Integrated Health Care Best Practices and Culturally and Linguistically Competent Care: Practitioner Perspectives

Kiara Alvarez
Yesenia A. Marroquin
Luis Sandoval
Cindy L. Carlson

Practitioners in two federally qualified health centers (FQHCs) were interviewed to explore how their organizations carried out best practices in cultural and linguistic competence (CLC) when integrating mental health services into primary care. Archival data and data from interviews with eight clinical service providers were analyzed using exploratory cross-case synthesis. To highlight best practices in integrated health care (IHC), ethical, systemic, and organizational themes were identified: patient-centered care for underserved populations, building and sustaining a successful multidisciplinary team, and increasing capacity and adapting to changing circumstances. CLC did not emerge as a distinct interview theme, though it was present in subthemes and was discussed by both mental health and medical practitioners as central to effective health-care delivery. The results underscore the need for culturally-tailored research and training that examines how IHC can best serve diverse groups and communities.

That there are health and mental health disparities between ethnically diverse individuals is well-established (Blanco et al., 2007; Harris, Edlund, & Larson, 2005; Institute of Medicine, 2003; U.S. Department of Health and Human Services, 2001). Integration of mental health services into primary care has been advanced as a way to reduce mental health disparities (Blount, 2003; Sanchez, Chapa, Ybarra, & Martinez, 2012a) because members of racial and ethnic minority groups are more likely to seek mental health care in primary care than in specialized mental health settings (Chapa, 2004). However, primary care providers have been less likely to detect the mental health problems of racially and ethnically diverse patients (Borowsky et al., 2000). To provide effective mental health services to diverse populations in primary care settings, it is critical to adopt best practices in both integrated healthcare (IHC) and cultural and linguistic competence (CLC).

All authors are affiliated with The University of Texas at Austin. Correspondence about this article should be sent to Kiara Alvarez, Department of Educational Psychology, School Psychology Program, 1 University Station D5800, The University of Texas at Austin, Austin, TX 78712. Email: kiara.alvarez@gmail.com.

Note: This project was supported by HRSA Graduate Psychology Education Grant D40HP19644: Integrated Health Care Services for Underserved Children and Families Program. The authors thank Annie Holleman for her assistance with data collection.
IHC is the “systematic coordination of physical and mental health care” (Hogg Foundation for Mental Health, 2008, p. 7). Medical and mental health services can be integrated in a range of ways, from minimal collaboration between separate sites to full integration at a single site (Doherty, McDaniel, & Baird, 1996). This article uses the classification scheme developed by Blount (2003) to describe IHC programs (see Table 1 for a summary).

### Table 1. Blount (2003) Classification Scheme for IHC Settings

<table>
<thead>
<tr>
<th>Level of Service</th>
<th>Category</th>
<th>Characteristics</th>
</tr>
</thead>
</table>
| Service delivery system | Coordinated | • Separate services  
|                     |           | • Separate settings  
|                     |           | • Consultation between providers                                                 |
|                     | Co-located | • Separate services  
|                     |           | • Same setting  
|                     |           | • Consultation between providers                                                 |
|                     | Integrated | • Unified services  
|                     |           | • Same setting  
|                     |           | • Single treatment plan established by a multidisciplinary team                  |
| Programs            | Targeted  | • Provided for a specific population (e.g., for a particular age group or illness category) |
|                     | Non-targeted | • Provided for any patient needing mental health services                          |
| Treatment           | Specified | • Treatment is a specific approach applied to all patients                          |
|                     | Unspecified | • Treatment is based on skills and judgment of the provider                         |


While IHC increases access to mental health services for diverse groups, research on its effectiveness with racial and ethnic minorities is limited (Butler et al., 2008; Sanchez et al., 2012a). Two studies have suggested that IHC outcomes are equivalent across groups (Butler et al., 2008). Several recent studies of collaborative care models (a type of IHC in which a mental health provider is incorporated into a primary care practice) have demonstrated effectiveness in reducing the depression symptoms of Latino and African-American patients in the continental U.S. and with Puerto Rican patients in Puerto Rico (Davis, Deen, Bryant-Bedell, Tate, & Fortney, 2011; Dwight-Johnson et al., 2010; Vera et al., 2010). However, in a study of collaborative care among older patients, non-Hispanic Whites benefited more than did racial and ethnic minority patients; the authors suggested that culture-specific strategies are needed to improve minority outcomes (Bao et al., 2011).

The Office of Minority Health (OMH) has defined CLC as “a set of congruent behaviors, attitudes, and policies that come together in a system, agency,
or among professionals that enables effective work in cross-cultural situations,” with culture reflecting “integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups” (OMH, 2001, p. 4). Linguistic competence has been described as the provision of culturally competent services to individuals with limited English proficiency via bilingual staff or qualified interpreters and translators (Agency for Healthcare Research and Quality, 2003). The National Standards on Culturally and Linguistically Appropriate Services (CLAS standards) address culturally competent care, language access, and organizational support for cultural competence in healthcare settings; they mandate language access services in federally funded settings (OMH, 2001).

CLC in healthcare organizations has been conceptualized as occurring at the clinical, systemic, and organizational levels (Betancourt, Green, & Carrillo, 2002). A major focus of CLC at the organizational level has been building up a diverse healthcare workforce; at the systemic level CLC relates to design of healthcare systems that improve access to and quality of care (Betancourt et al., 2002). CLC at the clinical level historically has meant acquiring knowledge about particular cultural groups, but this approach has limited usefulness and can lead to stereotyping (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003). A more comprehensive approach focuses on the process of cross-cultural interactions and emphasizes developing awareness and skills in such areas as communication styles, decision-making approaches, family processes, cultural mistrust, and experiences of prejudice, racism, and sexism (Betancourt et al., 2003).

To provide guidance on serving diverse populations, the Hogg Foundation for Mental Health and OMH convened a panel of experts to draw up a framework for culturally and linguistically competent IHC services (Sanchez, Chapa, Ybarra, & Martinez, 2012b). The IHC organization was conceptualized as a mediator that engages with patients across the lifespan to improve behavioral and physical health outcomes and reduce disparities. The framework integrated best practices in IHC (multidisciplinary integrated care teams, one treatment plan for both physical and mental health, data collection to track and improve outcomes, patient-centered care that emphasizes prevention across the lifespan) with best practices in CLC (accessible location and hours, responsiveness to community needs, culturally and linguistically competent staff, programs that address social determinants of health). The framework was summarized in five consensus statements that recommended (a) culturally and linguistically competent and responsive IHC organizations and teams located in reasonably accessible areas and with flexible hours of service; (b) teams cross-trained in health and behavioral health that actively engage with patients, their family members, and their community across the lifespan; (c) teams that recognize and incorporate the strengths of patients/consumers, their family members, and their cultures at all points—assessment, diagnosis, and intervention; (d) one health and behavioral health history and treatment plan for each patient, under one roof, with a focus on wellness and continuous health promotion; and (e) participation by the IHC organization as a member of a
learning community in which health and behavioral health professionals gain knowledge, adopt data collection plans, and foster growth of an ethical workforce that represents and is competent to serve the diversity of the community.

THE PRESENT STUDY

The purpose of this study was to explore how two healthcare organizations, both federally qualified health centers (FQHCs) that provide services to a culturally and linguistically diverse population of uninsured and uninsured patients, applied best CLC practices in the context of IHC. The study gave particular attention to the role of mental health counseling. Medical and mental health professionals in each organization were interviewed using the five consensus statements (Sanchez et al., 2012b) as a guide. Public archival information was a source of additional data on culturally and linguistically competent IHC within each organization.

METHOD

Participants

Eight clinical service providers from two IHC organizations were interviewed; they represented primary care medicine, psychiatry, psychology, and social work. All provided direct clinical services to patients; two from each setting were also involved in administration. Table 2 summarizes demographic information for all participants.

Procedure

Interview and archival data were obtained from two IHC organizations in Texas. The study, which was exempt from institutional review board review, was overseen by the Office of Research Support at the University of Texas at Austin. Both organizations approved the study. Because the organizations differed in size, the authors selected two programs in each to enhance data comparability. All physicians and mental health clinicians in the programs selected were invited by email to participate.

The research team consisted of three doctoral candidates (first, second, and third authors), one faculty member with a Ph.D. (fourth author), and a doctoral student/research assistant, all affiliated with applied psychology programs within the educational psychology department. The first three authors are bilingual (Spanish/English) and had served previously as therapy trainees at one of the sites. Interviews were conducted by telephone by the first and second authors and the research assistant. To reduce interviewer and respondent bias, the authors interviewed personnel from the site where they had not trained.

Participants provided written consent for the data to be used for research purposes. No incentive was provided for participation. Participants were informed that participation was completely voluntary and would not affect their employment, and that though the organizations had approved authors contacting staff, their participation and individual responses would be confi-
Table 2. Participant Demographic Characteristics

<table>
<thead>
<tr>
<th>Demographic Characteristic</th>
<th>Site A</th>
<th>Site B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Languages spoken</td>
<td></td>
<td></td>
</tr>
<tr>
<td>English only</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>English and basic Spanish</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>English and fluent Spanish</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Profession</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care physician</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Mental health professional&lt;sup&gt;a&lt;/sup&gt;</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Age range</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31–40</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>41–50</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>51–70&lt;sup&gt;b&lt;/sup&gt;</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Length of employment at agency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.5–5 years</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>6–10 years</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>11–20 years&lt;sup&gt;c&lt;/sup&gt;</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

<sup>a</sup> Mental health professional here refers to a psychologist or licensed clinical social worker. The decision to combine these separate disciplines into one category was made to protect participant confidentiality.

<sup>b</sup>,<sup>c</sup> Ranges for age and length of employment were collapsed to protect participant confidentiality.

Participants could choose to be interviewed at work or after hours on a personal phone. Six were interviewed during scheduled breaks at work and two outside of work hours. Interviews lasted about 30 minutes and with participant consent were audiotaped.

**Measures**

Semi-structured interviews. The authors drew up a semi-structured interview guide composed of 12 open-ended prompts. Participants were asked about their views of their organization (e.g., “What drew you to work at this organization?”; “What are the strengths of this organization?”; “What do you see as the direction this organization needs to take in the next 5 years?”) and were read each of the five consensus statements and asked follow-up questions (“On a scale from 1 to 10, how much does your organization carry out the goals described in that statement?”; “What would it take to move your organization
to a [insert higher number] on the scale?"; "What is an example of how your organization has carried out one of the goals described in that statement?"). A copy of the interview guide is available upon request.

**Archival data.** The authors obtained client demographics, program evaluations, annual reports, and other archival documents from the organization websites.

**Data Analysis**

An exploratory cross-case synthesis technique was applied in which each setting was treated as a unit of analysis and separate study, and then the findings for the two cases were brought together (Swanborn, 2010; Yin, 2009). The first three authors analyzed the content of the interviews. Each first independently reviewed each interview transcript and drew up a list of themes from Site A and Site B. They then met to come to consensus on the main themes and subthemes that had emerged—all three authors had to agree on themes and subthemes. The first author then summarized the consensus themes and subthemes, with supporting details from the transcripts. The other two authors reviewed the summary independently and gave their approval. The authors then reviewed the interview transcripts again to identify statements exemplifying themes and subthemes and triangulated archival data for convergence with and divergence from the themes. For an additional informed perspective, the fourth author reviewed the results section summarizing the themes.

**Site Descriptions**

Site A is situated in an urban area in Texas that also serves clients from suburban and rural communities. This FQHC serves more than 10,000 patients, of which about 78% are Latino, 13% White American, 7% African American, and 2% from other racial or ethnic groups. The household income of 75% of the patients is at or below 100% of the federal poverty level. Patients are primarily English- and Spanish-speaking. The five mental health providers on staff are all clinical social workers; the clinic also contracts with psychology and psychiatry consultants who work with providers in multidisciplinary teams. This study focused on the pediatric and adolescent programs.

Based on the Blount (2003) classification scheme, Site A mental health services are integrated. All clients are clinic primary care patients. Services provided to adults and adolescents in the integrated behavioral health (IBH) program are targeted and specified. Patients are referred to the IBH program by a primary care physician (PCP) for treatment of depression or anxiety. Clinical social workers screen patients, conduct clinical assessments, establish treatment plans, provide therapy, and act as care managers. The PCP prescribes and manages medications with advice from a consulting psychiatrist. The pediatrics program is similarly targeted (youth aged 4–23 with developmental and behavioral challenges) but given the wide variety of diagnoses and concerns addressed, the services provided are unspecified. Incoming patients are evaluated jointly by medical and mental health staff. Treatment plans are
established by multidisciplinary collaboration; a psychiatrist and a psychologist may be called in.

Site B is a network of over 25 urban, suburban, and rural FQHCs in Texas that serves more than 73,000 patients, of which about 50% are Latino, 33% White American, 11% African American, and 5% from other groups; 70% have incomes at or below 100% of the U.S. poverty level. There are 41 mental health providers on staff, representing psychiatry, psychology, social work, mental health counseling, and psychiatric mental health nursing. This study focused on two of the network locations, one a behavioral health clinic providing psychiatry and therapy services and the other a clinical hub containing both a behavioral health clinic and primary care medical clinics. Because participants answered questions by referring to the network as a whole rather than their specific location, their responses were analyzed as one case study unit.

At Site B, mental health services may be either integrated or co-located. The behavioral health clinic has a multidisciplinary team of psychiatrists and therapists. Though this clinic interfaces with nearby network primary care clinics, sharing electronic medical records and a common appointment system, because it is in a physically distinct location it is classified as co-located. Patients may either be referred by PCPs within the system or access services from outside the system. The other location studied houses both a co-located behavioral health clinic and an integrated setting in which mental health providers see clients within the primary care clinic. Services are non-targeted (available to any patient needing services), and unspecified.

RESULTS

Three major themes were identified: (a) patient-centered care for underserved populations; (b) building and sustaining a successful multidisciplinary team; and (c) increasing capacity and adapting to changing circumstances (see Table 3).

Patient-centered Care for Underserved Populations

The interview theme of patient-centered care for underserved populations was reflected in the mission statements of each site and other archival materials.

Patient-centered care. Being patient-centered was viewed as being accessible and strengths-based and meeting client needs across the lifespan. One element was being responsive to the cultural and linguistic needs of patients:

We try to look at the whole patient. We feel like we’re here to provide care for the patient, to partner with the patient over the long haul, and we don’t think of ourselves as a place just for…band-aid solutions to issues that patients have acutely, but rather that we’re going to be involved with patients over time. (Site A, PCP)

[Site B] is a patient-centered medical home, which means that all the people that work here have a philosophy of putting the patient at the center of the treatment, more so than traditional medicine, which is
<table>
<thead>
<tr>
<th>Themes/Subthemes</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical: Patient-centered care for underserved populations</strong></td>
<td><strong>Patient-centered care</strong>&lt;br&gt; (100%; n = 8)&lt;br&gt; - Strengths-based, preventive approach&lt;br&gt; - Inclusion of family in treatment</td>
</tr>
<tr>
<td><strong>Linguistic competence</strong>&lt;br&gt; (100%; n = 8)</td>
<td><strong>High number of bilingual (Spanish/English) staff</strong>&lt;br&gt; <strong>Telephone interpreters</strong></td>
</tr>
<tr>
<td><strong>Cultural competence</strong>&lt;br&gt; (100%; n = 8)</td>
<td><strong>Provider self-report of competence with groups that are well-represented in the patient population (e.g., Latino patients)</strong>&lt;br&gt; <strong>Adaptation to less familiar groups in the community</strong>&lt;br&gt; <strong>Awareness of best practices versus skill in implementing them</strong></td>
</tr>
<tr>
<td><strong>Systemic: Building and sustaining a successful multidisciplinary team</strong></td>
<td><strong>Interprofessional communication</strong>&lt;br&gt; (100%; n = 8)&lt;br&gt; - Electronic medical records&lt;br&gt; - Physical proximity to other providers&lt;br&gt; - Building trust among providers</td>
</tr>
<tr>
<td><strong>Utilizing strengths of the team</strong>&lt;br&gt; (100%; n = 8)</td>
<td><strong>Importance of addressing both physical and mental health</strong>&lt;br&gt; <strong>Provider awareness of the contributions of other providers</strong>&lt;br&gt; <strong>Flexibility in meeting client needs</strong></td>
</tr>
<tr>
<td><strong>Professional development</strong>&lt;br&gt; (88%; n = 7)</td>
<td><strong>Release time for continuing education activities</strong>&lt;br&gt; <strong>Multidisciplinary team meetings</strong>&lt;br&gt; <strong>Ongoing process of learning from other disciplines on the team</strong></td>
</tr>
<tr>
<td><strong>Organizational: Increasing capacity and adapting to changing circumstances</strong></td>
<td><strong>Importance of community resources and partners</strong>&lt;br&gt; (100%; n = 8)&lt;br&gt; - Increasing program capacity via strategic partnerships&lt;br&gt; - Working with community groups to understand patient needs&lt;br&gt; - Partnerships for evaluation, research, and training</td>
</tr>
<tr>
<td><strong>Workforce development to reflect diversity</strong>&lt;br&gt; (63%; n = 5)</td>
<td><strong>Continued need for more bilingual (Spanish/English) providers</strong>&lt;br&gt; <strong>Pipeline issues in health and mental health fields</strong>&lt;br&gt; <strong>Developing a workforce that reflects community diversity</strong></td>
</tr>
</tbody>
</table>

Note: Percentages refer to the number of participants who endorsed each theme.
more paternalistic... It's a culture of care, in and of itself, which is more patient-centered, looking at cultural differences, paying attention to those things and knowing that one size doesn't fit all. (Site B, psychiatrist)

The patient-centered perspective was also reflected in how mental health staff discussed their approach to working with clients: “I feel like the patients are really treated with respect...they're in control over the extra services that they want” (Site A). Another provider noted that

Everybody seems to be focused on patients and their families.... I often see brothers and sisters, boyfriends, parents and kids.... Not only does it give them a sense of support when they're seeing me, but I think it also helps them take what we learn and take it back in their life. (Site B, mental health staff)

**Accessibility.** Accessibility was considered a patient-centered strength of both organizations and encompassed hours of operation, location, and appointment availability. Both offered evening and Saturday hours, though participants noted that it was difficult to provide mental health services given there were fewer therapists than PCPs. One solution was to stagger provider availability: “Time-wise, almost every night there’s a social worker who stays late, so they can meet with clients during the day and after hours. So, I feel like we’re able to accommodate, for the most part, meeting with clients” (Site A, mental health staff).

At Site A, which is in an urban area, participants also discussed the importance of being centrally located and accessible by car and public transportation. Site A had outreach facilities in high-need community locations (e.g., shelters) and offered programs for particular patient groups (e.g., those with chronic illnesses, pregnant and parenting adolescents). At Site B, where many of the clinics serve rural populations, strategic planning places new locations in areas identified as having high need and few resources.

According to participants, accessibility also meant shorter wait times. At Site B, accessibility was increased in the primary care clinics through open mental health appointment times that provided flexibility to see high-need patients: “We keep four half-hour appointments open every day...so that you can always have at least that opportunity to have someone seen the same day... so they don’t have to wait weeks ” (Site B, mental health staff).

**Linguistic competence.** Participants at both sites frequently referenced the high number of Spanish-speaking staff as an important component of patient-centered care: “It seems that most people at the clinic are bilingual, in Spanish and English. If they aren't, there’s someone on staff right next to them that can sit in during an examination, or whatever's needed to translate services” (Site A, mental health staff). Mental health staff in particular were considered critical to ensuring the clinic's linguistic competence, because more of them than medical professionals spoke Spanish: “We have one of the largest bilingual therapy and psychiatry groups that I’ve ever worked with.” (Site B, mental health staff).
Professional telephone interpretation was used for other languages: “We’ve worked very hard at hiring bilingual staff, and we provide interpreter service for many different languages” (Site B, mental health staff). Though Spanish speakers were the largest patient group, providers reported linguistic diversity: “We do see other cultures, so we do use some translation, you know, some Korean families, Burmese, African” (Site A, PCP).

**Cultural competence.** Many participants considered their organizations to be very responsive to patients from Latino cultural backgrounds. However, providers also discussed the complexity of working with different cultural groups, including ones not represented on staff: “Mental health can be tricky, and treating it and assessing it can be as well... especially when you mix mental health with different cultures” (Site A, mental health staff). Another provider noted:

> You know, I have a [lot of] experience... with Latino, Hispanic families, but I haven’t worked a lot with families that are Hindustani or Pakistani, and I’m learning a lot about their views on healthcare, behavioral health, and roles and dynamics in the family. This has become, on an individual basis, about... getting resources and... learning a little bit about the culture that I’m working with. And my clients teach me a lot more than I teach them [laughs]. (Site B, mental health staff)

**Building and Sustaining a Successful Multidisciplinary Team**

The importance of the multidisciplinary team in IHC was a second theme discussed in all participant interviews and highlighted on both websites. Mental health professionals reported that medical services enhanced their ability to care for patients, and PCPs reported mental health services were critical to meeting patient needs:

> Now I wouldn’t work in any other kind of setting. [I] almost consider my former work to be malpractice, to be working isolated, because I think you really need to have the whole approach, to help all the people that we see. (Site B, mental health staff)

**Interprofessional communication.** Most participants at both sites discussed the importance of a shared electronic medical record (EMR), containing both medical and mental health records, in communicating with other professionals about patients. However, several noted that the EMR was not a substitute for direct communication; for instance:

> We all have access to everything that we need to have. The medical provider can look at my notes and vice versa, and if they refer someone I always look at what they’ve seen, so I can get a background, and they probably do the same. But if they really need to know something, I go talk to them, because I know how busy they are. (Site B, mental health staff)

**Clinical consultation and collaboration.** Participants noted that their sites had some multidisciplinary administrative meetings or case conferences;
however, participants primarily discussed informal consultation throughout the workday and emphasized the importance of physical proximity in building relationships between mental health providers and physicians. At Site A, participants appreciated having the majority of providers in one place: “It’s a...one-stop shop...communicating [with doctors], a dietician on staff, or a nurse...helping families with diabetes health, asthma health” (Site A, mental health staff).

At Site B, the way primary care and mental health providers collaborated varied by location. For counselors co-located with primary care, examples of collaboration included therapists taking clients directly to PCPs to assess a medical concern, and vice versa. In the stand-alone behavioral health clinic, there was more emphasis on collaboration between therapists and psychiatrists, with PCPs accessible by phone. These types of collaboration were viewed as a continuum of services:

The primary care providers provide a medical home that is behaviorally enhanced through either embedding mental health in those non-behavioral health clinics, or sharing care of the patient within the same medical record, such that even if we’re in different locations, ... we all see what each other does, with clinical encounters, so there’s more of a safety net for these patients. Mental illness is much more recognized and better treated in an integrated model. And when you do that, you have much better physical outcomes as well. (Site B, psychiatrist)

Utilizing strengths of the team. Participants valued the different perspectives represented on the multidisciplinary team. Providers from other disciplines were valued not only for their specialized training but also for their flexibility in filling multiple roles to enhance patient care. At Site A, social workers were considered critical to coordinating team communication and providing patient follow-up, along with therapy and case management: “The care manager serves as the conduit for a lot of that communication [between the PCP and the psychiatrist], although the psychiatrist will pop in and have a conversation with the PCP now and then” (Site A, PCP).

At Site B, the number of psychiatrists on staff and their board certification in specialty areas (e.g., child and adolescent, geriatric, consultation-liaison) were cited as enhancing the ability of PCPs to manage mental health concerns. It was also noted that PCPs had a commitment to continuing education: “Our [PCPs] are really getting more comfortable managing behavioral health medications. They really act as a bridge between the patient and the psychiatrist” (Site B, mental health staff).

Professional development. At both sites, participants expressed interest in more opportunities for multidisciplinary case conferences and continuing education:

I’d like us to do more with the providers to bring their skill level up even more. I think in the IBH program a lot of that happens just with the communication and one-on-one interaction between the psychiatrist and the PCP, and just
the information passing from psychiatrist to primary care provider, people learn that way...[but] if you’re not at that conference, it’s harder to achieve that learning and improve your own skill levels.... We should probably do quarterly education sessions and case discussions. (Site A, PCP)

Many participants also noted that different provider schedules and time away from patients are barriers to pursuing on-site professional development. This was more of a concern at Site B: “I think time is the enemy ... it’s just trying to...get those needs met in the most time-effective way, and learning how to hand off to each other, in an easier way” (Site B, mental health staff). One provider described the challenge:

We are often discussing treatment plans and approaches, and how to help improve the quality of care, so there’s progress being made. [An improvement might be] providing time in our schedules to have these more detailed discussions. Right now we currently do it between sessions. But you know, that’s difficult, because if we have time for that, then we could be using that time to be seeing even more people. (Site B, mental health staff)

Professional development in cultural competence also occurred through on-the-job exposure and individual continuing education. One participant expressed interest in further formal training within the organization, rather than pursuing training individually:

[Since I began working here] I haven’t had any training in terms of ... diversity training, a refresher. It seems like we’ve all had training at some point, but being able to check in...and being aware of our own biases would be helpful... across the different disciplines, and for us to attend these trainings together. (Site A, mental health staff)

**Increasing Capacity and Adapting to Changing Circumstances**

A third theme was the importance of organizational adaptation to changing circumstances. Participants cited changes in national and local healthcare policy, population increases in the areas served by the clinics, and changing population demographics leading to a wider range of client cultural groups and languages. Organizational adaptations included efforts to utilize community resources, develop organizational partnerships, expand services, and further diversify the workforce.

**Importance of community resources and partners.** Interviews reflected a continuous process at both sites of increasing the organization’s capacity by expanding and improving services, often in collaboration with community partners. The archival data supported the emphasis on community collaboration, with both sites having partnerships with universities, medical schools, hospitals, nonprofit organizations, and foundations. Partnerships with community groups were suggested as a way of understanding the particular healthcare needs of culturally diverse communities: “The key to that is the continual giving and learning of knowledge because the population changes all the time” (Site B, mental health staff).
Expansion of services. Participants often discussed expansion of services as a goal, and archival data supported the emphasis on growth in both organizations. A key difference participants noted was that Site A’s approach to expansion was based on increasing capacity from the base of their independent clinic in a densely populated urban area, while Site B’s approach was based on expansion to new clinics in underserved areas. Participants from both discussed enhancing the integration of primary care medical and mental health services. At Site A, one priority was to add additional psychiatry consultation hours; at Site B, several participants discussed having more mental health staff embedded in primary care.

Workforce development to reflect diversity. Building a workforce that represents patient cultural and linguistic diversity, particularly physicians, was a priority for several participants, including all involved in administration:

Most of our providers are not fluent in Spanish and lots of our patients are Spanish-speaking. ... Our social workers bridge that gap very well [but] we have very few providers that are fluent in Spanish and can understand the subtleties of a conversation with a patient. The medical assistants pretty much all speak Spanish and primarily serve as interpreters. (Site A, PCP)

A psychiatrist at Site B concurred: “We need to do better at attracting a workforce that mirrors the cultural demographics of our patient population, especially more Hispanic doctors, for example.” However, participants also noted that the hiring of culturally and linguistically diverse staff is impacted by their availability in the community: “There aren’t as many LCSWs who are bilingual. The pool isn’t that great. I’m probably always going to say we can hire more” (Site B, mental health staff).

To do this there has to be community outreach to ethnic minorities early in their lives to attract them to the healthcare profession... introduce it earlier, introduce schools that have emphasis on that, and then with financial aid; just like there’s affirmative action, if there can be extra financial compensation if one is a member of an ethnic minority that can be helpful. (Site B, psychiatrist)

DISCUSSION

This study interviewed medical and mental health practitioners to explore how two IHC settings have pursued provision of culturally and linguistically competent mental health services in primary care. The interviews were guided by the consensus statements on CLC in IHC developed by Sanchez and colleagues (2012b). The general themes that emerged indicated that practitioners valued IHC as a method of providing mental healthcare to culturally, linguistically, and socioeconomically diverse patients. The themes highlighted best IHC practices; subthemes were related to specific ways in which the organizations carried out patient care, interdisciplinary collaboration, and the improvement of systems. CLC did not emerge as a separate theme but was present in multiple subthemes and discussed as an aspect of effective healthcare delivery.
CLC aspects that arose were primarily related to accessibility of services; language access for clients via bilingual staff and interpreters; knowledge of and comfort with groups that were well-represented in the client population; awareness of the need to adapt services to less familiar cultural groups; and the importance of having a diverse healthcare workforce.

The consensus statements that guided the interviews similarly focused on best IHC practices as a means of delivering culturally and linguistically competent services. The logic is that high-quality IHC with attention to issues of CLC will improve access to and quality of mental health services for ethnically and culturally diverse populations. On the other hand, participant responses also indicated areas that needed further attention to CLC to deliver mental health services more effectively: how to adapt to demographic shifts in the client population, how to ensure that workforce diversity represents client diversity when there is an inadequate pool of culturally responsive healthcare providers, how to assess cultural views on health and wellness, and how to incorporate client strengths into a medical model of diagnosis and treatment. The complexity of these issues indicates a need for increased training and multidisciplinary collaboration focused on day-to-day CLC in healthcare settings.

**Implications for Culturally-tailored Research**

The greater emphasis on IHC than on CLC in the interviews is consistent with the literature on IHC for diverse populations. There is ample evidence that IHC is generally effective, but far less on its effectiveness with particular racial/ethnic groups (Sanchez et al., 2012a). Research that links local implementation to treatment outcomes is critical to improving outcomes for diverse groups (Sue, Zane, Hall, & Berger, 2009). Mental health counselors in primary care settings are in a position to contribute by participating in practice-based research, such as program evaluations and clinical case studies, which can illustrate whether particular approaches to IHC and CLC improve patient outcomes.

**Implications for Culturally-tailored Practice**

Increased training on the process of CLC rather than simply knowledge of cultural groups is essential for healthcare professionals (Bétancourt et al., 2003). Examples of these processes are healthcare assessments that take into account cultural beliefs, values, and perceptions of illness; patient-centered treatment plans; and community outreach to address health disparities (Sanchez et al., 2012b). Participants in this study discussed issues of process but did not necessarily have a formal venue in which to share and expand their ideas. IHC organizations are in a position to formalize venues for providers to pursue advanced CLC training, consultation, and case discussions.

**Implications for Clinical Mental Health Providers**

Our study makes it clear that

- Bilingual mental health providers are highly valued in primary care settings that serve linguistically diverse populations. Providers would benefit
from building up their linguistic competency via continuing education, consultation with other bilingual providers, and bilingual supervision.

- Mental health providers in our study were often the cultural and linguistic brokers who helped patients navigate systems effectively. Those who appreciate the value of this role will be a good fit for IHC settings.

- Effective interprofessional communication and collaboration (e.g., taking the initiative to seek and provide consultation; providing case coordination for patients and providers; cross-training in health and mental health services) will be critical to successful mental health practice in a primary care setting, as will an understanding of the pace of primary care.

- With healthcare reform IHC opportunities are rapidly expanding, providing considerable opportunity for mental health providers to shape their roles in evolving programs and dynamic systems. Providers who have experience in organizational change, program development, or program evaluation will be particularly valuable.

**Strengths and Limitations of the Study**

This study was exploratory and relied on a small sample of participants. Sites were selected based on availability and represented a particular geographic area. Since one site had been in the community significantly longer than the other, there was a difference in the length of time providers had been employed. CLC was also explored broadly. Data were not collected on specific provider knowledge or competencies or on patient outcomes. Finally, there was a focus on clinical provider perspectives on their organization; nonclinical staff might have different perspectives.

Despite these limitations, the medical and mental health providers interviewed underscored the value of mental health in primary care. We concur with the conclusion of Aitken and Curtis (2004) that IHC settings provide unique and valuable opportunities for counselors. We further posit that the value of counselors in these settings will be enhanced by a commitment to best practices in both IHC and CLC. Mental health counselors in primary care settings are in a position to improve access to and the quality of mental health services to culturally and linguistically diverse populations.

**REFERENCES**


