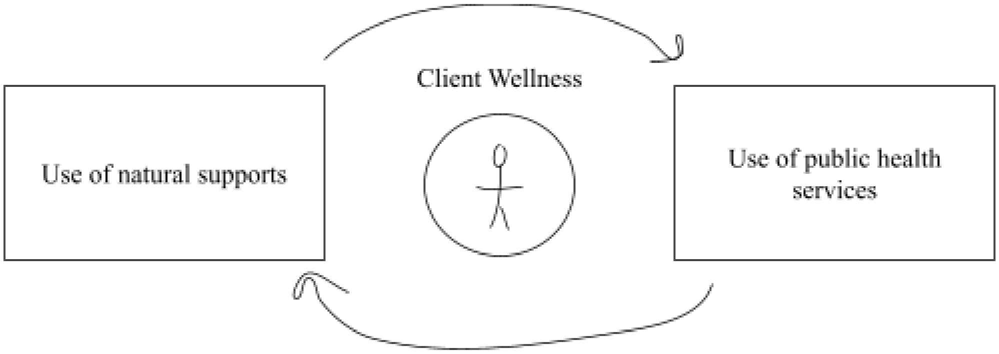
6.2.1 Natural Supports and Depression

While natural supports can be revolutionary among women of color operating within interlocking systems of oppression (Lorde, 1988), there may also be a shadow side to self-care practices when women struggle with mental health concerns. In a qualitative study with Black women, one participant described self-care practices as empowering to her because she has “ultimate authority of [herself]. It’s completely just taking ownership and responsibility for the things that happen” (Adkins-Jackson et al., 2023). While some women may be comforted by a greater sense of control over their wellness, results in this study suggested that women with mental health concerns may feel burdened by the idea of their wellness being entirely in their hands.

Leading symptoms of depression include loss of interest in activities once pleasurable, fatigue, and decreased concentration (American Psychiatric Association, 2022). As was evident in the study, engaging in self-care practices while depressed was challenging, and inability to mitigate depressive symptoms on one’s own seemed to compound depressive symptoms of guilt and worthlessness. Therefore, multi-system supports are critical in addition to women leveraging natural supports to promote their wellness. This is supported by findings by Kim (2014). In their dissertation with rural Hispanic women, they found that women experiencing depression reported higher utilization of self-care practices when they had additional supports, such as spirituality and social support. This suggests an interaction between multiple levels of support that coalesce to improve client wellness. In the context of integrated care, these findings are encouraging. Providing institutional supports to encourage clients’ use of natural supports is a strengths-based approach that can optimize wellness. Simultaneously, integrating natural supports into public health services may improve clients’ trust and utility of these services (re: according to clients’ self-reported survey results), which is another support system that clients can access to promote their wellness (Figure 3). One client example of natural supports integration came from Justinia, a 20 year-old woman whose pregnancy was unexpected (thus isolating her from her friends to whom she no longer felt she could relate). She recommended that the public health department create a walking group for young mothers who may not otherwise know how to connect with one another.

Figure 3

Integrating Natural Supports and Public Health Services to Optimize Client Wellness



6.3 Future Directions

6.3.1 Implications for Practice

Public health clinics may be key settings for integrated care, particularly with the aim of promoting behavioral health equity among Black and Hispanic women of LIEM backgrounds (Shastri, 2024; U.S. Department of Health and Human Services, n.d.). However, there are unique considerations for successful implementation of integrated care in public health settings that were illuminated by client experiences and recommendations.

Person-centered care can overcome stigmas. Clients reported that they were skeptical of the public health department's care quality for a number of reasons (i.e., stigmas surrounding public assistance, mistrust of the government, negative prior experiences, awareness of health inequities facing Black and Hispanic women of LIEM backgrounds in the U.S.). Overall, women questioned whether the providers at the public health department really cared or if they were just there for a paycheck. This is a significant challenge for integrated behavioral health care because mental health disclosure is much more challenging with "strangers" than physical health disclosure. Unlike other healthcare settings, public health providers often do not have the luxury of developing a long-term relationship with their clients due to the preventive, short-term care provided. Public health providers are tasked with overcoming stigmas and making clients feel seen and heard with only a short consultation. Fortunately, women in this study reported positive integrated experiences because their providers demonstrated person-centered care. Therefore, public health settings that employ person-centered care may be better positioned for successful behavioral health integration.

In clients' words. "[The behavioral health provider and I] were able to actually bond from that conversation, and she was able to give me resources tailored to my needs, versus what she would typically give everyone else… It made me hopeful." Clients rely on health systems and providers to translate clients' services to their day-to-day realities. When providers are able to affirm a client's uniqueness and ensure what matters to them is reflected in their care, it positively influences the client experience. A thorough behavioral health assessment that considers social determinants of health seems like a promising way to personalize services and referrals, which is paramount for person-centered care and increased uptake of services.

A warm handoff can overcome gaps in care. Particularly in instances where clients experience more severe depressive symptoms, delayed contact from the behavioral health provider may come too late. In the best-case scenario, the gap in care appears to damage client trust in the public health department, and in the worst-case scenario, the outcome could be fatal. This is of particular concern in public health settings because unlike their more affluent counterparts, public health clients report limited access to mental health services besides the public health department. Having an on-site warm handoff (i.e. the referring provider immediately connects the client to the behavioral health provider) can emphasize to clients that their depressive symptoms are taken seriously and connecting them to services is a priority.

In clients' words. "Let's be real. It's all about convenience. Someone's more inclined to take advantage of the service if it's part of the appointment." Clients reported a number of competing priorities that trumped their mental health. They emphasized that the more convenient it was to get help, the more likely they would. Women recommended "step-by-step" support when completing applications (e.g., SNAP) and scheduling appointments with referral agencies. They also indicated that seemingly small things can feel like barriers – like needing to look up a phone number of a referral agency or needing to look up the prices rather than having them told to them up front. Having in-person handoffs and in-person behavioral health consultations can provide more on-site support and convenience for clients.

Enhanced coordination can ensure clients make it to mental health services. While clients were given resources to access on their own, there were a number of barriers to access. Many women reported limited resources and capacities (e.g., spousal support, income, insurance, transportation, time, mental health education). To reduce barriers, public health settings should consider a higher degree of behavioral health integration. At minimum, enhanced care coordination is required to prevent clients from "slipping through the cracks." This could be coordination within the health department (e.g., having therapists on-site) or coordination external to the health department (i.e., developing partnerships with community organizations that include data sharing and follow up with clients). Until there is more system-level integration, the public health department could follow up with clients directly to offer additional support reaching mental health services. This may not only improve the relationship between clients and the public health department, but also provide necessary outcome data for program evaluation.

In clients' words. "What is the point of having all these things, but no one's following up to see how many people are actually utilizing them? Is this really working?" Clients indicated that they were slipping through the cracks and would benefit from follow up to a) remind them of the resources available to them, b) hold them accountable to access resources, and c) help them troubleshoot barriers to care. Follow up would also indicate to clients that the public health department truly cared about their well-being. In addition, some clients reflected that beyond the direct value provided to clients, follow up provides necessary outcome data to determine the efficacy of the program.

Integrated care in WIC clinics promote the holistic wellness of pregnant women. WIC governmental clinics face a number of competing priorities amidst limited resources when providing care. As a result, staff may question the value of integrated behavioral health services. If the goal is to provide supplemental nutrition assistance, are behavioral health services necessary? Results suggested yes, and a number of pregnant women in the sample talked about how getting their mental health under control was a necessary part of a healthy pregnancy.

In clients' words. "It's really important to highlight mental health during pregnancy... From my experience, that wasn't really talked about." There is an emphasis on Postpartum Depression identification and treatment among perinatal women, but clients suggested it may overshadow the mental health resources needed by women *during* pregnancy. WIC Clients reported that in their experiences, it was even more challenging to talk about mental health concerns while pregnant in part due to the societal pressures to celebrate pregnancies. As women grappled with complex feelings during pregnancy, they wanted a non-judgmental space to process them.

6.3.2 Implications for Research

The results of this study add to a growing body of research that suggests that client satisfaction is a myopic measure of client experience (Ahmed et al., 2014; Berkowitz, 2016; Goodrich & Fitzsimons, 2019; Karam, 2017; LaVela & Gallan, 2014). Yet, given the cost-effective nature of brief satisfaction surveys, these are still heavily utilized in healthcare settings. There are a number of challenges with implementing patient-reported outcome measures and patient-reported experience measures which have frustrated their widespread use (Ahmed et al., 2014; Benson, 2023; Larson et al., 2019), yet true understanding of the client experience is salient for service improvement and goals of health equity. Thus, researchers are tasked with a) determining the domains that contribute to client experience and b) developing short surveys with content validity across each of these domains. For example, a 12-item assessment across the domains of patient experience, result satisfaction, and service integration (Benson & Benson, 2023). Identifying a measure with conceptual complexity, administrative feasibility, and psychometric validity is an important future direction for researchers.

Better understanding best practices for implementing behavioral health services in public health settings is an important topic of future research. Integrating behavioral health services into public health settings is an important systems-based solution to expand mental health care access and promote health equity. While gaining traction, integrated care in public health clinics is still understudied. Therefore, this study, which highlights some unique implementation considerations germane to public health settings, seems to be one of the first of its kind. To increase the widespread adoption of this promising approach to promote mental health equity, additional research should a) qualify the generalizability of the findings in this study and b) identify solutions to overcome these barriers .

Finally, the patient experience is ecologically determined (Dessers et al., 2019; Halsall et al., 2018; Hunter et al., 2018; Reifsnider et al., 2005; Rosenbloom et al., 2023; Woolcott et al., 2019). Thus, researchers should seek to understand the client experience across ecological levels. In addition, as applied researchers think about quality improvement mechanisms for client experience, they may think beyond client-provider interactions to include the possibility of social and structural change to improve client experience and promote health equity.

6.4 Limitations

There are a few considerations to hold while interpreting the findings. First, due to ongoing construction at two of the clinic sites, which precluded in-person recruitment, there was an overrepresentation among two of the five public health clinics implementing H.O.P.E. in the county. The eligibility criteria for clients are the same across Clinic A and WIC sites, and all clinics are within the same county, but there are different providers at each clinic. Because the providers play such a large role in client experience, it is possible that a larger proportion of clients with different providers would influence the results. However, conditions under which public health providers exist that are likely to inform behavior (e.g., clients served, services provided, salaries, understaffed) are expected to be consistent across public health sites. Second, to measure client perception of cultural responsiveness, the Clients' Perceptions of Providers' Cultural Competency Instrument was used (Pacquiao et al. 2021). The response options were a dichotomous yes/no. While the yes/no format prevented participant response burden, this likely restricted the true variance within items among participants. Nonetheless, having multiple dichotomous items within the scale (in this case, 14) mitigates some of the psychometric concerns. The more recent version of the scale (which did not exist during the research design) uses a four-point scale. Finally, given that the research questions are concerned with the experiences of both Black and Hispanic women, it would have been ideal to have qualitative data from Hispanic women to compare to the experiences of Non-Hispanic, Black women. However, given feasibility restraints (time, linguistic, financial) this was not possible. Consequently, the lack of qualitative data from Hispanic women means that the answers to the research questions are slanted heavily towards the experiences of Non-Hispanic, Black women, which may not be representative of the experiences among Hispanic women. That being said, there are generalizable elements of the public health client experience that would likely be consistent across all women of color from LIEM backgrounds, who face structural oppression both within and outside of the healthcare system. This is known as analytic generalizability in idiographic studies (Yin, 2013). It describes deviating from statistical/probabilistic generalizations and instead identifying findings that are reasonably transferable based on similarities in demographics and social context. Despite these limitations, this study still provides valuable contributions for integrated care, health equity, and public health scholars.

6.5 Concluding Remarks

This study began with a rhetorical question: where is the client in client-centered care? By centering the client voice, women revealed that it is not client-centered, but *person*-centered care that is necessary to optimize holistic health. Overall, this study provides valuable contributions to research and practice due to its phenomenological, mixed methods nature and its focus on public health clinics as a promising integrated care setting. While the value of the results are detailed above, it is the process that deserves additional attention. The complexity of these results and the nuanced recommendations for practice would not have been revealed without asking the supposed beneficiaries of integrated care services for their experiences and their suggestions for improvement. Their narratives and reflections situated the client experience in a broader ecosystem, underscored the synergistic value of both natural supports and professional mental health supports, highlighted the importance of behavioral health integration in public health settings, and identified opportunities for practice improvement. While phenomenological inquiry is more resource intensive than traditional client satisfaction and experience surveys in healthcare settings, the return on investment cannot be overstated. When integrated care research and practice invests in understanding clients, leveraging their strengths, and learning from their power, integrated care's potential to promote health equity may be realized.

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APPENDIX A

Survey Questions (English)

This research is led by UNC Charlotte. Your participation in this research study is completely voluntary. Your responses will in no way be tied back to you or affect your care experience.

You received services at public health department sites that want to promote your holistic wellness, both physical and mental wellness.

While there, your provider asked you questions about how you've been feeling recently (*ex: have you been feeling down or stressed? How have you been feeling about yourself? Have you felt like doing things you like? Have you had energy? Is there anything that bothers you or is making you unhappy or hopeless?*). You may have been referred to a social worker/ behavioral health provider for Support.

1. Which of the following services did you receive? (Circle all that apply).
   A. My provider asked me questions about how I've been feeling recently, such as have I been feeling down, stressed, unhappy, hopeless, or depressed
   B. Based on my responses, my provider recommended that I talk to the social worker/behavioral health provider on staff
   C. I met with the social worker/Behavioral Health in-person or on the phone to talk about how I've been feeling
   D. None of the above

2. Based on the services you circled above, **how satisfied or dissatisfied are you with these <u>specific</u> services?**
   A. Strongly dissatisfied
   B. Dissatisfied
   C. Neither dissatisfied or satisfied
   D. Satisfied
   E. Strongly satisfied

3. How satisfied or dissatisfied were you with the <u>overall</u> services you received while at the clinic.
   A. Strongly dissatisfied
   B. Dissatisfied
   C. Neither dissatisfied or satisfied
   D. Satisfied

E. Strongly satisfied

4. What range reflects your current age?
   A. 18-24
   B. 25-34
   C. 35-44
   D. 45-54
   E. 55+

5. Do you identify as Hispanic/Latina?
   A. Yes
   B. No

6. Which of the following best describes your race? (Circle all that apply).
   A. Asian
   B. Black/African American
   C. Native Hawaiian
   D. Native Indian
   E. White
   F. Other (please specify) ____________________
   G. Prefer not to answer

7. At which of the following clinics did you receive services? (Circle all that apply).[5]
   A. **WIC** Clinic A
   B. **WIC** Clinic B
   C. **WIC** Clinic C
   D. County Health Department (**family planning, STI testing, vaccinations, testing & screening**) Clinic D
   E. County Health Department (**family planning, STI testing, vaccinations, testing & screening**) Clinic E

<u>Instructions</u>:
You indicated that while at the WIC of Family Planning clinic, you received at least one of the following services:

- Your provider asked you questions about how you've been feeling recently, such as have you been feeling down, stressed, unhappy, hopeless, or depressed?
- Based on your responses, your provider recommended that you talk to the social worker/behavioral health provider on staff

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[5] Actual clinic names removed for confidentiality of the sites

- You met with the social worker/Behavioral Health in-person or on the phone to talk about how you've been feeling

When answering the following questions, please refer ONLY to the times that you received the above services.

When the questions refer to your provider(s), consider ONLY the providers that delivered the specific services listed above (such as a nurse, physician's assistant, nutritionist).

In the past 6 months, when receiving these services:

1. I was able to practice important routines and traditions related to my health.
    A. Yes
    B. No

2. I was comfortable sharing private and personal information with my provider(s).
    A. Yes
    B. No

3. I was understood and comforted after speaking with my care provider(s).
    A. Yes
    B. No

4. I had enough time to talk to my provider(s).
    A. Yes
    B. No

5. I was treated with respect.
    A. Yes
    B. No

6. I was consulted regarding my care.
    A. Yes
    B. No

7. I received care that fit my beliefs, work, and family.
    A. Yes
    B. No

8. The provider(s) worked with me to identify my needs and goals.
    A. Yes

B. No

9. I am confident in my ability to get care for myself when needed.
   A. Yes
   B. No

10. My family or friends have access to resources to help me.
    A. Yes
    B. No

11. My provider(s) understood my needs.
    A. Yes
    B. No

12. The provider(s) was directly involved in my care.
    A. Yes
    B. No

13. I was connected with resources (ex: health information, support, services, etc) available in my community.
    A. Yes
    B. No

14. Other people I consider important participated in my care.
    A. Yes
    B. No

<u>Instructions</u>:
Please check the box that reflects the frequency of your behavior (how much or how often) **in an average week** from never (0 days) to regularly (6 to 7 days).

In an average week:

1. I exercise at least 30 to 60 min.
   A. Never (0 days)
   B. Rarely (1 day)
   C. Sometimes (2 to 3 days)
   D. Often (4 to 5 days)
   E. Regularly (6 to 7 days)

2. I take part in sports, dance, or other scheduled physical activities (ex: sports teams, dance classes).
    A. Never (0 days)
    B. Rarely (1 day)
    C. Sometimes (2 to 3 days)
    D. Often (4 to 5 days)
    E. Regularly (6 to 7 days)

3. I practice yoga or another mind/body practice (ex: Tae Kwon Do, Tai Chi).
    A. Never (0 days)
    B. Rarely (1 day)
    C. Sometimes (2 to 3 days)
    D. Often (4 to 5 days)
    E. Regularly (6 to 7 days)

4. I spend time with people who are good to me (ex: support, encourage, and believe in me).
    A. Never (0 days)
    B. Rarely (1 day)
    C. Sometimes (2 to 3 days)
    D. Often (4 to 5 days)
    E. Regularly (6 to 7 days)

5. I feel supported by people in my life.
    A. Never (0 days)
    B. Rarely (1 day)
    C. Sometimes (2 to 3 days)
    D. Often (4 to 5 days)
    E. Regularly (6 to 7 days)

6. I feel that I have someone who would listen to me if I became upset (ex: friend, counselor, group).
    A. Never (0 days)
    B. Rarely (1 day)
    C. Sometimes (2 to 3 days)
    D. Often (4 to 5 days)
    E. Regularly (6 to 7 days)

7. I feel confident that people in my life would respect my choice if I said no.
    A. Never (0 days)

   B. Rarely (1 day)
   C. Sometimes (2 to 3 days)
   D. Often (4 to 5 days)
   E. Regularly (6 to 7 days)

8. I schedule/plan time to be with people who are special to me.
   A. Never (0 days)
   B. Rarely (1 day)
   C. Sometimes (2 to 3 days)
   D. Often (4 to 5 days)
   E. Regularly (6 to 7 days)

9. I do something intellectual (using my mind) to help me relax (ex: read a book, write).
   A. Never (0 days)
   B. Rarely (1 day)
   C. Sometimes (2 to 3 days)
   D. Often (4 to 5 days)
   E. Regularly (6 to 7 days)

10. I do something interpersonal to relax (ex: connected with friends).
   A. Never (0 days)
   B. Rarely (1 day)
   C. Sometimes (2 to 3 days)
   D. Often (4 to 5 days)
   E. Regularly (6 to 7 days)

11. I do something creative to relax (ex: draw, play an instrument, write creatively, sing).
   A. Never (0 days)
   B. Rarely (1 day)
   C. Sometimes (2 to 3 days)
   D. Often (4 to 5 days)
   E. Regularly (6 to 7 days)

12. I listen to relax (ex: to music, a podcast, radio show, rainforest sounds).
   A. Never (0 days)
   B. Rarely (1 day)
   C. Sometimes (2 to 3 days)
   D. Often (4 to 5 days)
   E. Regularly (6 to 7 days)

13. I seek out images to relax (ex: art, film, window shopping, nature).
    A. Never (0 days)
    B. Rarely (1 day)
    C. Sometimes (2 to 3 days)
    D. Often (4 to 5 days)
    E. Regularly (6 to 7 days)

14. I seek out smells to relax (lotions, nature, candles/incense).
    A. Never (0 days)
    B. Rarely (1 day)
    C. Sometimes (2 to 3 days)
    D. Often (4 to 5 days)
    E. Regularly (6 to 7 days)

15. I turn to prayer for emotional support.
    A. Never (0 days)
    B. Rarely (1 day)
    C. Sometimes (2 to 3 days)
    D. Often (4 to 5 days)
    E. Regularly (6 to 7 days)

16. I turn to family for emotional support.
    A. Never (0 days)
    B. Rarely (1 day)
    C. Sometimes (2 to 3 days)
    D. Often (4 to 5 days)
    E. Regularly (6 to 7 days)

17. I meditate.
    A. Never (0 days)
    B. Rarely (1 day)
    C. Sometimes (2 to 3 days)
    D. Often (4 to 5 days)
    E. Regularly (6 to 7 days)

For the following question, please indicate the frequency (how much or how often) of your behavior within a typical month from never (0 days per month) to regularly (6 to 7 days per month):

18. I seek out a place of worship (ex: church, mosque, synagogue, temple, etc.).

   A. Never (0 days/month)
   B. Rarely (1 day/month)
   C. Sometimes (2 to 3 days/month)
   D. Often (4 to 5 days/month)
   E. Regularly (6 to 7 days/month)

19. Are there any other communities, resources, or activities that you access to promote your wellness? If so, please list them below:

____

<u>Instructions</u>: The previous questions have asked about what communities, resources, and activities you access to promote your wellness. Based on these answers, please indicate the degree to which you agree with the following two questions.

Please note: **"Mental wellness services" refers to services that promote your mental wellness, such as being asked about your feelings, meeting with a social worker/behavioral health provider, and being connected to resources that would support the overall health of you and your family.**

1. If my care included more of the resources, communities, and practices I indicated above, I would be more likely to <u>trust</u> the mental wellness services offered.
   A. Strongly disagree
   B. Disagree
   C. Neither agree nor disagree
   D. Agree
   E. Strongly agree

2. If my care included more of the resources, communities, and practices I indicated above, I would be more likely to <u>use</u> the mental wellness services offered.
   A. Strongly disagree
   B. Disagree
   C. Neither agree nor disagree
   D. Agree
   E. Strongly agree

3. If there was an opportunity to serve on a patient advisory board (a group of community members who meet with clinic staff to improve care), would you be interested? *This is not a commitment.*

A. Yes, I would be interested in serving on a patient advisory board. If the opportunity becomes available, please contact me.
B. No, I would not be interested in serving on a patient advisory board if the opportunity became available.

4. What additional accommodations would you need to be able to volunteer your time on an advisory board (ex: childcare, virtual meeting option, transportation cost being covered, translator, etc.)? Please list below:

____

Thank you for your participation. The primary researcher will email you your electronic $10 Amazon gift card in the next 72 hours. To ensure you receive your gift card, please enter in the following information, which will not be shared with anyone beyond the primary researcher. When data collection closes, data will be deidentified.

- First Name _______________
- Last Name _______________
- Email address (*you will receive the electronic gift card at this email address. Please make sure you have access to it*)

  ____

APPENDIX B

Survey Questions (Spanish)

Cuestionario

Esta investigación es conducida por UNC (University of North Carolina, por sus siglas en inglés) Charlotte. Su participación en este estudio de investigación es completamente voluntaria. Sus respuestas de ninguna manera estarán vinculadas a usted ni afectarán su experiencia en cuanto al cuidado recibido.

1. ¿Tiene usted 18 años o más?
    - A. Sí
    - B. No

2. ¿Con cuál sexo se identifica más?
    - A. Mujer
    - B. Hombre
    - C. Otro
    - D. Prefiero no contestar

Usted recibió servicios ya sea en el WIC (Women Infant Children, por sus siglas en inglés) o en una Clínica de Planificación Familiar. Estos sitios de Public Health (por sus siglas en inglés) están dedicados a promover su bienestar holístico a través de un cuidado integrado, lo que significa que su doctor desea promover su salud físico tanto como mental. Mientras estuvo allí, su doctor le hizo preguntas sobre cómo se ha sentido recientemente. Es posible que le hayan hecho las siguientes preguntas: "¿Se ha sentido deprimido(a) o estresado(a)? ¿Cómo se ha sentido acerca de si? ¿Ha tenido ganas de hacer las cosas que le gustan? ¿Ha tenido energía? ¿Hay algo que le moleste o le haga sentir infeliz o sin esperanza?" Estas preguntas se relacionan a su salud mental.

3. ¿Cuál de los siguientes servicios recibió? Por favor marque todos los que apliquen.
    - A. Mi doctor me hizo preguntas sobre cómo me he estado sintiendo recientemente, por ejemplo, si me he sentido deprimido, estresado, infeliz, desesperanzado o deprimido
    - B. Según mis respuestas, mi doctor me recomendó que hablara con un trabajador social/o con un proveedor de salud mental
    - C. Me reuní con un trabajador social/con un proveedor de salud mental en persona o por teléfono para hablar sobre cómo me he estado sintiendo
    - D. Ninguna de las anteriores

4. ¿Según los servicios que marcó arriba, qué tan satisfecha o insatisfecha está usted con estos servicios <u>específicos</u>?
    - A. Totalmente insatisfecho
    - B. Insatisfecho
    - C. Ligeramente insatisfecho
    - D. Ni insatisfecho ni satisfecho

E. Ligeramente satisfecho
F. Satisfecho
G. Totalmente satisfecho

5. ¿Qué tan satisfecha o insatisfecha está usted <u>en general</u> con los servicios que recibió en la clínica?
A. Totalmente insatisfecho
B. Insatisfecho
C. Ligeramente insatisfecho
D. Ni insatisfecho ni satisfecho
E. Ligeramente satisfecho
F. Satisfecho
G. Totalmente satisfecho

6. ¿En cuál rango esta su edad actual?
A. 18-24
B. 25-34
C. 35-44
D. 45-54
E. 55+

7. ¿Se identifica usted como hispano(a)/latino(a)?
A. Sí
B. No

8. ¿Cuál de la siguiente lista describe mejor su raza? (seleccione todas las que correspondan)
A. Asiático
B. Negro/Afroamericano
C. Nativo Hawaiano
D. Indio Nativo
E. Blanco
F. Otro
G. Prefiero no contestar

9. ¿Recibió servicios en el WIC o en una Clínica de Planificación Familiar?[6]
A. Clínica WIC A
B. WIC B
C. Clínica WIC C
D. Clínica A D (**planificación familiar, pruebas de infecciones de transmisión sexual, vacunación, proyección médica**)
E. Clínica A E (**planificación familiar , pruebas de infecciones de transmisión sexual, vacunación, proyección médica**)

Instrucciones:

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[6] Clinic names removed for confidentiality of sites

Usted indicó que mientras estuvo en la oficina del WIC o en la Clínica de Planificación Familiar, usted recibió al menos uno de los siguientes servicios:

● Su proveedor de servicios le hizo preguntas sobre cómo se ha sentido recientemente, por ejemplo, ¿se ha sentido deprimido, estresado, infeliz, desesperanzado o deprimido?
● Basado en sus respuestas, su doctor le recomendó que hablara con un trabajador social o con un proveedor de salud mental de la clínica.
● Se reunió usted con el trabajador social o con un proveedor de salud mental de la clínica en persona o por teléfono para hablar sobre cómo se ha estado sintiendo.

Al responder las siguientes preguntas, por favor refiérase ÚNICAMENTE a las veces que recibió los servicios anteriores.

Cuando las preguntas se refieran a su(s)doctor(es), considere ÚNICAMENTE al personal que brindaron los servicios específicos anteriormente (como enfermera, asistente médico, nutricionista).

<u>En los pasados seis meses, al recibir los servicios:</u>

1. Pude practicar rutinas y tradiciones importantes relacionadas con mi salud
   A. Sí
   B. No

2. Me sentí cómoda compartiendo información privada y personal con mi(s) doctor(es).
   A. Sí
   B. No

3. Me entendieron y me consolaron después de hablar con mi(s) doctor(es) que me atendió.
   A. Sí
   B. No

4. Tuve suficiente tiempo para hablar con mi(s)doctor(es).
   A. Sí
   B. No

5. Me trataron con respeto.
   A. Sí
   B. No

6. Me consultaron acerca de mi cuidado.
   A. Sí
   B. No

7. Recibí cuidado que se ajusta a mis creencias, trabajo y familia.
   A. Sí
   B. No

8. El(los) doctor(es) trabajaro conmigo para identificar mis necesidades y metas.
    A. Sí
    B. No

9. Confío en mi capacidad para cuidarme cuando sea necesario.
    A. Sí
    B. No

10. Mi familia o amigos tienen acceso a recursos para ayudarme.
    A. Sí
    B. No

11. Mi(s) doctor(es) entendieron mis necesidades
    A. Sí
    B. No

12. El(los) doctor(es) estuvo/estuvo directamente involucrado(s) en mi cuidado.
    A. Sí
    B. No

13.Me conectaron con recursos (por ejemplo, información de salud, apoyo, servicios, etc.) disponibles en mi comunidad .
    A. Sí
    B. No

14. Otras personas que considero importantes participaron en mi cuidado.
    A. Sí
    B. No

Instrucciones: Marque la casilla que refleja la frecuencia de su comportamiento (cuánto o con qué frecuencia) en la última semana (7 días); nunca (0 días), rara vez (1 día), a veces (2 a 3 días), a menudo (4 a 5 días) y regularmente (6 a 7 días). Tenga en cuenta que una pregunta se califica al revés (ver Cuidado físico*). Para uso clínico, los elementos se pueden administrar en orden.

1. Hago ejercicio por lo menos de 30 a 60 min.
    A. Nunca (0 días)
    B. Casi nunca (1 día)
    C. A veces (2 a 3 días)
    D. A menudo (4 a 5 días)
    E. Regularmente (6 a 7 días)

2. Participó en deportes, baile, o otras actividades físicas programadas (por ejemplo, equipos deportivos, clases de baile).
    A. Nunca (0 días)
    B. Casi nunca (1 día)

C. A veces (2 a 3 días)
D. A menudo (4 a 5 días)
E. Regularmente (6 a 7 días)

3. Practico yoga u otra ejercicio de mente/cuerpo (p. ej., Tae Kwon Do, Thai Chi).
A. Nunca (0 días)
B. Casi nunca (1 día)
C. A veces (2 a 3 días)
D. A menudo (4 a 5 días)
E. Regularmente (6 a 7 días)

4. Paso tiempo con personas que son buenas conmigo (p. ej., me apoyan, me alientan y creen en mí)
A. Nunca (0 días)
B. Casi nunca (1 día)
C. A veces (2 a 3 días)
D. A menudo (4 a 5 días)
E. Regularmente (6 a 7 días)

5. Me siento apoyado por personas en mi vida.
A. Nunca (0 días)
B. Casi nunca (1 día)
C. A veces (2 a 3 días)
D. A menudo (4 a 5 días)
E. Regularmente (6 a 7 días)

6. Siento que tengo a alguien que me escucharía si me siento triste (p. ej., amigo, consejero, grupo).
A. Nunca (0 días)
B. Casi nunca (1 día)
C. A veces (2 a 3 días)
D. A menudo (4 a 5 días)
E. Regularmente (6 a 7 días)

7. Yo me siento confiado que las personas en mi vida respetarán mi decisión si dijera no.
A. Nunca (0 días)
B. Casi nunca (1 día)
C. A veces (2 a 3 días)
D. A menudo (4 a 5 días)
E. Regularmente (6 a 7 días)

8. Yo programo/planificó tiempo para estar con personas que son especiales para mí.
A. Nunca (0 días)
B. Casi nunca (1 día)
C. A veces (2 a 3 días)
D. A menudo (4 a 5 días)

E. Regularmente (6 a 7 días)

9. Yo hago algo intelectual (usando mi mente) para ayudar a relajarme (por ejemplo, leer un libro, escribir).
A. Nunca (0 días)
B. Casi nunca (1 día)
C. A veces (2 a 3 días)
D. A menudo (4 a 5 días)
E. Regularmente (6 a 7 días)

10. Yo hago algo interpersonal para relajarme (por ejemplo, conectado con amigos).
A. Nunca (0 días)
B. Casi nunca (1 día)
C. A veces (2 a 3 días)
D. A menudo (4 a 5 días)
E. Regularmente (6 a 7 días)

11. Yo hago algo creativo para relajarme (por ejemplo, dibujo, toco un instrumento, escribo creativamente, canto).
A. Nunca (0 días)
B. Casi nunca (1 día)
C. A veces (2 a 3 días)
D. A menudo (4 a 5 días)
E. Regularmente (6 a 7 días)

12. Yo para relajarme escucho (ej., música, un podcast, un programa de radio, sonidos de la selva tropical).
A. Nunca (0 días)
B. Casi nunca (1 día)
C. A veces (2 a 3 días)
D. A menudo (4 a 5 días)
E. Regularmente (6 a 7 días)

13. Yo para relajarme veo pinturas (ej., arte, cine, ir a las tiendas para distraerme, naturaleza).
A. Nunca (0 días)
B. Casi nunca (1 día)
C. A veces (2 a 3 días)
D. A menudo (4 a 5 días)
E. Regularmente (6 a 7 días)

14. Yo busco olores para relajarme (lociones, naturaleza, velas/incienso).
A. Nunca (0 días)
B. Casi nunca (1 día)
C. A veces (2 a 3 días)
D. A menudo (4 a 5 días)
E. Regularmente (6 a 7 días)

15. Recurro a la oración en busca de apoyo emocional.
    - A. Nunca (0 días)
    - B. Casi nunca (1 día)
    - C. A veces (2 a 3 días)
    - D. A menudo (4 a 5 días)
    - E. Regularmente (6 a 7 días)

16. Recurro a la familia para apoyo emocional.
    - A. Nunca (0 días)
    - B. Casi nunca (1 día)
    - C. A veces (2 a 3 días)
    - D. A menudo (4 a 5 días)
    - E. Regularmente (6 a 7 días)

17. Yo medito.
    - A. Nunca (0 días)
    - B. Casi nunca (1 día)
    - C. A veces (2 a 3 días)
    - D. A menudo (4 a 5 días)
    - E. Regularmente (6 a 7 días)

Para las siguiente pregunta, por favor indica su frecuencia de los siguientes comportamientos en un mes típico de nunca (0 días por mes) a regularmente (6 a 7 días por mes).

18. Busco un lugar de oración (ej., iglesia, mezquita, sinagoga, templo, etc.).
    - A. Nunca (0 días por mes)
    - B. Casi nunca (1 día por mes)
    - C. A veces (2 a 3 días por mes)
    - D. A menudo (4 a 5 días por mes)
    - E. Regularmente (6 a 7 días por mes)

Las preguntas anteriores fueron acerca de qué comunidades, recursos y actividades usted accede para promover su bienestar. Según sus respuestas anteriores, por favor indique el nivel en que está de acuerdo con las siguientes dos preguntas.

"Servicios de bienestar mental" se refiere a los servicios que promueven su bienestar mental, como que se le pregunte sobre sus sentimientos (ej., ¿se ha sentido deprimido o estresado? ¿Cómo se ha sentido consigo mismo? ¿Ha tenido ganas de hacer las cosas que le gustan? ¿Ha tenido usted energía? ¿Hay algo que le molesta o le hace sentir infeliz o sin esperanza?), reunirse con un trabajador Social o con un doctor de conducta saludable y estar conectado a recursos que apoyan su salud general y la de su familia.

1. Si mi cuidado incluyera más recursos, comunidades y prácticas que yo indiqué arriba, sería más probable que <u>confiara</u> en los servicios de bienestar mental que se ofrecen.

A. Totalmente en desacuerdo
B. No estoy de acuerdo
C. Ni de acuerdo ni en desacuerdo
D. De acuerdo
E. Totalmente de acuerdo

2. Si mi cuidado incluyera más recursos, comunidades y prácticas que indiqué arriba, sería más probable que usara los servicios de bienestar mental que se ofrecen.
A. Totalmente en desacuerdo
B. No estoy de acuerdo
C. Ni de acuerdo ni en desacuerdo
D. De acuerdo
E. Totalmente de acuerdo

Si hubiera una oportunidad de formar parte de una junta asesora de pacientes (un grupo de miembros de la comunidad que se reúnen con el personal de la clínica para mejorar la atención), ¿estaría interesado? Esto no es un compromiso.
A. Sí, me interesaría formar parte de una junta asesora de pacientes. Si hay una oportunidad, por favor póngase en contacto conmigo
B. No, no me interesaría formar parte de una junta asesora de pacientes.

Gracias. Debido a que hay una tarjeta de regalo de $10 por completar la encuesta, necesitaremos recopilar su nombre y dirección de correo electrónico para distribuir el incentivo. Esta información se mantendrá confidencial y se asociará temporalmente con sus respuestas. Una vez que se complete la recopilación de datos, sus identificadores personales se eliminarán de sus respuestas en el cuestionario.

El investigador principal hará todo lo que pueda para asegurar que el pago se envié dentro de las 72 horas después de que se haya finalizado la encuesta.

nombre de pila______________________
apellido___________________________
dirección de correo electrónico (*recibirá la tarjeta de regalo electrónica en esta dirección de correo electrónico. Por favor, asegúrese de tener acceso a él*)_________________

APPENDIX C

Interview Guide

Before we get started, are you in a private space where you feel comfortable answering questions related to your mental health and your experience at the health department?
If at any time throughout the interview that changes, we can pause or re-schedule the call.
Is it okay for me to record this?

QUESTIONS

Anticipated 45 mins with 15 mins built in for probing questions as appropriate (5 min)

Screening (5 min)

[script] You received services at either a WIC or Family Planning Clinic. While there, your provider asked you questions about how you've been feeling recently. They may have asked you questions like the following, "have you been feeling down or stressed? How have you been feeling about yourself? Have you felt like doing things you like? Have you had energy? Is there anything that bothers you or is making you unhappy or hopeless?" These questions all relate to your holistic wellness.

1. Can you tell me about this experience? How did it make you feel to be asked mental health questions while receiving services?
    1. How comfortable did you feel being asked this question by your provider?
        1. Did you feel comfortable enough to answer honestly?

Referral (5 min)

1. Based on your responses to how you've been feeling, your provider (either a nutritionist, nurse practitioner, or PA) may have recommended that you talk to the social worker/behavioral health provider on staff. How did the conversation go with your provider?
    1. Did you get the sense that this staff member would be able to support your holistic needs (such as childcare, housing, food assistance)? Why or why not?
    2. DId you have any expectations for the behavioral health provider?

Consultation with BHP (10-15 min)

1. In three words, how would you describe your experience with the social worker/ behavioral health provider?
2. Can you tell me more about your visit with *[BHP's name]*?
    1. What did you gain?
    2. What suggestions for improvement?
3. Were you able to access the community resources that you were referred to?

        a. Did you feel like the resources were appropriate and useful for you and your life?
            1. How could they be made more effective?

Whole-Person Care

1. How have the services and resources you discussed (e.g., talking to someone about your feelings, seeing a social worker/BHP, being referred to community resources) shape your overall perception of the public health clinics?

Integrating Natural Supports into the Care Plan (10-15 min)

[script] I'm going to shift gears a little bit and focus now on wellness and non-medical supports that you use to promote your wellness. Wellness is not just physical wellness, it includes your spirituality, healthy relationships with friends and family, and positive mental health. Really wellness is whatever holistically makes you feel like your best self. In the survey you reported practices, resources, and communities that promote your wellness, such as religious groups, family, exercise, food, dancing, etc. Think about those when answering this question:

1. What do you do to keep yourself well?
2. How would you recommend incorporating these practices, resources, and communities into your treatment plan?
    1. How might your recommendations improve your overall healthcare experience?

Barriers to Care

1. What is the biggest barrier to accessing mental health care in your community?
    a. What can be done to overcome this barrier?

APPENDIX D

Member Check Guide

Script

Thank you for choosing to participate in this study and to provide us more of your time. By joining us today, you will receive an additional $10 Amazon gift card. Your participation today will in no way influence the care that you are eligible to receive or will receive through the public health department. Instead, we would like to invite your feedback on the themes we have identified during the preliminary stage of analysis.

You will be presented with the analysis that we have already conducted. We want to know from you, do the themes that we identified resonate with you? Is there anything that we are missing or that we misinterpreted?

We will do everything we can to keep your identity private and your responses confidential. However, because we are asking you to participate in focus groups, we cannot guarantee how others in the group may use your information. We ask that you each respect the information shared in this group today and keep it confidential.

For our records, we will be audio recording this session today. It will be deleted after the study is over.

Questions

First, we will present our preliminary findings. We will use the following questions as our guide. However, we will remain flexible to ensure that organic reactions, reflections, and suggestions can be provided by the participants.

1. What are your initial reactions or thoughts to what we just shared?
2. Were there any codes or themes that strongly resonated with you? If so, why?
3. Were there any codes or themes that did not agree with you? If so, why?
4. Is there anything else that comes to mind related to your experience and what we share