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ABSTRACT

Research indicates that living in poverty exacerbates the risk for poor mental health, yet low-income people are less likely to seek mental health treatment than are people in higher income brackets. The research literature reports that this reluctance to seek behavioral health care is often due to a variety of barriers, such as stigma, costs, victimization, discrimination, and labeling. Federally Qualified Health Centers (FQHCs) are collaborative healthcare clinics that are uniquely positioned to eliminate many recognized barriers to care that hinder access to mental health services for some vulnerable and underserved populations. Most of the collaborative health care literature is reported from the perspectives of healthcare professionals and administrators, while consumers' viewpoints are vastly underrepresented and unexplored. This study helped to address this research gap.

The purpose of this qualitative study was to understand perceptions and experiences of clients utilizing behavioral health services within a collaborative healthcare FQHC. Using a phenomenological methodology, this study explored the real-lived experiences of 11 low-income clients who voluntarily participated in individual interviews. Using data analysis procedures recommended by Moustakas (1994), the participants' interviews were examined and went through multiple levels of abstraction to explore the deeper meanings of their experiences. Data analysis suggested that the participants' positive and caring relationships established with their therapists had a profound impact on their behavioral health experiences. Through the trusting relationships established with their therapists, participants felt safe to engage in the therapeutic process and work towards change. Participants described their behavioral

health experiences as being a safe-haven that helped them achieve personal growth and better self-understanding.

Relationships with the health center's staff and the environment of care at the FQHC were additionally acknowledged as having a meaningful impact on the participants' experiences of care received. The collaborative health care relationship also surfaced as an indispensable resource in breaking barriers to mental health treatment, and thus, increased the likelihood for consumers to utilize behavioral health services. The results of the study support much of the literature pertaining to the effectiveness of the collaborative health care approach and have clinical implications for Marriage and Family Therapists and other healthcare professionals.

CO-CREATING COLLABORATIVE HEALTH CARE IN A FEDERALLY
QUALIFIED HEALTH CENTER: EXPLORING CLIENTS' EXPERIENCES OF
BEHAVIORAL HEALTH SERVICES

By

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M.A., University of Louisiana at Monroe, 2002

DISSERTATION

Submitted in partial fulfillment of the requirements for the
degree of Doctor of Philosophy in Marriage and Family Therapy
in the Graduate School of Syracuse University

May 2011

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LIST OF ABBREVIATIONS

AA	African American
AAMFT	American Association for Marriage and Family Therapy
AHRQ	Agency for Healthcare Research and Quality
AAMA	Association of American Medical Colleges
BH	Behavioral Health
BPHC	Bureau of Primary Health Care
C	Caucasian
CHC	Community Health Center
COAMFTE	Commission on Accreditation for Marriage and Family Therapy Education
Delta NIRE	Lower Mississippi Delta Nutrition Intervention Research Initiative Consortium
DHHS	U.S. Department of Health and Human Services
DRA	Delta Regional Authority
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IRB	Institutional Review Board
LaDHH	Louisiana Department of Health and Hospitals
LaDHH/BPCR	Louisiana Department of Health and Hospitals/Bureau of Primary Care and Rural Health
LaDHH/GHCRP	Louisiana Department of Health and Hospitals/Governor's Health Care Reform Panel

LaDHH/OPH	Louisiana Department of Health and Hospitals/Office of Public Health
LaDHH/SCHS	Louisiana Department of Health and Hospitals, State Center for Health Statistics
LCSW	Licensed Clinical Social Worker
LHIS	Louisiana Health Insurance Survey
LMFT	Licensed Marriage and Family Therapist
LPC	Licensed Professional Counselor
LPCA	Louisiana Primary Care Association
LSU	Louisiana State University
MFT	Marriage and Family Therapy or Therapist
MHA	Mental Health America
MUA	Medically Underserved Area
MUP	Medically Underserved Population
NAMI	National Alliance for the Mentally Ill
NACHC	National Association of Community Health Centers
NASMD	National Association of State Medicaid Directors
NCHS	National Center for Health Statistics
NCHC	National Coalition on Health Care
NFCMH	President's New Freedom Commission on Mental Health
NHC	Neighborhood Health Center
NIH	National Institutes of Health
NIMH	National Institute of Mental Health
PCMH	Patient Centered Medical Home

PHSC	Primary Health Services Center
PIN	Policy Information Notice
SAMHSA	Substance Abuse and Mental Health Services Administration
SES	Socioeconomic Status
SSI	Social Security Income
SU	Syracuse University
ULM	University of Louisiana at Monroe
WFMH	World Federation for Mental Health
WHO	World Health Organization

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CHAPTER ONE: INTRODUCTION

Personal Journey

For almost four years, I have worked in a behavioral health program in a Federally Qualified Health Center (FQHC) in Northeast Louisiana providing counseling services to individuals, couples, and families. The FQHC clinic in which I am currently working, Primary Health Services Center (PHSC), has been established for over 11 years in Monroe, Louisiana in Ouachita Parish. The health center offers integrated primary care, behavioral health, and dental healthcare services to low-income, uninsured, and vulnerable residents of the local and surrounding areas. My presence at PHSC is a result of both personal and professional growth that began with my graduate training and ultimately found expression with this research.

Although I am a native southerner and a life-long resident of Louisiana, the pursuit of my doctoral education led me north to attend Syracuse University (SU) in Central New York. Relocating from one geographical region to another, south to north, proved to be challenging on many levels. The sharp abruptness and directness of northeastern culture was in stark contrast to my accustomed southern background, which was easygoing and laidback. My southern accent was an immediate giveaway that I was not a native of the north. I was frequently questioned *where* I was from in the south, not *if*, as my semantics and lingo were notably identified as southern. Many behaviors, comments, and questions that appeared “normal” for my SU cohort offended me, yet my dismay perplexed them. They could not understand my chagrin or why I felt slighted so often, and I had difficulty articulating my experiences in a culture I perceived to be antithetical to mine.

Throughout numerous challenging experiences in the north, I was able to learn about different cultural systems, and the manner in which these cultural systems play out in day-to-day human interaction. Additionally, I became aware of the multiplicity of meanings that people could attach to experiences, specifically the marginalized perceptions of oppressed populations. With a deeper understanding of the interplay between social and cultural context, I recognized more visibly the inequities in human conditions. My various experiences broadened me to understand the world in a multifaceted manner and to appreciate the complexity of diversity without the bureaucracy of homogenized ideals. In essence, I was able to understand behaviors, perceptions, and emotions through an intricate web of contextual meaning that began to change my life's path and also redefined my own identity.

Home was never the same and was unable to provide the solace that it had furnished previously. Its brilliance lacked luster after I was sensitized to injustices and atrocities in the world. As a result of my "northernization," I was able to experience the south in a different way – as an outsider looking in, but with the anguish of an insider wondering how I could have been so blind to the extensive neediness and disparities of countless persons and families in the Deep South. My sorrow and inner shame were overwhelming, and in its midst, a new journey began - a journey that created a path to lead me back home. Tears once shed over leaving the south resurfaced upon my return home.

Journey to Help the Poor and Underserved

My hometown in Louisiana is a 23 hour drive from Syracuse. The drive home to Monroe was a journey through New York, Pennsylvania, Maryland, West Virginia,

Virginia, Tennessee, Georgia, Alabama, Mississippi and finally ending in Louisiana. Each of these states has its own unique personalities and individual flair, but I distinctly remember crossing the state line into Mississippi. Sadness engulfed me, and my despair continued throughout the drive to my home state as I viewed the backdrops that saturate the deeply impoverished South. With a new perspective, I was able to see my surroundings for what they were – a constant struggle for many people to merely survive in the world.

The sight of condemned, abandoned homes, or rather shacks, which are consistent pieces of the landscape in the Deep South, was a gloomy vision. Many of these shacks are falling apart with rotted porches and boarded or broken windows. They often have no running water or electricity and appear as though a strong wind could blow them away. More disconcerting than the sight of them, however, was fact that many people actually lived in these homes. Children and families had taken shelter in these shacks, despite the horrendous conditions. Observing these hardships through my expanded understanding of oppression and injustice magnified the intensity of the destitution.

As a southerner, I am aware of the south's disproportionate ratio of poverty compared to the vast majority of the nation, but I was unprepared for the depth of emotional turbulence I experienced upon returning home. Somehow, perhaps through the social justice advocacy I acquired at Syracuse, the deprivation seemed worse than I remembered. Unfortunately, this deprivation was not imagined and was worse due to the recent hurricanes the region had experienced. Hurricanes Katrina and Rita struck and devastated Louisiana only one year prior to my return. Louisiana and other southern gulf states were still attempting to mend the repercussions of these natural disasters. The

actuality of poverty and adversity in the Delta region is a painful cry for intervention, change, and necessary reform; yet, without experiencing daily life in these economically depressed areas, it is practically impossible to fully comprehend the effects of the immense devastation.

Although over five years have passed since their occurrences in 2005, the aftereffects and subsequent devastation of Hurricanes Katrina and Rita are still felt throughout Louisiana, predominantly among the poor. For the vast majority of the country, those two hurricanes were news events in the past. Unfortunately for the residents who lived through these events and lacked the resources to rebuild their lives, the struggles are everyday and interminable. Many residents of New Orleans have chosen to make Monroe their home for fear of moving back to the southern part of the state and re-living the horrors of massive hurricanes tearing apart their lives. PHSC still provides services for an abundance of the hurricanes' survivors, who continue to suffer from the ramifications. Likewise, the substantial majority of PHSC's clinic users suffer from inadequate housing, homelessness, unemployment, impoverishment, violence, chronic diseases, physical ailments, hunger, and scarce resources.

After coming back to my hometown and home state, I am acutely more aware of my social surroundings and the suffocating effects of poverty in individuals' and families' lives. As a clinician at PHSC, I have been privy to clients' personal stories of hardship, pain, grief, and loss. Many of my clients' personal struggles have given voices and faces to the oppressive, impoverished conditions in Louisiana that I previously described. Being aware of the mass destitution in Louisiana, I am amazed by the strength and resilience of the state's most vulnerable residents who struggle on a daily basis, yet

continue to thrive in the face of extreme odds. I believe that a community-based, culturally appropriate behavioral health program, driven by consumers' needs, is a necessity for comprehensive healthcare services. My desire and motivation for these positive changes in Louisiana brought the current study into existence.

Introduction to the Research Topic

Mental health has increasingly gained attention as a critical component in overall health and well-being. National, as well as international, efforts have campaigned for recognizing mental health's importance and impact on health, quality of life, and relationships. It is estimated that one in four American adults suffer from a diagnosable mental disorder in any given year (Kessler, Chiu et al., 2005), and approximately half of the U.S. population will meet the diagnostic criteria for one or more mental disorders in their lifetime (Kessler & Wang, 2008).

Living in poverty exacerbates the risk for poor mental health by increased exposure to stressors that strain health and well-being (Cameron & Mauksch, 2002; U.S. Department of Health and Human Services [DHHS], 1999, 2001; Falconnier, 2009; Zimmerman & Katon, 2005). Since racial and ethnic minorities are disproportionately represented among the poor, these populations are placed at elevated risk and have a high propensity for mental health issues through the duress of socioeconomic status, racial discrimination, and marginalization (Gary 2005; Snowden, 1999, 2003). Although the risk and likelihood to suffer from mental health problems is higher for the low-income, they are less likely to seek help for mental health problems than are people in higher income brackets (DHHS, 1999, 2001).

The research literature reports that stigma, costs, and other barriers to care prevent low-income people from accessing needed mental healthcare services. As an alternative, these consumers often present to primary care settings for mental health treatment instead of specialty mental health. For this reason, primary care is referred to as the “de facto mental health care system” (Reiger, Goldberg, & Taube, 1978; Reiger et al., 1993). However despite this trend to seek mental health services from primary care facilities, the majority of consumers’ mental health conditions go unrecognized and undiagnosed in this setting (Campbell et al., 2000). One explanation has been that primary care providers are often not prepared and many times nominally trained and educated to identify, diagnose, and treat mental health issues (McDaniel, 1995; Sotile, 2005; Weston, 2005).

A possible solution to the problem of primary care providers treating mental health issues could be the collaborative healthcare approach, which integrates primary care and behavioral health services. Research suggests this integration has lowered overall healthcare costs and improved health outcomes for consumers by attending to their needs with a holistic focus (Dobscha et al., 2009; Doherty, Baird, & Becker, 1987; Engel, 1977; Ludman et al., 2003; McDaniel, Hepworth, & Doherty, 1992; Seaburn, 2005; Simon et al., 2002; Strosahl, 2001). Collaborative health centers also allow consumers to receive mental health services without the connotation of stigma because clients are able to maintain privacy in the type of services sought due to the range of comprehensive services offered at these centers (Simpson, 1998). The effectiveness of this approach is supported by the research that indicates lower client no-show rates for

behavioral health services in integrated healthcare settings as compared to stand-alone, non-integrated behavioral health clinics (Guck, Guck, Brack, & Frey, 2007).

Federally Qualified Health Centers (FQHCs) are collaborative healthcare facilities that are particularly well-placed to offer a viable option that removes many of the identified barriers that prevent access to mental health services for some low-income populations. FQHCs are federally funded, community-based organizations that provide comprehensive primary care and preventive care, including medical, dental, and behavioral health services to persons of all ages, regardless of their ability to pay. Vulnerable populations frequently rely on FQHCs as their fundamental source of healthcare (Hadley & Cunningham, 2004). In 2008, FQHCs provided services to 18 million people nationwide, a 67% increase from the year 2000 (National Association of Community Health Centers [NACHC], 2009). The majority of consumers are (a) low income, (b) uninsured or publicly insured, and (c) members of racial and ethnic minorities (NACHC, 2009). As economic and demographic trends indicate these populations will only continue to increase, along with their need for accessible mental health services (Chow, Jaffee, & Snowden, 2003; National Coalition on Health Care [NCHC], 2009; U.S. Census Bureau, 2009), FQHCs are a salient solution and uniquely positioned to meet the needs of these vulnerable populations.

In summary, although the prevalence of mental illness in the United States is high, many of those afflicted with mental health disorders do not seek treatment due to a variety of barriers. Primary care providers are often used in lieu of mental health services, but this can be a problematic solution as many primary care providers are ill-equipped to diagnose or treat mental illness. The integration of primary care services

with behavioral health services appears to be a viable alternative particularly when offered in the form of a FQHC. The goal of FQHCs is to “successfully increase access to care, promote quality and cost-effective care, eliminate health disparities and improve patient outcomes, especially for traditionally underserved populations” (Bureau of Primary Health Care [BPHC], 2008). These health centers remove many of the barriers to receiving mental health services.

Statement of the Problem

Primary Health Services Center (PHSC) is a FQHC that provides services to nearly 12,000 low income, uninsured or publicly insured, vulnerable, and medically disenfranchised individuals yearly in the city of Monroe, Ouachita Parish, and the surroundings areas. Ninety-five percent of PHSC’s clinic users are 100% or more below poverty level. PHSC’s demographics of clinic users by self-reported race/ethnicity are 76% African American, 23% Caucasian (non Hispanic or Latino), and less than 1% reporting more than one race or another race. The population of Ouachita Parish is roughly 150,000 and includes Monroe, the Parish seat, with a resident population of approximately 52,000 (U.S Census Bureau, 2008b). These figures roughly estimate that one out of every five people in Monroe use healthcare services at PHSC, and 1 in every 13 in Ouachita Parish.

Although a large number of people benefit from the low cost, high quality primary care and dental services at PHSC, the proportion of people actually and actively seeking behavioral health services is small. Only about 5% of PHSC’s primary care users also use behavioral health services. Given the overwhelming poverty in this region and the devastating effects of living in poverty, it would seem that vulnerable residents of

Northeast Louisiana could benefit immensely from utilizing behavioral health services provided in this integrated setting. However, underutilization of these services remains high.

PHSC employs a number of strategies to ensure that potential consumers are aware of the services offered. For example, fliers, brochures, and cards, which define and create awareness for the behavioral health program at PHSC, are dispersed all over the clinic and in the private exam rooms. Outreach workers educate the community about the available services at PHSC by going into the public housing and low income neighborhoods and interacting with residents. PHSC also participates in community health seminars. Additionally, the primary care providers make referrals, and the behavioral health providers and staff take great efforts to inform and recruit clinic users for the services. Despite these efforts, usage, compared to what it could be, is very small.

Drawing upon my own experiences at PHSC and the countless times I was summoned into an exam room to talk with distressed clients, I became intrigued with some of these client interactions. I had several experiences where, after I consoled persons dealing with crises and was successfully able to engage them in signing on for behavioral health services, they stated things such as “this isn’t what I thought! I feel so much better after talking with you.” Although I never asked, I became interested in what their perceptions of behavioral health services were because, much to their delight, services were *not* as they anticipated. These interactions sparked my curiosities about how clients perceived these services and what meaning they attached to receiving them.

It is possible that the underutilization of behavioral health services by clients could be related to how those services are perceived by them. This prompted the

following questions: What are clients' points of view and frames of reference about behavioral health services? How does the meaning they attach to receiving these services impact their utilization of them? I wanted to obtain this information in a way that allowed clients to inform me of their experiences, not my presuppositions of what I thought those experiences were.

In addition, most of the collaborative healthcare literature focuses on the viewpoints of healthcare providers, administrators, or "experts" on the topic. Studies involving consumers' perspectives of behavioral health services integrated with primary care services are underrepresented and unexplored. Consistent with the federal government's healthcare goals, I believe that culturally competent behavioral health services are an essential lifeline in overall health, especially for vulnerable populations who are at higher risk for mental health problems. Research suggests that without a clear awareness of consumers' frames of references, culturally competent services cannot be tailored to the unique needs of its clientele (Fox, Merwin, & Black, 1995; Singer, 2005). Research projects are needed to examine cultural differences in factors affecting mental health, and "such work will lay the groundwork for developing new prevention and treatment strategies – building upon community strengths to foster mental health and to ameliorate negative health outcomes" (DHHS, 2001, p. 162). In order to meet the need of providing culturally appropriate services, the voices of consumers having experiences in a collaborative healthcare setting were explored.

Purpose of the Study

The purpose of this qualitative study was to understand perceptions and experiences of clients utilizing behavioral health services within a collaborative

healthcare paradigm in a FQHC in Northeast Louisiana. Using a phenomenological methodology, this study explored the real-lived experiences of these clients. The goals of the study were to (a) allow participants to describe in their own voices their lived experiences of receiving behavioral health services at PHSC, (b) understand the meanings clients placed on these experiences, (c) explore how clients' perceptions of behavioral health services have evolved, if at all, throughout utilizing the services, (d) learn about clients' experiences of receiving behavioral health and primary healthcare services at the same health center, and (e) be informed of ways the services could be changed to better meet clients' needs.

Rationale for the Study

As a family therapist, I strongly believe in the power of mental health and the integrity of the Marriage and Family Therapy (MFT) profession to help create positive, systemic, and healing changes in individuals' and families' lives. MFT scholars have argued that, as clinical professionals, we have a responsibility to our clients and communities that extends far beyond the therapy room. Doherty and Mendenhall (2006) proposed the idea of therapists engaging collaboratively with clients in a citizen health care paradigm, which goes beyond individual outcomes and concerns itself with health outcomes of the larger community.

Doherty (2008) also believed that as agents of change, therapists must look at clients' problems from the larger social context which gives them meaning, but also use this knowledge to be catalysts for change within communities. A citizen-therapist should take problems from clinical practice and engage collaboratively with the community in a joint effort to heal them (Doherty, 2008). Doherty and Mendenhall (2006) contend:

within this partnership, hierarchical differences are flattened, and all participants work together to create knowledge and effect change... citizen health care aims to engage a resource that is largely untapped in our strained health care system: the knowledge, wisdom, and energy of individuals, families, and communities who face challenging health issues in their everyday lives. (p. 253)

Challenges need to be confronted to create change and to break down barriers including attitudes, fears, and misunderstandings about mental health (DHHS, 1999, 2001). Through understanding the social and cultural perspectives of clients about behavioral health services, therapists and clients can work together collaboratively to help improve the health statuses of individuals, families, and their communities by developing culturally appropriate and accessible community-based healthcare services.

Marriage and Family Therapy is recognized as a distinct discipline and one of the core mental health professions by the Federal Government (HRSA, 1993), which means that MFTs are part of the collaborative team needed to examine and improve the healthcare challenges faced by indigent populations. Impoverished and underserved populations have the greatest gaps in mental health care treatment (DHHS 1999, 2001). This research study could contribute pertinent knowledge to effectively implement behavioral health programs with low-income populations in a FQHC collaborative healthcare setting.

Theoretical/Conceptual Framework

Systems Theory and Social Constructionism

The theoretical frameworks which provided the structural platform for the study were systems theory and social constructionism. Systems theory asserts understanding

experiences through the reciprocity of interactions, specifically in a given context, and recognizes relationships as interconnected and circular, rather than individualistic and linear (Becvar & Becvar, 2003; Hoffman, 1981; Jackson 1965). Espousing a systemic framework emphasizes understanding the mutual influence of behaviors. No incident exists in isolation as patterns of behavior are created and maintained by the shared interaction between individuals (Jackson, 1965; Watzlawick, Weakland, & Fish, 1974). Watzlawick, Beavin, and Jackson (1967) defined interaction as “two or more communicants in the process of, or at the level of, defining the nature of their relationship” (p. 121). Each person’s behavior gives meaning to other’s behavior as all are involved in a relational context (Bateson, 1972; Keeney, 1983). By taking into account contextual factors that influence behaviors and meanings, actions and perceptions can be explained in a more holistic manner. When adopting a systemic framework, the focal point goes beyond evaluating individual patterns of behavior and seeks to understand the larger, relational processes which give them meaning.

Systems theory recognizes the subjectivity of human experiences as a process with “both/and complementarities” instead of “either/or dichotomies” (Becvar & Becvar, 2003). “Through social exchange, people give meaning to human experience” (Gehart-Brooks & Lyle, 1999, p. 58). Reality is unique to the person experiencing it, yet is connected to broader socially constructed realities (Anderson & Goolishian, 1992).

Social constructionism is “the creation of meaning through our collaborative activities” (Gergen & Gergen, 2004, p. 7) and “concerns itself with the way that people arrive at their descriptions, explanations, and understandings of themselves and their world” (Anderson, 2007, p. 12). A social constructionist framework punctuates social

exchange and knowledge created through social processes, especially the meaning derived from language, as key in the creation of realities. “The important point is that whenever people define what ‘reality’ is, they are always speaking from a cultural tradition” (Gergen & Gergen, 2004, p. 11). Anderson (2007) contends:

What is created in and through language (e.g., realities such as knowledge, truth, and meaning) is multiauthored among a community of persons. The reality that we attribute to the events, experiences, and people in our lives does not exist within the thing or person; instead, it is socially created within a particular culture and is continually reshaped in language. (p. 9)

Gergen and Gergen (2004) advocate understanding meaning as a “coordinated action” which suggests any utterances in isolation are meaningless; the potential for meaning can only be understood through reciprocal communication with others; and traditions offer alternatives for meaning, but do not bind them. In simplest terms, how people understand their world and their personal meanings created about themselves is a result of social interactions with others and can change over time. Lax (1996) states:

Rather than seeing the individual as the site of problems, these approaches see an understanding of social and historical relational networks and linguistic practices as central to both problem formation and resolution: they stress our relational nature to one another and how problems arise (and are dissolved) through language and through social interactions. In keeping with postmodern thinking, these approaches attend to the local and global contexts of our lives, both in and out of therapy, including issues related to politics and diversity (which includes gender, class and race, and local cultures). The role of the ‘other’ is shifted from

foreigner to extension of self, as self is viewed as arising out of the interaction between self and other. (p. 195-196)

This study was conducted with the theoretical underpinnings of systems theory and social constructionism. With these frameworks in mind, it is noted that consumers' perceptions of behavioral health services were unique based on their personal encounters yet, at the same time, were a result of relational interactions. Moreover, the social and cultural context of these encounters were also taken into account and acknowledged to better understand the meanings that clients created about these experiences.

Significance of the Study

The study is significant in several ways. First, the study helped bring marginalized voices to the forefront and give some of the underserved residents of Northeast Louisiana a chance to express their viewpoints about behavioral health services, specifically when received in a collaborative care framework. Second, with consumer-driven information, it is possible that PHSC, as well as other interested collaborative healthcare centers, could learn better methods to deliver behavioral health services that are more congruent with consumers' needs and wishes. Third, by systemically recognizing individuals as pieces of the larger community and understanding their help-seeking experiences, the information obtained in the study could be used to help other community members in need of services. Fourth, being aware of the unmet mental health needs in Louisiana, as well as the numerous individuals who fit the criteria for being "high-risk," this study could help make services more accessible and user-friendly through utilizing community perspectives to break down barriers and expand consumer knowledge in culturally and linguistically appropriate manners. Fifth,

through exploring consumers' experiences, the study may assist in preventive measures to promote mental health, as opposed to treatment of mental illness, through the community's constructed meanings.

Additionally, the study takes a public health approach which "attaches high importance to public health practices that seek to identify risk factors for mental health problems; to mount preventive interventions that may block the emergence of severe illnesses; and to actively promote good mental health" (DHHS, 1999, p. viii). Finally, this study also addressed a gap in the research literature by focusing on the experiences of consumers and their perspectives of behavioral health services in a collaborative healthcare paradigm, as opposed to the perspectives of healthcare providers and experts.

Delimitations

This study focused on those participants who were currently utilizing, or had previously utilized, behavioral health services and primary care services in a FQHC in a small urban community in Northeast Louisiana. As participation was voluntary, these participants were self-selected. Therefore, the study did not include the voices of those behavioral health and primary care users who chose not to participate, those primary care users who were not utilizing behavioral health services, or those consumers exclusively using behavioral health services without primary care services. Those individuals may have a very different perspective from the actual participants. In addition, since these participants were utilizing the services of a FQHC, they were low-income, vulnerable, medically disenfranchised, uninsured or publicly insured persons.

While the majority of FQHCs serve a variety of racial and ethnic minority groups, the largest demographic of PHSC's consumers are primarily homogeneous and members

of the African American community. Therefore, the research literature on ethnic and racial minorities supporting this study will focus primarily on research involving the African American population. Additionally, although this study focused on clients' experiences of behavioral health services with behavioral health providers in a collaborative healthcare setting, the study did not focus on clients' experiences of the collaborative team relationship between their behavioral health and primary care providers.

Definition of Terms

Federally Qualified Health Centers (FQHCs) - are “community-based and patient-directed organizations that serve populations with limited access to health care” and provide “comprehensive, culturally competent, quality primary health care services to medically underserved communities and vulnerable populations” (Health Resources and Services Administration [HRSA], 2009). FQHCs are also referred to as Community Health Centers (CHCs) or Neighborhood Health Centers (NHCs). FQHCs are grant-supported “public and private non-profit health care organizations that meet certain criteria under the Medicare and Medicaid Programs...and receive funds under the Health Center Program (Section 330 of the Public Health Service Act)” (HRSA, 2009). These health centers provide comprehensive health care services to people of all ages, races, and ethnicities with adjusted fee scales and are located in vulnerable communities identified as Medically Underserved Areas (MUAs) or Medically Underserved Populations (MUPs) (HRSA, 2009) or Health Professional Shortage Areas (HPSAs) (HRSA, 2008).

Medically Underserved Areas (MUAs) – are areas where residents have a shortage of personal health services, usually in combination with a shortage of health care providers, high infant mortality, high poverty and/or high elderly population (HRSA, 2008).

Medically Underserved Populations (MUPs) – “may include groups of persons who face economic, cultural, or linguistic barriers to health care” (HRSA, 2008).

Health Professional Shortage Areas (HPSAs) – “may be designated as having a shortage of primary medical care, dental or mental health providers. They may be urban or rural areas, population groups or medical or other public facilities” (HRSA, 2008).

Safety net – “the institutions, programs, and professionals devoting substantial resources to serving the underserved or socially disadvantaged” (Baxter & Mechanic, 1997, p. 9).

Mental health – “the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity” (DHHS, 1999, p. vii).

Mental Illness - “refers collectively to all mental disorders...health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning” (DHHS, 1999, p. vii).

Mental health problems – “signs and symptoms of insufficient intensity or duration to meet the criteria for any mental disorder” (DHHS, 1999, p. x).

Behavioral health – For the purpose of this study, behavioral health will be used interchangeably with mental health and represents the same meaning.

Behavioral health services – are confidential mental health care services where therapists and clients are partners in a therapeutic process to improve clients’ mental health statuses. Behavioral health providers and clients establish treatment goals that are relative to each

client's unique situation to achieve positive outcomes. Behavioral health services also include mental health screenings to assess for challenges, identify problems, and explore solutions involving any strain on consumers' mental well-being.

Behavioral health providers – are mental health clinicians, including psychiatrists, marriage and family therapists, psychologists, social workers, professional counselors, and psychiatric nurses.

Primary care providers – are general medicine providers, including doctors, nurse practitioners, physician assistants, and nurses.

Healthcare providers – refer to both behavioral health and primary care providers.

Collaborative health care – is the integration of primary care and behavioral health services in a co-located facility that recognizes the systemic connection between mental and physical health to overall health. Collaborative health care is also referred to as integrated healthcare, integrated primary care, integrated behavioral health care, primary mental health care, biopsychosocial model, and medical family therapy.

Cultural competence – “is a set of attitudes, skills, behaviors, and policies that enable organizations and staff to work effectively in cross-cultural situations. It reflects the ability to acquire and use knowledge of the health-related beliefs, attitudes, practices and communication patterns of clients and their families to improve services, strengthen programs, increase community participation, and close the gaps in health status among diverse population groups. Cultural competence also focuses its attention on population-specific issues, including health-related beliefs and cultural values (the socioeconomic perspective), disease prevalence (the epidemiologic perspective), and treatment efficacy (the outcome perspective)” (BPHC, 2009).

Racial and ethnic minorities – “refer collectively to people who identify as African Americans, American Indians and Alaska Natives, Asian American and Pacific Islanders, and Hispanic Americans. The term ‘minority’ is used to signify the groups’ limited political power and social resources, as well as their unequal access to opportunities, social rewards, and social status...not meant to connote inferiority or to indicate small demographic size” (DHHS, 2001, p. 5).

Patients - is the term used to describe people utilizing healthcare services in medical, dental, and collaborative health care settings.

Clients – is the term used to describe people utilizing healthcare services primarily by mental health clinicians, with the exception of psychiatrists who predominantly use the medical term *patient(s)*. For the purpose of this dissertation, I am intentionally choosing to use the term *client(s)* instead of *patient(s)*. The majority of collaborative healthcare literature uses the word *patient(s)* and encourages mental health providers to use this term when working in collaborative or medical settings. I, however, am sensitive to the use of meaning created through language, and I believe that *patient(s)* automatically implies mental illness with the focus of treatment being on the clinician to “fix” the sick person. In my perception, the word *client(s)* implies a person who is a “customer” of a service that can be beneficial for personal growth. The term *client(s)* is more congruent with my philosophical framework of therapeutic work, and, for this reason, I opt to use *client(s)* in collaborative healthcare settings also.

Consumers – is an all-encompassing term used to describe people utilizing any type of healthcare services, including behavioral health, medical/primary care, and dental services.

Uninsured – refers to individuals without any type of health insurance.

Publicly insured – refers to individuals with government assisted health insurance, such as Medicaid and Medicare.

Parish – is the equivalent to a county. Louisiana is the only state where a county is referred to as a parish. For all governmental intents, it is a distinction in terminology only.

Federal Poverty Level (FPL) – is calculated by comparing dollar value thresholds in relation to family size. If an individual or family's combined income is less than the threshold, then every person in that family is considered in poverty. The 2008 poverty threshold dollars are: one person-\$10,991; two people-\$14,051; three people-\$17,163; four people-\$22,025; five people-\$26,049; six people-\$29,456; seven people-\$33,529; eight people-\$37,220; nine or more people-\$44,346 (U.S. Census Bureau, 2009).

Health Resources and Services Administration (HRSA) - is housed under the U.S. Department of Health and Human Services and “is the primary Federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable” (HRSA, 2008).

Bureau of Primary Health Care (BPHC) – is a branch of HRSA, which regulates FQHCs to “improve the health of the Nation's underserved communities and vulnerable populations by assuring access to comprehensive, culturally competent, quality primary health care services” (BPHC, 2008).

Dissertation Overview and Summary

This chapter has introduced my study and has explained the theoretical framework that guided this project. In Chapter Two, my comprehensive review of the literature integrates health and mental health, and the most current findings related to the

relevance of this study. I include prevalence rates of mental disorders in the United States, the ensuing consequences of untreated mental disorders, and barriers to mental health care for low-income, potential consumers. Additionally, cultural, contextual, and perceptual factors that may affect mental health service utilization, specifically with vulnerable populations, are examined.

Next, the treatment of behavioral health problems in primary care settings is reviewed, including a rationale for the use of collaborative health care in general. Subsequently, I evaluate the current state of collaborative care, inclusive of FQHCs as viable options for the provision of behavioral health services, particularly for the large population of underserved. This includes detailing FQHCs' impact and importance in providing healthcare to these needy populations. Additionally, I investigate health disparities and outcomes of Louisiana's most vulnerable residents, who comprise the participant sample of this study. Ultimately, this literature review provides evidence of the need for consumer driven information in the provision of mental health services for low-income populations. Chapter Two concludes with a summary and justification for the research study.

Chapter Three explains the qualitative methodology of the study. In this chapter, I review and explain phenomenology to describe the design's appropriateness for this study. I also delineate the methods of the research procedure and present an overview of the entire research process. In Chapter Four, I present the findings and results of the analysis, including an introduction to the research participants. The findings and results of the study are presented in themes and narrated through the participants' voices, which

offer illustrations of their experiences. In Chapter Five, I discuss the results of the study, clinical implications, limitations, and directions for future research.

CHAPTER TWO: REVIEW OF THE LITERATURE

Health

Health has been defined as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (World Health Organization [WHO], 2001). The growing diversity of the U.S. population presents many healthcare challenges due to “variation in health, health behaviors, and health care among people by race and ethnicity, gender, education and income level, and geographic location” (National Center for Health Statistics [NCHS], 2009, p. 3). Worldwide, the U.S. lags far behind other countries for healthy life expectancy (United Health Foundation, 2008a) but has the highest healthcare expenditures per capita than any other country (NCHS, 2009). Healthcare spending increased to over \$2 trillion in 2006, almost a 7% increase from 2005, and these expenditures have continued to grow (NCHS, 2009).

Given these challenges, clinical prevention continues to be a major objective in the federal government’s vision for all aspects of healthcare. Yet, despite intentions, healthcare efforts continue to fall short of this goal, which is verified through escalating healthcare overheads with unmatched clinical outcomes (Agency for Healthcare Research and Quality [AHRQ], 2008). Healthcare providers are treating increasing numbers of diseases that preventive measures have failed to diminish. A crucial piece of this problem is consumers’ underutilization of recommended services, however due to the high rates of uninsured, lack of access to health care is largely to blame (NCHS, 2009). Over 46 million Americans were uninsured in 2008, which is approximately 18% of the U.S. population (U.S. Census Bureau, 2009). Healthcare costs continue to increase, yet

healthcare outcomes have not progressed to the equivalency of spending (United Health Foundation, 2008a).

Although health is a combination of both mental and physical well-being, some perceptions of health problems would appear to diametrically oppose the connection of mind and body. In the past, health care treatment has regarded mental health and physical health as separate systems, particularly based on the use of language in describing each as exclusive functions (DHHS, 1999). To address these issues and broaden perceptions of health, global and national exertions have sought to revolutionize the recognition and importance of mental health, specifically in relationship to overall health and well-being (DHHS, 1999, 2001; President's New Freedom Commission on Mental Health [NFCMH], 2003; World Federation for Mental Health [WFMH], 2009; WHO, 2001, 2007, 2009b).

The magnitude of the relationship between mental health and physical health cannot be ignored in understanding the concept of health (Engel, 1977; Honiotes, 1994). Mental health and physical health are not dichotomies; therefore any health concerns must take into account the impact of one on the other. Acknowledging the intricate union of mind and body utilizes a holistic approach to health care, which attends to the totality of consumers' health care needs (Citrome & Yeomans, 2005; McDaniel et al., 1992; Robson & Gray, 2007; Seaburn, Lorenz, Gunn, Gawinski, & Mauksch, 1996). Holistic approaches to health care are becoming the preferential practice standards, as "the direction is clearly toward an integrated system, with behavioral health playing a central role throughout the health care continuum of care" (Gray, Brody, & Johnson, 2005, p. 128).

Mental Health

According to the World Health Organization (WHO, 2007), “there is no health without mental health.” WHO described mental health as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (2009b). DHHS defined mental health as “the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity” (1999, p. vii). Despite the subtleties of their seemingly simple descriptions, both of the abovementioned definitions depict mental health as a combination of multifaceted complexities. Many factors contribute to mental health including physical health, socioeconomic status, living environment, housing, education, and relationships (WHO, 2007). Mental health is a continuum that develops throughout the entire span of one’s life cycle and is an essential cornerstone in treatment outcomes and health conditions (DHHS, 1999, 2001).

Every year, one in four American adults experiences a diagnosable mental disorder (Kessler, Chiu et al., 2005), yet more than half will not seek treatment (DHHS, 1999). Other estimates report that as many as 70% of people suffering with mental health issues remain untreated (Kessler, Demler et al., 2005; Thornicroft, 2007). Of those with mental disorders, almost 50% meet the criteria for having two or more disorders simultaneously (Kessler, Chiu et al., 2005) with roughly 15% also having co-occurring drug and/or alcohol problems (DHHS, 1999). In the U.S. alone, roughly 60 million people are struggling with issues associated with mental disorders, which, in turn, greatly compromise their overall health and well-being (National Institute of Mental Health

[NIMH], 2008). Kessler and Wang (2008) purported that about half of the U.S. population is likely to experience the symptoms of a mental disorder in their lifetime.

Mental illness ranks highest among the recorded disabilities in the U.S., Canada, and Western Europe (WHO, 2001). Worldwide, major depression ranks among the top ten disabilities of the population (DHHS, 1999) and, nationwide, affects nearly 15 million Americans annually (NIMH, 2008). With the high encumbrance of depression, it is not astounding that the leading cause of disability in the U.S. for people ages 15 to 44 years old is Major Depressive Disorder (NIMH, 2008). Major depression is a serious debilitating state that is highly correlated with suicide and other chronic conditions including heart disease and diabetes (Mental Health America [MHA], 2007; NCHS, 2009).

Untreated mental disorders can have dire consequences, yet the mass majority of those affected do not receive treatment. Those in greatest peril of unmet mental health care needs are vulnerable populations, which include the uninsured, low-income, racial and ethnic minorities, elderly, and rural residents (Wang et al., 2005). Additionally, other predictors of not receiving adequate treatment include being young, residing in the South, being previously diagnosed with a psychotic order, and being treated in primary care settings (Wang, Demler, & Kessler, 2002).

Of the many consequences of untreated mental illness, suicide is the most severe and devastating. Suicide is ranked as the fourth leading cause of death in the U.S. for people between the ages of 10 to 60 years (Cole & Glass, 2005). In 2003, estimates concluded that approximately 30,000 Americans take their own lives each year (NFCMH, 2003). In 2006, that number had risen to nearly 34,000 Americans (NIMH,

2008). Internationally, suicide accounts for 850,000 deaths each year with depression playing a major role in these losses (WHO, 2009a). Conwell and Brent (1995) reviewed suicide patterns and stated, “studies of general population samples consistently find diagnosable psychopathology in 90% or more of completed suicide victims... psychiatric illness is a powerful determinant of suicide risk” (p. 150).

Although not as severe as suicide, other consequences of untreated mental disorders are noteworthy as well, especially considering the cost incurred as a result. The U.S. spends an average of \$79 billion annually on mental illness (NFCMH, 2003), but not for the reason it would appear. Unfortunately, the substantial majority of this total is attributable to the direct loss of productivity resulting from mental illness (NFCMH, 2003). Therefore, more money is spent on lost efficiency from mental illness, rather than the actual treatment of mental illness itself.

Nationally, over the past decade, three significant reports brought awareness to unmet mental health needs: (1) *Mental Health: A Report of the Surgeon General* (DHHS, 1999); (2) *Mental Health: Culture, Race, and Ethnicity - A Supplement to Mental Health: A Report of the Surgeon General* (DHHS, 2001); and (3) *Achieving the Promise: Transforming Mental Health Care in America* (NFCMH, 2003). These groundbreaking documents provided the gateway to begin overcoming barriers, creating reform, and stopping the silence surrounding mental health issues.

Mental Health: A Report of the Surgeon General (DHHS, 1999) was the first comprehensive mental health report of its kind and was created to endorse mental health as mainstream health, and, ultimately, to eliminate myths, stereotypes, stigmas, and misconceptions about mental illness (DHHS, 1999, 2001). This publication was created

in collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Institutes of Health (NIH). Both the SAMHSA and the NIH are federal agencies, branched under DHHS, whose paramount objectives are to improve the Nation's health through research, prevention, intervention, treatment, recovery, education, and advocacy (NIH, 2009; SAMHSA, 2009). *Mental Health: Culture, Race, and Ethnicity - A Supplement to Mental Health: A Report of the Surgeon General* (DHHS, 2001) was purposeful to expose that, in regard to mental health, there are important cultural and contextual aspects to consider for services to be delivered effectively and, thereby, utilized successfully. This report's content focused exclusively on mental health issues that are germane to vulnerable populations, primarily racial and ethnic minorities, who bear the greatest burden of unmet mental health needs.

The President's New Freedom Commission on Mental Health was a task force created in 2002 during President George W. Bush's Administration to review the Nation's existing state and accessibility of mental health care treatment, while proposing changes for improvement (NFCMH, 2003). This Commission's report, *Achieving the Promise: Transforming Mental Health Care in America*, had a specific, targeted goal to transform the mental health system beginning with the advancement of the American consumers' knowledge of the systemic connection between their mental and physical health to their general health (NFCMH, 2003). In addition, this report also campaigned for promoting equality in mental health's importance in the health care structure; "Understanding that mental health is essential to overall health is fundamental for establishing a health system that treats mental illnesses with the same urgency as it treats physical illness" (NFCMH, 2003, p.7).

Taken together, the Surgeon General's and the President's New Freedom Commission's reports on mental health publicized the need to address inadequacies in mental health care treatment, including revising behavioral health services to be more culturally appropriate for various populations. Simultaneously, these manifestos advocated for a healthcare infrastructure that not only streamlines mental health into all aspects of healthcare, but also is adapted to the unique needs of consumers. Therefore, fundamental modifications are necessary to ensure that behavioral health services are consumer driven and are effective in improving health outcomes. Combining the aforementioned reports, their core messages and recommendations can be summed up as follows: (1) mental health is cardinal to health; (2) mental disorders are legitimate, treatable health conditions and impact society enormously; (3) mental disorders are present in all populations, but vulnerable populations are at higher risk and have less access to care; (4) mental health care treatment should be culturally competent and focused on consumers' needs; (5) mental health care treatment should help clients create meaningful, lasting changes of sustainability with facing problems, instead of sole symptom management; and (6) people should be pro-active in help-seeking for mental health problems, illness, or concerns (DHHS, 1999, 2001; NFCMH, 2003).

Significant factors appear to place some individuals at higher risk for poor mental health, and "risk factors are those characteristics, variables, or hazards that, if present for a given individual, make it more likely that this individual, rather than someone selected at random from the general population, will develop a disorder" (DHHS, 1999, p. 63). Although some highly probable risk factors are connected to biology and genetics, poverty poses a tremendous threat to mental health (DHHS, 1999). Largely, people

suffering with mental health problems or disorders do not receive treatment due to a variety of barriers. The following is a discussion of these barriers.

Barriers to Mental Health Care

Stigma

In general, stigma discourages people from seeking mental health services and has been identified as an overarching barrier to access mental health care treatment (DHHS, 1999, 2001; Corrigan, 2000, 2004; Corrigan, Watson, Warpinski, & Gracia, 2004; Gary, 2005; Kondrat & Teater, 2009; Nadeem et al., 2000; NFCMH, 2003; Perese, 2007; Somma & Bond, 2006; Thornicroft, 2007, 2008; Thornicroft, Rose, & Kassam, 2007; Vogel, Wade, & Haake, 2006). Stigma indicates “a collection of negative attitudes, beliefs, thoughts, and behaviors that influences the individual, or the general public, to fear, reject, avoid, be prejudiced, and discriminate against people with mental disorders” and “is manifest in language, disrespect in interpersonal relationships, and behaviors” (Gary, 2005, p. 980).

Stigma has been dissected into two categories: public stigma and self-stigma (Corrigan, 2004). Simply defined, public stigma refers to a person’s fear, or the actual event, of being ostracized or ridiculed by others for utilizing or needing mental health services (Corrigan, 2004). Self-stigma describes an individual’s internal chastisement when adopting the negative societal views of mental health conditions about oneself (Corrigan, 2004). Stigma diminishes self-esteem, confidence, and personal worth, and “discourages major segments of the population, majority and minority alike, from seeking help” (DHHS, 2001, p. 42).

Self-stigma, in particular, has been determined to be a major deterrent in obtaining mental health treatment and has gained recognition as indicated by recent studies. Vogel et al. (2006) conducted several studies measuring self-stigma associated with mental health help-seeking behaviors. The researchers concluded that self-stigma was a major impediment in help seeking, with greater perceptions of self-stigma lessening the likelihood to seek care. The results also revealed that participants perceived help seeking for mental health conditions as weakness, connoting feelings of inferiority, and degrading self-esteem - all of which interfere with utilization (Vogel et al., 2006). Additionally, these same findings reported that participants, who had former experiences with mental health treatment, had much lower self-stigmatizing attitudes toward receiving professional help (Vogel et al., 2006).

Schomerus, Matschinger, and Angermeyer (2009) also validated the impact of self-stigma to hinder help-seeking behaviors. These researchers evaluated the relationship between stigma and mental health service utilization (seeing a psychiatrist) for symptoms of depression with a sample size of 2,303 participants. These results confirmed that self-stigma hampers help seeking for behavioral health issues, but, contrary to expectations, public stigma was not determined to restrict intentions to seek mental health treatment (Schomerus et al., 2009). This study also acknowledged that being female and having previous experiences with the mental health system were variables that increased the likelihood of help-seeking behaviors. This discovery is consistent with conclusions from the studies by Vogel et al. (2006) reporting that consumers having previous encounters with behavioral health services reported less stigmatization about utilizing them than those without prior behavioral health visits.

These findings support the powerful influence of stigma in dissuading mental health care treatment. A major indication of these studies appears to be that people are willing to sacrifice their healthcare needs as a result of negative meanings associated with help-seeking for mental health. In essence, the outcomes of the studies support underutilization of needed mental health services due to the negative implications of stigma and labeling. However, an interesting finding was that those reporting less stigma with help-seeking were actually people who had previously used mental health services.

Racial and ethnic minorities may experience additional barriers associated with stigma. For example, Gary (2005) utilized the term, double stigma, in discussing stigma as a barrier to mental health care treatment for racial and ethnic minority groups due to additional hardships which impede on these populations, such as discrimination and prejudice. In particular, the author suggests that often minority groups are treated based on stereotypes and misconceptions about their populations in lieu of real facts (Gary, 2005). These types of treatment are discriminatory practices, which harm clients and compromise their well-being. Therefore, double stigma is a culmination of the interface between minority membership status and having a mental illness. Many minority groups are discouraged from seeking needed mental health services, due to the system's bigotry in inadequately treating these populations compared to their Caucasian counterparts (Gary, 2005).

Additionally, the NFCMH (2003) reported additional barriers to mental health care for racial and ethnic minorities. These include mistrust and fear of treatment, different cultural norms about mental health and illness, racism, differences in help-seeking behaviors, and differences in communication and language (NFCMH, 2003).

DHHS (1999, 2001) conveyed that the most valuable remedy to stigma is effective mental health treatment, as stated below:

Because stigma and help-seeking behaviors are two culturally determined factors in service use, research is needed on how to change attitudes and improve utilization of mental health services...These messages should be tailored to the languages and cultures of multiple racial and ethnic communities. (DHHS, 2001, p. 161)

Victimization, Discrimination, and Labeling

Victimization, discrimination, and labeling are the repercussions of stigma associated with mental disorders and mental problems. Most people in all cultures are misinformed about mental health issues (Thornicroft, 2008). For example, Corrigan (2000) reported that members of society sanction stigmas about mental disorders and perceive people with these disorders as “potentially violent and fear them” (p. 50). These misconceptions lead to discrimination and victimization of those with mental disorders (Corrigan, 2000, 2004; Kondrat & Teater, 2009). Additionally, many people suffering with mental conditions avoid help due to fear of being labeled “mentally ill” or “crazy” (Thornicroft, 2008; Thornicroft et al., 2007).

Not only does stigma result in avoidance of help, it can also interfere with the continuation of treatment once begun due to stigmatizing labels that can result as a byproduct (Corrigan et al., 2004). For example, consumers of behavioral health services can be identified with stigmatizing labels in two ways: (1) being diagnosed by a mental health provider or (2) being labeled by association due to being seen leaving a mental health provider’s office (Corrigan, 2004). These labels may play into the stereotypes and

myths that perpetuate mental health conditions as shameful, which can affect fair employment opportunities, social relationships, safe housing options, and community integration (Perese, 2007).

Additionally, research has shown that some mental health professionals have negative perceptions towards people with mental disorders, which can also play a role in the stigmatization of seeking mental health care treatment (Nordt, Rossler, & Lauber, 2006). In this vein, Snowden discussed bias in mental health treatment when behavioral health providers make assumptions about consumers and engage with them based on these perceptions (2003). Snowden (2003) explained:

Bias occurs in the beliefs and actions of individual clinicians, and it is at this level that it has received the greatest amount of attention. Bias also occurs when unfounded assumptions become normative beliefs shared by members of practitioner networks or treatment organizations. (p. 241)

When these factors are considered, it appears evident how people with mental problems become victimized not only by society, but also by the mental health system as well. A critical component of effective mental health treatment is to understand the contextual world of consumers and “speak their language” (DHHS, 2001).

Costs, Affordability, and Access to Care

Lack of financial resources is a barrier to mental health care and a serious detriment to well-being. Unfortunately, most low-income populations cannot afford the costs of adequately meeting their healthcare needs. Access to needed health care services is largely determined by insurance status, yet those living in poverty are much less likely to have coverage than the non-impooverished (NCHS, 2009). The working poor are prone

to be uninsured, not only because they cannot afford private health insurance, but also because they have great difficulty obtaining publicly funded health insurance as well (Elliot, Beattie, & Kaitfors, 2001).

For those with health insurance, Medicaid is the primary source of provision and is the largest public payer source for behavioral health services for low-income persons (National Association of State Medicaid Directors [NASMD], 2008). For Medicaid beneficiaries, coverage restrictions place limitations on the amount of services that are eligible for Medicaid reimbursement (Perese, 2007). With imposed, limited access to specific health care services and without the ability to pay out-of-pocket, the poor and underserved cannot access the comprehensive care they usually need (Elliot et al., 2001). Additionally, many people living in poverty with mental health conditions are not eligible for Medicaid due to homelessness, incarceration, “not being disabled enough,” or being too sick to even explore the possibility of Medicaid as an option (Cunningham, McKenzie, & Taylor, 2006, p. 694).

Elliot et al. (2001) conducted a study to understand the health needs and behaviors of people living below poverty level. A total of 750 people participated in the study. All had incomes below 200% of Federal Poverty Level (FPL), and more than half were uninsured. The study found that participants’ concerns included access to health care, costs of health care, and affordability of needed medications. Additionally, nearly half of respondents specifically expressed concerns about access to mental health treatment due to problems with depression, anxiety, isolation, and other mental health conditions. Most respondents reported positive experiences with mental health treatment, but had limited availability to behavioral health services due to inadequate health insurance coverage or

no coverage at all. Almost two-thirds of participants in the study reported having monthly budgeting that included choosing between food or health care expenses, and respondents reported only using medical services when “desperately” needed (Elliot et al., 2001).

The results of this study suggest that consumers’ behaviors that are often considered non-compliant by health care providers can be the result of real financial setbacks (Elliot et al., 2001). The researchers stated, “the results of the current study reveal that these behaviors may not be the result of being uninformed or uneducated about health care. Rather, these behaviors are the result of being unable to afford health care and health insurance” (Elliot et al., 2001, p. 366). Other additional setbacks which can affect healthcare utilization and present barriers to care for low-income populations are “non-financial barriers to care, including transportation problems, employment conflicts, and cultural/language impediments” (Politzer, Schempf, Starfield, & Shi, 2003, p. 302).

Lack of access imparts another barrier to care and is an impediment to health, especially considering “problems that are untreated on an outpatient basis could eventually increase the need for more intensive inpatient treatment” (Cunningham et al., 2006, p. 703). However, problems with access to mental health care are not simply defined (George & Rubin, 2003). Access contains the interchange between need, utilization, and provision of healthcare services and includes “acceptability, affordability (direct and indirect costs to the patient), availability (the supply and demand relationship), physical accessibility (geographical and physical barriers) and accommodation (the way services are related to clients’ needs, including waiting times,

opening times, booking facilities” (George & Rubin, 2003, p. 183). DHHS (2001) declared that improving access to mental health treatment includes the provision of quality, culturally competent, and linguistically appropriate services in feasible locations for the populations served.

Poverty and Mental Health Disparities

There are approximately 40 million Americans living in poverty (U.S. Census Bureau, 2009). Additionally, the number of medically disenfranchised, who lack access to primary care, is estimated to be even higher at 56 million (NACHC, 2009). The connection between income and health status has been well established (DHHS, 1999, 2001; Muntaner, Eaton, Diala, Kessler, & Sorlie, 1998; NACHC, 2009; NCHS, 2009; Northam, 1996; Wilton, 2003, 2004; Zimmerman & Katon, 2005). Adults and children living near or below federal poverty thresholds have poorer health compared to those in higher income brackets – “often poverty causes poor health by its connection with inadequate nutrition, substandard housing, exposure to environmental hazards, unhealthy lifestyles, and decreased access to and use of health care services” (NCHS, 2009, p. 26).

DHHS (1999) reported that “socioeconomic factors affect individuals’ vulnerability to mental illness and mental health problems” (p. xiv). Adults, below poverty level, are 4 times more likely to experience severe mental distress than those living with incomes at twice the poverty level (NCHS, 2009). Lower socioeconomic status (SES) increases the risk of mental and physical problems due to repetitious exposure to stressors which strain health (Falconnier, 2009). Economic resources help to shield families from disparities, and, conversely, lack of resources creates tremendous vulnerabilities in the day-to-day survival for adults and children (Kliman, 1998). For

example, in a study that interviewed mental health consumers about the impact of poverty on their mental health, the researcher found that living in poverty for the consumers “worked directly against their participation in meaningful activities, their ability to build and sustain relationships, and opportunities to enhance self-esteem and reduce social stigma” (Wilton, 2003, p. 152).

Principal mental health disparities are connected to limitations in income, education, and occupation (Muntaner et al., 1998). DHHS (2001) asserted, “people in the lowest stratum of income, education, and occupation are two to three times more likely than those in the highest stratum to have a mental disorder” (p. 42). In two analyses with a combined sample size of over 10,000 Americans, the researchers found inverse relationships between occupation, education, income, and mental disorders (Muntaner et al., 1998). The conclusions of these studies reported that those with lower incomes, education, and SES had the highest prevalence of anxiety, mood, drug, and alcohol disorders (Muntaner et al., 1998). These results are aligned with other studies that also recognized the relationship between income, education, housing, and other social factors to mental health status (Adler & Newman, 2002; Wilton, 2003, 2004).

Mental health disparities are disproportionately high in impoverished areas, and minority populations are overrepresented in high-poverty communities (Chow et al., 2003; Snowden, 1999). The uninsured, low-income, and racial and ethnic minority populations suffer from more unmet mental health needs than the general population, which contribute to the great decline in the overall health of these populations (DHHS, 2001). However, although living in poverty exacerbates poor mental health, lower SES is

also reported as a factor in non-compliance to mental health treatment and premature termination (Chen, 1991; George & Rubin, 2003).

Fiscella (2002) stated, “insufficient attention has been given to the clinical challenges of providing care to low-income patients...using outdated paradigms to treat such patients will only perpetuate disparities in care and health” (p. 365). Mental health disparities persist and cannot be eliminated without understanding the challenges, perceptions, and needs of the consumer. Likewise, “quality mental health assessment and treatment rely on understanding local representations of illness and distress for all populations” (DHHS, 2001, p. 162). The public health approach to reduce mental health disparities requires understanding consumers’ behavioral health needs, maximizing service availability, equalizing access to services, and modifying treatment to accommodate the healthcare needs of consumers (DHHS, 1999, 2001; NFCMH, 2003).

Concerning the underserved, “mental health treatment, especially for lower-income populations, is still a low-priority societal activity” (Dentzer, 2009, p. 635). Although behavioral health services cannot mitigate the actual stressors experienced by the poor, these services can be advantageous and utilize strength-based approaches to assist low-income clients in more effectively handling and coping with life’s adversities (Falconnier, 2009). Behavioral health care can also boost mental well-being by reducing the gravity of mental problems through customized care (DHHS, 2001). “Behavioral health care is widely considered essential to ensuring the well-being of individuals and a critical component of strengthening the nation’s health care system” (NASMD, 2008, p. 3).

Cultural and Contextual Considerations in Mental Health Treatment

According to DHHS (2001), “what it means to be mentally healthy is subject to many different interpretations that are rooted in value judgments that may vary across cultures” (p. ix). Perceptions about what is viewed or classified as mental health issues or problems vary immensely from one culture to another, including the meanings ascribed to problems (Cross, 2003). In addition, the language used to describe problems, as well as how symptoms are displayed relative to the problem, are denoted in ways uniquely representative of their cultural context (Sing, McKay, & Sing, 1998). The role and processes that culture and language play in perceptions of health and help-seeking behaviors are important to understand and warrant attention. McGoldrick, Giordano, and Garcia-Preto (2005) stated “cultural identity has a profound impact on our sense of well-being within our society and on our mental and physical health” (p. 1).

Culture has been defined as “a group of people organized around a set of implicit norms, values, and beliefs that influence attitudes, behaviors, and customs” (Hardy & Laszloffy, 1992, p. 364). Lopez (2003) argued that “culture” is more than “presumed characteristics” or “essentializing features,” and to only view culture as norms, beliefs, values, and practices, ignores the connection between social and cultural factors (p. 427). For example, the underutilization of mental health services by particular populations may be viewed as “culture” with little consideration of how not using services may serve as a coping mechanism to specific social processes (Lopez, 2003). Without understanding the limitations in labeling what is cultural versus social, the research fails to depict “the richness of cultural process” in the day-to-day communications between people (Lopez, 2003, p. 427).

Gemignani and Pena (2008) proposed culture as a postmodern concept best understood through social constructionism. These authors contend:

Culture is not simply a theoretical conceptualization. Rather, it is embedded in the daily life of every person; everyone belongs to or is represented within cultural dynamics. Far from being a stable or fixed entity, culture is an ongoing organization of material and social constructions that, within place, time, and history, is locally experienced and represented through processes of identification and relationship. (p. 276)

Culture can be used as a resource in therapy and, perhaps, is “one of our greatest assets for healing and mental wellness” (Cross, 2003, p. 359). Hall (2001) proclaimed that psychotherapy research with racial and ethnic minorities should be cognizant of cultural factors. For example, the interdependence and group identity of minority cultures is not necessarily the norm for white cultures, yet should be contemplated in the conceptualization of understanding the experiences of minorities (Hall, 2001).

Other examples include the possibilities that minority groups are highly likely to terminate treatment prematurely because of (1) lack of access to culturally fitting providers and (2) cultural, religious, and socially endorsed values and beliefs (Chow et al., 2003). Some members of minority groups prefer behavioral health providers that are representative of their population, but this presents challenges due to the overwhelmingly disproportionate ratio of white clinicians (DHHS, 2001). The value of spirituality is also a cultural element for consideration because “spiritual values are often a component of ethnic minority cultures” (Hall, 2001, p. 506). In particular, spirituality and stigma have been identified as major barriers for African Americans in help seeking for mental health

issues, as compared to Caucasians (Cooper-Patrick et al., 1999). Perhaps this offers some explanation about why African Americans have been reported as more likely to use the services of a primary care provider for their mental health needs rather than a behavioral health provider (Snowden & Pingitore, 2002).

Recent research has also reported that inequities in mental health care treatment between whites and racial and ethnic minorities is likely related to underutilization of mental health services by minority groups rather than overutilization by Caucasians (Zuvekas & Fleishman, 2008). However, it will take more than promoting equal access to care for racial and ethnic minorities to calibrate the differences in mental health treatment; mental health services must be customized, culturally competent, and delivered in a manner that will narrow these health care gaps (Zust & Moline, 2003).

In summary, “mental illness and less severe mental health problems must be understood in a social and cultural context, and mental health services must be designed and delivered in a manner that is sensitive to perspectives and needs” (DHHS, 1999, p. xii). Therefore, “providing BH treatment services in a culturally competent manner then becomes paramount to ensuring that diverse populations receive behavioral health services in a safe environment” (Proser & Cox, 2004, p. 11).

Perceptions of Mental Health

Understanding consumers’ perceptions of mental health care is an important component of developing effective service delivery. DHHS (2001) reported “race, ethnicity, culture, language, geographic region, and other social factors affect the perception, availability, utilization, and potentially, the outcomes of mental health services” (p.162). For example, clients’ expectations regarding counseling have been

shown to factor into their commitment to therapy (Patterson, Uhlin, & Anderson, 2008). Clients who “contribute to the process of therapy by being motivated, open, and responsible actually fulfill these expectations during counseling, and as a result, they form a collaborative, productive, and emotionally satisfying relationship with the therapist” (Patterson et al., 2008, p. 532). However, there is a paucity of research that explores clients’ perceptions of mental health and mental health delivery services, particularly in underserved populations.

One notable study conducted by Roberts et al. (2008) explored perceptions of mental health in an underserved minority neighborhood via focus groups. The purpose of the study was to understand the mental health needs of the community, perceived barriers to care, and receptiveness to adding mental health services into their primary care clinics. Participants included 45 community residents from three communities in Louisville, Kentucky, who were primarily African American women with ages ranging from 19-77 years old. The study’s respondents described good mental health as being able to cope and having a stable mind; On the contrary, perceptions of poor mental health were explained by descriptions consistent with severe mental illness such as “schizophrenic,” poor hygiene, “talking to themselves,” disruptive behaviors, and being isolated.

The results by Roberts et al. (2008) also revealed that the perceived need for mental health services was high due to stressors associated with living in poverty. Stigma was perceived as a barrier to seek mental health care, and respondents reported utilizing their churches and trusting God with their problems. An interesting finding of this study was that participants perceived mild and moderate symptoms of mental health problems such as mild depression, anxiety, dissatisfaction with life, and chronic

unhappiness as usual life occurrences. However, in comparison, “mental illness was recognized only when severe symptoms were observed, such as in psychosis, agitation, and severe depression” (Roberts et al., 2008, p. 214). These participants’ various descriptions of mental health problems appear to be cultural and contextual pieces to consider in providing culturally competent healthcare services. Additionally, the respondents conveyed that collaborative health care would be beneficial for consumers, specifically in regard to utilizing mental health services without being “visible to the community” (Roberts et al., 2008, p. 214).

While this study focused primarily on the respondents’ perceptions of the need for mental health services in their community and their receptiveness of adding these services into their primary care clinics, 75% of participants in this study, however, had never received mental health services. Therefore, as a collective majority, these participants do not have the actual experiences of receiving behavioral health services, specifically in a collaborative care setting. In essence, these respondents’ perspectives could represent differing viewpoints than those consumers’ perspectives that have had these experiences, particularly as perceptions of mental health services can evolve over time throughout utilizing them. In sum, Robert et al’s study (2008) concentrated on perceptions of and the need for mental health services, rather than the real-lived experiences of receiving mental health services.

Treatment of Behavioral Health Problems in Primary Care Settings

“Primary care is the essential foundation for an effective, efficient, and equitable health care system” (Grumbach & Mold, 2009, p. 2589). Primary care providers have been called “gatekeepers” of health because they provide the entrance point to access the

health care system (Grumbach et al., 1999). Due to a broad scope of practice, these general medicine providers are responsible for a variety of health care issues that present in primary care settings, including mental health.

Primary care has been referred to as the “de facto mental health care system” with more than half of mental health care treatment delivered by primary care providers (Reiger et al., 1978; Reiger et al., 1993). Researchers report that 50% to 70% of mental health treatment is delivered in the general medical sector alone (Kessler, Burns, & Shapiro, 1987; Reiger et al., 1993). Other estimates conclude that 75% of all general medicine visits include facets of mental health care treatment (Levant, 2005). Many studies have confirmed that some consumers are more likely to present to primary care providers rather than mental health providers when help seeking for mental health issues, especially low-income and racial and ethnic minorities (Olfson et al., 2000, 2002; Snowden, 2003; Snowden & Pingitore, 2002).

From 1990-2003, treatment rates for mental health disorders increased from 12% to 20% with the most significant increases in primary care settings with rates 2.5 times as high in 2003 than 1990 (Kessler, Demler et al., 2005). Depression is the most common mental disorder reported in primary care settings and has been linked with chronic conditions, including diabetes, cardiovascular disease, and chronic pain (Cameron & Mauksch, 2002; Dobscha et al., 2009; Kessler, Chiu et al., 2005; Kessler, Demler et al., 2005; Mauksch et al., 2007; Olfson et al., 2000, 2002; Sotile, 2005; Uebelacker, Smith, Lewis, Sasaki, & Miller, 2009). People with steady depression generate healthcare costs that are virtually 70% percent higher than those without such depression (Proser & Cox,

2004). Unfortunately, two-thirds of people suffering with depression go unrecognized in the primary care setting (Ani et al., 2008).

In a national study that reviewed the outpatient treatment of depression from 1987-1997, Olfson et al. (2002) found that the use of antidepressant medication increased from 37% to nearly 75%, predominantly in primary care settings, while the use of behavioral health services declined. This study concluded that 8 out of every 10 consumers that were treated for depression received this care from general medicine providers. Trends in mental health care suggest that antidepressant medications are increasingly being used to treat depression, but, unfortunately, without utilizing the services of a behavioral health provider (Olfson et al., 2002). This trend is supported by recent research, which has shown that the majority of psychotropic drugs are prescribed by general medicine doctors instead of psychiatrists (Mojtabai & Olfson, 2008).

Due to the high rates of mental disorders that present in this setting, primary care has received increasing attention as a resourceful module for mental health practice (Blount, 2003; Seaburn et al., 1996). Strosahl (1998) stated “nearly half of all individuals with a diagnosable mental disorder seek no mental health care from any professional, but 80% will visit their primary care physician at least once yearly” (p. 143). However, although present, the majority of mental health conditions are not detected by medical providers and, therefore, untreated in this setting (Campbell et al., 2000). Some problems with primary care providers recognizing mental health issues are (1) insufficient training in diagnosis of mental disorders; (2) not having ample time to assess for mental conditions in the short time frame of a primary care visit; and (3) many consumers deny the origins of their problems as psychosocial, and, instead, focus

primarily on somatic descriptions when describing problems (Gray et al., 2005).

Additionally, medical providers usually respond to treating only the chief medical complaint, which is primarily physical symptoms, even in the case that a mental health issue is recognized (Rost, Smith, Matthews, & Guise, 1994).

Based on the changing sectors of mental health service use and recognition of the mind-body connection, the integration of primary care and behavioral health services seems to be a practical solution in treating conditions often undetected, untreated, or inadequately treated by primary care provision alone (Blount 2003; Blount, DeGirolamo, & Mariani, 2006; Dobscha et al., 2009; Fiscella, 2002; Katon, 1995; McDaniel, 1995; Miller, Mendenhall, & Malik, 2009; NFCMH, 2003; Seaburn et al., 1996). The collaborative healthcare approach, which is the joining of behavioral health and primary care services, promotes “non-dichotomized thinking” in treating health as a complete whole (Griffith, 1998, p. 44). This nexus between mind and body utilizes a biopsychosocial approach attending to the needs of the whole person (Doherty et al., 1987; Engel, 1977; Seaburn, 2005). McDaniel et al. (1992) stated “Like it or not, therapists are dealing with biological problems, and physicians are dealing with psychosocial problems. The only choice is whether to do integrated treatment well or do it poorly” (p. 2). The following section provides an in-depth discussion of the collaborative health care field.

Behavioral Health + Primary Care = Collaborative Health Care

Collaborative health care “communicates the idea that all problems are at once biological, psychological, and social” (McDaniel et al., 1992, p. 2). Simply defined, collaborative care is the integration of medical and mental health care services in a co-

located facility that recognizes the systemic connection between mental and physical health to overall health (Blount, 2003; Blount et al., 2006; Doherty, 1995; McDaniel, 1995; McDaniel, Campbell, & Seaburn, 1995; Simpson, 1998; Strosahl, 1996, 1998, 2001). Butler et al. (2008) described “collaboration” as used throughout the health care literature in two ways: (1) “collaboration between patients and health providers in developing care plans to achieve agreed-on treatment goals and ongoing education and support of the patient’s self-management of the disease” and (2) “collaboration between providers, ensuring that the treatment plan and provision of services is appropriate and coordinated across providers with different expertise and treatment domains” (p. 10). Seaburn et al. (1996) explained collaboration as a “web” of interaction between medical providers, mental health providers, consumers and their families working together as a team to combat illness and promote health. Collaborative health care is also referred to as integrated healthcare, integrated primary care, integrated behavioral health care, primary mental health care, biopsychosocial model, and medical family therapy.

With some debate in the literature about the meaning of collaborative care versus integrated care, Blount et al. (2006) described integrated care as the conceptual design for collaborative care, and collaborative practice as “the pattern of interaction necessary to make the program design work” (p. 112). Other descriptions have termed collaborative health care as “relationship-centered” (Suchman, 2005) and “patient-centered” (Weston, 2005) health care. In essence, there is no uniformity in the terminology to describe collaborative health care, nor is there a standardized model of practice in the implementation of this service type (Linville, Hertlein, & Lyness, 2007).

Five Levels of Collaboration

Doherty (1995), along with colleagues McDaniel and Baird, described five levels of collaborative healthcare. These collaborative levels will vary among practice settings based on the capacities and functions of the structural system as a whole and are referred to as the “Levels of Systemic Collaboration Model” (Doherty, McDaniel, & Baird, 1996). The levels are hierarchical with each increasing level indicating higher intensity of systemic integration between healthcare providers. The following briefly describes the five collaborative levels:

Level one is *minimal collaboration*. In minimal collaboration, mental health and medical professionals are located in separate sites and seldom interact with each other regarding consumer care. At level one, healthcare providers are at opposite continuums in attending to consumers’ needs. Quite often, these settings are private practice offices or agencies.

Level two is *basic collaboration at a distance*. In this level of collaboration, providers are also in different facilities yet communicate periodically about mutual consumers. Usually, a provider’s contact with the other is limited to phone calls or written communication. Mental health and medical providers each consider the other as a resource, yet function in entirely different cultures of providing care.

Level three is *basic collaboration on site*. In level three, mental health and medical providers are located in the same setting, but basically operate as distinct systems. Providers value each other’s work and the significance of the other, but they do not speak the same language of care or fully comprehend the other’s scope of treatment. However, these providers do have some sense of team purpose, although not clearly

defined. There is no protocol or explicit system of collaboration. Providers at level three of collaboration correspond face-to-face, as well as with written communication. This level is primarily practiced in medical settings which generate internal referrals to co-located mental health specialists.

Level four is *close collaboration in a partially integrated system*. In a partially integrated collaborative system, mental health and medical providers are in the same site and have access to common systems including scheduling and charting. Consumer treatment plans are coordinated between mental health and medical providers, as well as consistent and regular discussions regarding consumers' care. Providers understand the culture and language of each other and adhere to the beliefs of the biopsychosocial model.

Level five is *close collaboration in a fully integrated system*. In a fully integrated system, both mental health and medical providers are involved in a "seamless web of biopsychosocial services." This includes a joint system which shares location, vision, and systemic delivery of care. Consumers experience both types of providers as a team. These providers have a detailed understanding of the other's professional culture and customary team meetings are utilized to discuss issues concerning consumers, as well as any internal problems within the collaborative team.

Doherty et al. (1996), in reference to utilizing the aforementioned levels, suggested they could "be used by organizations to evaluate their current structures and procedures in light of their goals for collaboration and to set realistic steps for change" (p. 25). In essence, the authors recommend employing these levels as a baseline assessment to determine the future direction of collaboration among behavioral health and medical

providers. Doherty specifically acknowledged that level five is quite difficult to achieve and proposed this level of care as a vision for the future (1995).

Goals of Collaborative Health Care

McDaniel et al. (1992) described two major goals of collaborative health care as promoting *agency* and *communion* with consumers. Agency refers to a person's participation and decisions in his/her own care, which includes meaningful, personal choices in health care alternatives. In essence, agency affirms the power of consumers to have voice in their healthcare decisions and involves looking at those choices from the consumers' meaning-making experiences. Communion describes the emotional experience involved in healthcare encounters, which includes consumers' relationships with their healthcare providers, families, friends, and social network of interactions. Both agency and communion have an impact on clients' health, and how these experiences influence consumers will affect the quality of their other relationships. By promoting agency and communion, healthcare providers are encouraging "self-determination" and autonomy in consumers, who many times feel powerless in their own treatment and are consigned to the system's arbitrary standards (McDaniel et al., 1992).

In referring to the mental health system, the NFCMH (2003) acknowledged "the system has neglected to incorporate respect or understanding of the histories, traditions, beliefs, languages, and value systems of culturally diverse groups" (p. 49). Based on this recognition, the NFCMH recommended that collaborative care models should be expanded in primary care settings, and stated "consumers, along with service providers, will actively participate in designing and developing the systems of care in which they are involved" (2003, p. 8).

Seaburn (2005) stated “if the great strength of the biopsychosocial model is its capacity to help us ‘see’ more clearly, perhaps its greatest limitation is that it doesn’t tell us exactly what to ‘do’ with what we see” (p. 397). Perhaps, this limitation could be addressed by utilizing the NFCMH’s suggestion to purposefully include consumers in health care development to learn what to “do” with what is “seen.” As the major goals of collaborative health care are to promote *agency* and *communion*, consumers’ perspectives of services should be explored to learn the most pragmatic options in making these goals a reality. Suchman (2005) proclaimed “there is still much work to be done” in grasping the nature of consumers’ collaborative experiences in healthcare (p. 450).

Advantages and Outcomes of Collaborative Health Care

Benefits of behavioral health and primary care integration have been well documented in improving treatment outcomes (Dobscha et al., 2009; Doherty et al., 1987; Engel, 1977; Ludman et al., 2003; McDaniel et al., 1992; Seaburn, 2005; Simon et al., 2002; Strosahl, 2001). Health care costs are reduced through lessening the demand and need for medical services (Fries et al., 1993). Untreated mental health conditions in primary care settings often result in higher frequencies of medical visits, preventable healthcare evaluations, referrals to specialists, and unnecessary hospitalizations (Campbell et al., 2000). On the contrary, treatment of mental health issues in general medicine settings has lowered overall healthcare costs by reducing the need for services through detection, diagnosis, and treatment of behavioral health issues (Campbell et al., 2000). Strosahl (1996) postulated “a great proportion of medical care is driven by psychological and psychosocial concerns that the ability of the two systems to contain

utilization (and cost) depends on the provision of appropriate behavioral health services in the general medical setting” (p. 2).

Seaburn (2005) stated “we are moving in the right direction by understanding that the patient’s experience is a whole and developing collaborative approaches” (p. 399). Collaborative settings offer compelling promise to reshape health as a conceptual, complete “whole,” and maximize the accessibility and utilization of needed mental health services. Proser and Cox (2004) pointed out that “many behavioral health conditions may be discovered during a visit for a physical ailment with a primary care physician, who then serves as a point of entry into behavioral health” (p. 6).

Collaborative care also offers advantages in eliminating some deterrents to mental health care. For example, through the privacy of obtaining behavioral health services in an integrated setting, the stigma frequently attached to receiving these services can be minimized discreetly (Guck et al., 2007; Simpson, 1998). Other identified benefits of collaborative care include better coordination of client care through multidisciplinary treatment perspectives, less health care service system fragmentation, lowered overall health care costs, improved health outcomes, and increased treatment compliance through valuing consumers’ perspectives in their own health care decisions (Gray et al., 2005; Kessler, 2008; McDaniel et al., 1992; Strosahl, 1996, 1998, 2001; Uebelacker et al., 2009). Several studies have found that primary care providers find integrated behavioral health services as beneficial to consumers’ care and their practice, especially due to the wide range of mental health problems present in healthcare settings (Gallo et al., 2004; Knowles, 2009; Westheimer, Steinley-Bumgarner, & Brownson, 2008).

Collaborative care has been shown to increase clients' likelihood of overcoming barriers to seek care, especially with vulnerable populations. Guck et al. (2007) conducted a study with 173 adults seen in two outpatient university-affiliated general medicine clinics, which served ethnically diverse consumers from low-income to middle class neighborhoods. The study found that co-located behavioral health and primary care services improved no-show rates for behavioral health appointments compared to stand-alone care. Additionally, the results revealed that the more integrated that services were than the higher likelihood of keeping a behavioral health appointment, especially for at-risk, vulnerable populations (Guck et al., 2007). The researchers concluded that collaborative care created a greater level of support and "buffered" some of the high stress experienced by low-income consumers in help-seeking for mental health (Guck et al., 2007).

As poverty adds additional challenges to mental health, the prevalence of mental disorders in uninsured, low-income primary care populations is 2 to 3 times higher than general primary care settings (Mauksch et al., 2001, 2007; Olfson et al., 2000). Research has determined the most highly prevalent mental disorders with low-income primary care consumers are major depression, generalized anxiety disorders, panic disorders, substance abuse disorders, and suicidal ideations (Olfson et al., 2000). Additionally, many of these consumers also have co-occurring mental disorders (DHHS, 1999, 2001; Olfson et al., 2000). Because the poor and underserved are most likely to seek mental health care from primary care facilities and the majority of their conditions are undiagnosed in these settings, collaborative healthcare provides an opportunity to help

remove some barriers to care and better meet the healthcare needs of these traditionally underserved populations.

As vulnerable populations are at greatest risk for untreated mental health problems, increasing their accessibility to behavioral health services in primary care settings may have an enormous impact on improving the health conditions of these consumers. DHHS (2001) supported the integration of behavioral health and primary health care services and elaborated: “the introduction, expansion, and improvement for mental health services in settings where these groups are is critical to reducing mental health disparities” (p. 163). However, increasing access to behavioral health will include understanding consumers’ perceptions to transform acceptability and higher utilization of these services. Although studies show that collaborative health care improves health outcomes and treatment compliance, less is known about the real-lived experiences of clients utilizing collaborative care, specifically from the perspective of receiving behavioral health services in this integrated setting.

Challenges to Collaborative Health Care

While the union of behavioral health and primary care services has clear-cut benefits, there are also integration challenges to overcome. Problems with integration are a nationwide problem, including lack of effective communication between behavioral health and primary care providers; costs and reimbursements for mental health services; and organizational challenges within the health care settings (Kessler, 2008; Knowles, 2009; Levant, House, May, & Smith, 2006; McDaniel et al., 1992; McDaniel et al., 1995; Proser & Cox, 2004). All efforts toward creating solutions in day-to-day clinical practice should be shared endeavors between the entire collaborative team of consumers, primary care providers, and behavioral health providers. Unfortunately, most of the literature

reports on complications arising from the differing paradigmatic perspectives of health care providers.

Regarding these specific challenges, McDaniel et al. (1992) elaborated “differences in training, language, theoretical model, and culture have traditionally made it difficult for mental health professionals and medical providers to build successful collaborative relationships” (p. 40). For example, behavioral health providers have approximately 45-minute scheduled sessions with each client(s), which are centered on psychosocial aspects, while primary care providers’ service provision time is about 10-15 minutes and focused on biological features (McDaniel et al., 1992). Primary care providers give medical advice, are action-oriented, and share consumers’ health information; yet, in contrast, behavioral health providers are focused on process, do not give advice, and have more rigid guidelines regarding clients’ confidentiality with information shared (McDaniel et al., 1992).

The differences between the two healthcare professions’ models and practices present barriers to successfully integrating the holistic practice of health care. However, without effective collaboration, health outcomes cannot evolve to their maximum potential (Blount et al., 2006). Blount et al. declared:

The need for improving behavioral health services in primary care is dramatic. Primary care is the setting that offers the health care system access to the most people, and behavioral health is the area in which the most impact on morbidity and mortality can be achieved. (2006, p. 111)

Collaborative health care is an evolving practice requiring the participation of all team players, healthcare providers and consumers alike, to resourcefully develop a

coordination of care that has the greatest potential to improve health statuses (McDaniel et al., 1995; Seaburn et al., 1996).

Perceptions of Collaborative Health Care

In a qualitative study conducted by Todahl, Linville, Smith, Barnes, and Miller (2006), the researchers conducted interviews with a total of 14 physicians, therapists, staff, and consumers exploring the actual practice of collaborative health care in a primary care setting and how this particular practice was perceived. Their guiding question was, “What is collaborative family health care?” The primary care clinical practice setting was a private doctor’s office. Most consumers had health insurance coverage through health maintenance organizations or Medicare, and less than 5% of consumers were uninsured.

In this study, both physicians and therapists alike believed that referrals from the physicians increased consumers’ attendance to behavioral health services (Todahl et al., 2006). Physicians, therapists, and consumers all specified that the persuasion of the doctors appeared to influence the patients’ decisions to accept the referrals (Todahl et al., 2006). Additionally, the physicians suggested that utilization of behavioral health services usually decreased their primary care visits with consumers. Furthermore, all patients in this study were in agreement that the accessibility, familiarity, comfort, and confidentiality of on-site behavioral health services enhanced their willingness to seek these services, in combination with the doctors’ recommendations. All participants in the study experienced collaborative health care as a positive experience that was advantageous to their overall healthcare (Todahl et al., 2006).

Todahl et al. (2006) reported their investigation as one of the first qualitative explorations about collaborative health care in a primary care setting. In encouraging future qualitative research on collaborative health care, the researchers stated “the qualitative nature of this study, however, facilitates the process of developing a context-sensitive description of collaborative health care” (Todahl et al., 2006, p. 61). In other words, more research is needed to broaden understandings and meanings of collaborative health care.

Collaborative Relationship Development with Consumers

Seaburn et al. (1996) stated “relationship is the most important ingredient in any recipe for collaboration” (p. 47). Doherty (1995) stressed the importance of relationships with consumers in collaborative health care and stated, “unless we collaborate with the consumers of health care, with individuals, and with families, it won’t matter if we’re collaborating with one another” (p. 275). Additionally, the author reported that collaboration with consumers of healthcare services is essential for four reasons based on (a) ethics, (b) outcomes, (c) conserving resources, and (d) shared responsibility.

Doherty (1995) elaborated on his rationale: First, ethically, all people have the right to their own decisions regarding their health care, and helping professionals should be in partnership with consumers to modify treatment to their needs, with their input, to achieve the best outcomes. Second, treatment cannot be effective without consumers’ participation, therefore “diagnosis must be a shared meaning or it is meaningless” (p. 275). Third, resource-conserving corresponds with preventive measures promoting utilization of needed services rather than underutilization, which, in the long run, is more costly and usually leads to chronic or acute care. Finally, collaboration creates shared

responsibility between providers and consumers, which augments consumer satisfaction and improves health outcomes.

The importance of including consumers in their own healthcare has been proclaimed as more of a truth in theory, rather than actual practice (Horwitz, Horwitz, Orsini, Antoine, & Hill, 1998; Zubialde, Eubank, & Fink, 2007). DHHS (2001) stated “it is incumbent upon those who control the organizational structure of local programs to engage consumers, families, and other community members in the process of reducing mental health service disparities” (p. 166), and added “concerted efforts are needed to give voices to these relatively unheard stakeholders of the mental health system” (p. 167). Collaborating with consumers enhances the capability of healthcare providers to communicate respectfully with clients through understanding their worldviews and perceptions, while simultaneously providing opportunities to advance behavioral health services to the cultural norms of those consumers (DHHS, 1999, 2001). Therefore, utilizing consumers’ voices “shift a great deal of responsibility for health care from providers to consumers, a healthy shift from a past in which people with mental and physical disorders were often relegated to passive roles in their own treatment” (Kennedy, 2004, p. 504).

Importance and Need for Collaborative Health Care

The World Federation for Mental Health (2009) summed up the importance of integrating behavioral health into primary care settings for the following reasons: (1) primary care is the place where most people go for mental health problems; (2) behavioral health problems are frequently unrecognized and undiagnosed in the medical sector; (3) people with conditions, such as diabetes and heart disease, are more likely to

have mental health problems; (4) failure to treat mental problems associated with chronic medical conditions impairs all health outcomes; (5) uninsured, low-income, racial and ethnic minorities, and older adults seen in the public sector are often inadequately treated for mental illnesses; and finally (6) recognizing behavioral health problems that present in primary care settings encourages intervention strategies, promotes prevention, and offers more access to those who do not use specialty mental health care.

Gaps in the Collaborative Health Care Literature

Throughout the healthcare literature, it is evident that collaborative health care is effective in improving health outcomes, lowering healthcare costs, increasing consumer satisfaction, and increasing treatment compliance. However, most research on collaborative health care has been quantitative and has focused on the relationships and experiences of healthcare providers or experts knowledgeable about the topic. Conversely, very little has been reported about how clients perceive these experiences, despite the fact that consumers are important members of the collaborative team. Studies report that clients are satisfied with collaborative health care treatment, but less is known about the meaning that clients create as a result of these experiences. Additionally, studies on vulnerable populations' perceptions of behavioral health services are limited. The qualitative collaborative care study by Todahl et al. (2006) was conducted in a private primary care office where the majority of consumers had health insurance and less than 5% were uninsured. It could be inferred that this population sample, based on the private practice setting and healthcare coverage, was not low-income. Because the literature reports that living in poverty negatively influences mental health and increases

barriers to care, vulnerable populations who are utilizing the services of a FQHC may have different experiences than those in higher economic positions.

Researchers have acknowledged the gap in understanding consumers' perceptions of collaborative health care, yet "without collaboration with patients and their families, the health care process cannot be effective" (Doherty, 1995, p. 275-276). Linville et al. (2007) conducted a literature review on collaborative care, which they refer to as medical family therapy (MedFT), from 1965 to 2004. In their recommendations for future study, the authors proposed:

Too often, the researcher and the reader can only guess at the complex meanings that patients and families might provide to explain the quantitative results. Rather than exclusively looking at the presence or absence of symptoms, qualitative components of MedFT research could incorporate the patients' and families' perspectives of the therapeutic process, perspectives that are often neglected or marginalized. (p. 92)

Federally Qualified Health Centers

Brief History and Overview

For more than 40 years, FQHCs have "established a tradition of providing care for people underserved by America's health care system: the poor, uninsured, and homeless; minorities; migrant and seasonal farmworkers; public housing residents; and people with limited English proficiency" (BPHC, 2008, p. 1). FQHCs began as a result of President Lyndon B. Johnson's administration in the 1960s with a proclaimed "War on Poverty" to diminish health disparities and economic hardships (NACHC, 2009). The late Senator Ted Kennedy of Massachusetts has been deemed the "Godfather" of health centers

through his advocacy and activism for the underserved and “who as a first-term Senator in 1966 fought for the very first federal funding directed to these health centers, and who nearly a decade later authored the federal law that defines and sustains them to this day” (United Health Foundation, 2008b, p. 9).

The features listed below are representative of all FQHCs and are the hallmarks of these centers, which distinguish them as worthy of their designations to serve vulnerable populations (BPHC, 2008; HRSA, 2008, 2009; NACHC, 2008a, 2008b, 2009):

- Located in or serve high need communities that are designated as medically underserved areas (MUAs) or medically underserved populations (MUPs).
- Provide comprehensive services which integrate and coordinate primary care, behavioral health, dental, pharmacy, and social services with enabling services (transportation, case management, outreach, education, language translation) to promote access to care.
- Offer customized services that are congruent with the cultural and healthcare needs of the clinics’ consumers.
- Provide services to all people with adjusted fee scales based on ability to pay.
- Perform need-based assessments and continuous quality improvement endeavors.
- Meet requirements regarding the performance and accountability of financial, administrative, and clinical functions as mandated by federal law.
- Governed by a board of community members, among which 51% or more represent their populations served and are actual consumers of the health center’s services.

The last mentioned requirement, the governing board being primarily real consumers of FQHCs, is a unique trademark that ensures the specified needs of each individual community are carried out effectively (BPHC, 2008; HRSA, 2009). Another notable feature of these health centers is their enabling services, which include transportation, social services, and so forth. These services are provided to eliminate barriers to health care that the poor and underserved typically encounter - “Enabling services, such as those provided by health centers, are necessary to ensure access for vulnerable populations” (Poltzer et al., 2003, p. 302). Healthcare efforts in FQHCs are streamlined to focus on consumers’ overall well being through preventive measures, including consumer motivation and education (NACHC, 2008a, 2008b, 2009).

Profiles of FQHCs

In 2008, FQHCs provided healthcare services to 18 million people throughout U.S. communities identified as MUAs or MUPs (HRSA, 2008; NACHC, 2009). Nationwide, a total of 1,080 FQHCs were in operation providing care at over 8,176 service delivery sites (Kaiser Family Foundation, 2008a, 2008b). In Louisiana, a total of 23 FQHCs are in operation serving over 100,000 vulnerable state residents at 72 health center delivery sites (Louisiana Primary Care Association [LPCA], 2010).

Throughout serving the underserved, FQHCs experienced a propagation in consumer growth by 67% from 2000-2008 (NACHC, 2009). The majority of consumers served at FQHCs are (a) low income, (b) members of racial and ethnic minorities, and (c) uninsured or publicly insured (NACHC, 2009). Most consumers (71%) have incomes at and below 100% Federal Poverty Level (FPL); 14% are 101-150% FPL; 7% are 151-200% FPL; and 9% are over 200% FPL (NACHC, 2009).

The breakdown of demographics by race and ethnicity are as follows:

Hispanic/Latino (36%), Black/African American (23%), White (36%), Asian/Pacific Islander (4%), and American Indian/Alaska Native (1%). Minorities account for almost two-thirds of clinic consumers with Hispanics/Latinos and African-Americans more than doubling their overall population proportions in the U.S. (BPHC, 2008). Health insurance statuses of consumers are 39% uninsured, 46% publicly insured (35% Medicaid; 8% Medicare; 3% other public insurance), and a small number are privately insured at 16% (NACHC, 2009).

Making a Difference for Vulnerable Populations

FQHCs remove many barriers to care and are considered vital, safety-net providers in treating the most vulnerable persons and populations affected by health disparities (Hadley & Cunningham, 2004; Shi, Stevens, & Politzer, 2007). In 2008, over 46 million Americans lived without any health insurance (U.S. Census Bureau, 2009). Overall, uninsured patients receive more substandard healthcare than individuals covered by health insurance (Hicks et al., 2006). Estimates calculate that with the declining economy and rising unemployment rates, the U.S. uninsured population will reach 57 to 60 million by the year 2010 (NCHC, 2009).

With increasing rates of uninsured and medically disenfranchised, the need and demand for healthcare services will continue to unfold and highlight the increased necessity for safety-net providers. FQHCs serve as safe-havens for these populations in providing need-based healthcare services and are critical in their delivery as a main source of health care for uninsured and underserved populations. Without these health centers, the amount of medically underserved and untreated would be over 20% higher

(NACHC, 2008b). With such a high demand for services, Chow et al. (2003) stated “safety-net providers are too few and struggle to provide a level of care adequate to meet the needs of the most vulnerable populations...at the same time, racial/ethnic disparities in access are less pronounced among clients of safety-net providers” (p. 792).

Compared to those who receive care at a private physician’s office, FQHCs’ clinic users generally have poorer health (DeLeon, Giesting, & Kenkel, 2003). For example, FQHCs’ clinic users are more likely to suffer from diabetes, hypertension, asthma, and various mental illnesses than are patients seeking care from a private physician (DeLeon et al., 2003; NACHC, 2009). However, FQHCs’ uninsured consumers are more likely to have a regular source of care than the privately insured (NACHC, 2009). In a comparison of exclusively uninsured, FQHCs’ uninsured users were almost 16 times more likely to have a consistent source of care and report better health than those uninsured not utilizing the services of a FQHC (Shi et al., 2007).

Rates of Growth and Service Expansion

In the 1990’s, 1 in every 16 uninsured individuals received services at a FQHC (DeLeon et al., 2003); in 2001, that figure had risen to 1 out of every 10 uninsured individuals (Rosenbaum & Shin, 2003); and in 2008, one in seven uninsured individuals received healthcare services at a FQHC (NACHC, 2008b). The highest proportion of consumers at health centers is uninsured, and, nationally, consumer numbers at FQHCs have increased as the growth of uninsured has risen (NACHC, 2009). To balance this proliferation, established FQHCs apply for grants to expand their current services, and new health centers can also be established to compensate for the healthcare needs of their underserved residents (NACHC, 2009).

With considerable unmet health care needs incurred as a result of rampant proportions of U.S. uninsured populations, FQHCs have a targeted goal to reach 30 million consumers by the year 2015 with a strategy entitled *Access for All America* (NACHC, 2008a). This plan is projected to boost over 40 billion dollars in economic returns throughout communities served and save the Nation between 22 and 40 billion annually in healthcare expenses (NACHC, 2008a). In the *Access for All America* plan, all FQHCs will serve as health care homes with the “medical home model” (NACHC, 2008a).

The medical home model has also been referred to as the “Patient Centered Medical Home” (PCMH) and is based on core concepts to treat the whole person, respect consumers in all of their individuality, and encourage consumers’ collaboration in their own comprehensive healthcare (Robert Graham Center, 2007). The BPHC (2008) believes a health home should be (1) accessible, (2) continuous, (3) comprehensive, (4) family oriented, (5) coordinated, (6) compassionate, and (7) culturally effective. The Association of American Medical Colleges (AAMC, 2008) defined a medical home model as:

A concept or model of care delivery that includes an ongoing relationship between a provider and patient, around the clock access to medical consultation, respect for the patient/family’s cultural and religious beliefs, and a comprehensive approach to care and coordination of care through providers and community services. (p. 1)

With more focus on consumers' need and collaboration, FQHCs have the ideal setup for becoming healthcare homes to better the Nation's health and support consumers' needs and demands.

No two FQHCs are alike, and federal program requirements specify that each FQHC must provide diverse services that are representative of the community served, including culture, values, and language of its targeted population (BPHC, 2008). The Bureau of Primary Health Care (BPHC, 1998) issued a Policy Information Notice (PIN) to health centers detailing program expectations with a mission:

In order to fulfill the health centers' mission of improving the health status of underserved populations, health centers must continue to survive and thrive through health care reforms, marketplace changes, and advances in clinical care. Health centers must assess the needs of underserved populations and design programs and services which are culturally and linguistically appropriate to those populations. They must measure the effectiveness and quality of their services and continually evolve their programs to achieve the greatest impact. (p. 7)

Therefore, although the Bureau does hold FQHCs accountable to provide culturally competent and culturally sensitive services to underserved residents of its community, the Bureau does not direct health centers in how to carry out this mission. In essence, each health center is responsible to eliminate health disparities and increase quality of life for its community in a way that best serves that particular community. Building from this perceived need, the voices of consumers must be considered in understanding how services can be advanced to their satisfaction. Collaboration is an absolute necessity to

encourage clients to become more involved in their own healthcare, set their own goals, and work productively with their healthcare providers to achieve these goals.

Behavioral Health Services

“Community health centers...provide a vital frontline for the detection and treatment of mental illnesses and the co-occurrence of mental illnesses with physical illnesses” (DHHS, 2001, p. 163). One of the greatest challenges facing FQHCs today is the development and growth of their behavioral health programs. Federal mandates have required that all FQHCs have accessible behavioral health services. Proser and Cox (2004) stated:

It is abundantly clear that behavioral health stands out as a compelling and immediate issue facing the national health care system and health centers more directly. Clearly, controlling health care costs requires that behavioral health needs be adequately addressed...there remain challenges as health centers continue to expand their capacity to better meet the behavioral health care needs of their patients. (p. 23)

As FQHCs predominately serve vulnerable populations, who suffer the most from untreated mental health conditions, there is a “need for additional research on behavioral health and health disparities in order to better understand the gaps in prevention and treatment and to better care for these populations at health centers” (Proser & Cox, 2004, p. 23). Because more recognition is given to the existence of mental health disparities and their impact, rather than why these disparities exist, research and actions should be taken to eradicate these inequities (DHHS, 2001). DeLeon et al. (2003) stated “the foremost diagnoses and therapies for health center patients are for mental and behavioral

health problems...the substantial unmet need results, in part,...with the challenge of embedding culturally-and-community-appropriate mental health services into their primary care programs” (p. 581).

Disparities and Health Outcomes of Louisiana’s

Poor and Underserved Residents

Louisiana is located in the Deep South section of the U.S. and is part of the most impoverished region in the country, known as the Mississippi Delta. The Delta region includes parts of eight states (Louisiana, Mississippi, Arkansas, Alabama, Tennessee, Kentucky, Missouri, and Illinois) and covers 252 counties and parishes to “make up the most distressed area of the country” with a poverty rate exceeding 55% the national average (Delta Regional Authority [DRA], 2008). This territory is also home to nearly ten million people (DRA, 2009). As the geographical terrain of the Delta holds the highest concentration of poverty stricken areas in the nation, these disparities are evident through containment of the worst health outcomes, chronic diseases and conditions, and disadvantaged populations (Bloom & Bowser, 2008; Lower Mississippi Delta Nutrition Intervention Research Initiative Consortium [Delta NIRI], 2004). Arkansas, Louisiana, and Mississippi have the greatest disparities of the corresponding Delta states, and therefore, more challenges to overcome (Delta NIRI, 2004). Louisiana is comprised of 64 parishes, and 56 are in the Delta region, which accounts for 83% of state land (DRA, 2009).

Louisiana’s overall healthcare quality, when compared to all other states, straddles the line between very weak and weak (AHRQ, 2009). According to the United Health Foundation (2009a), Louisiana led the nation as the unhealthiest state of 2008, a

downward spiral from its previous year rank of 49th to 50th. Poverty, illiteracy, homelessness, obesity, cardiac disease, diabetes, lack of health insurance, mental illness, unemployment, teenage pregnancy, high infant mortality, chronic STDs, HIV/AIDS, domestic violence, and elevated high school dropout rates are among many indicators of disparities that residents of Louisiana experience (Louisiana Department of Health and Hospitals, Bureau of Primary Care and Rural Health [LaDHH/BPCR], 2009). The United Health Foundation's (2009b) report documented that a major obstacle affecting Louisiana's healthcare system is the high rates of uninsured at nearly 20% of the state's population which is higher than the national average of approximately 18% (U.S. Census Bureau, 2009).

In Louisiana, those afflicted with poorer health and endure more barriers to access care tend to be African American, not a high school graduate, uninsured, and earn less than 15,000 a year (LaDHH/BPCR, 2009). Lack of access to health care for Louisiana's vulnerable residents has largely been acknowledged throughout numerous state government reports (LaDHH, 2006, 2007; LaDHH/BPCR, 2009; Louisiana Department of Health and Hospitals, Governor's Health Care Reform Panel [LaDHH/GHCRP, 2005]; Louisiana Department of Health and Hospitals, Office of Public Health [LaDHH/OPH], 2005; Louisiana Department of Health and Hospitals, State Center for Health Statistics [LaDHH/SCHS], 2009; Louisiana Health Insurance Survey [LHIS], 2009, 2010). However, efforts involving solutions to these problems remain unfounded.

Louisiana's Uninsured

Louisiana reports, assessing the state's uninsured population, claim higher percentages than those at the national level (LHIS, 2009). The number of uninsured adults increased throughout Northeast Louisiana between 2007 to 2009 from 23.6% to 28%, thus marking the region as home to the state's largest population of uninsured residents (LHIS, 2009, 2010). Additionally, African Americans are about twice as likely to be uninsured than are Caucasians in Louisiana (LaDHH/BPCRH, 2009). Twenty six percent of Ouachita Parish's residents, which contain those living in the city of Monroe, do not have health insurance (LHIS, 2010). The high rates of uninsured in the state of Louisiana further verify the need and justification of FQHCs throughout the state. With the higher proportions of health care disparities in the Northeast territory of Louisiana, including the Delta region with the highest percentage of disadvantaged populations, PHSC's mission to improve health outcomes and eliminate health disparities for vulnerable populations is critical for the state and community's health. Encouraging consumers to be involved in their care is truly the difference that could make a difference.

Mental Health in Louisiana

The most noteworthy indicator for mental health conditions in Louisiana, which perpetuates failure to work and function routinely, is earning below \$15,000 yearly (LaDDH/ BPCRH, 2009). Estimates report that 1 in every 5 individuals in Louisiana has a diagnosable mental disorder which equals 650,000 adults and 245,000 children (LaDHH/OPH, 2005). With the high rates of poverty and disparities in Louisiana, these numbers are not surprising. However, due to inadequate resources, only the most severe cases of mental disorders are likely to receive services (LaDHH/OPH, 2005).

A key healthcare effort to reform mental health inadequacies in Louisiana began with the Governor's Health Care Reform Panel on Mental Health in 2004 (LaDHH/GHCRP, 2005). This panel acknowledged the need for more effective mental health service provision and recommended integrating mental health services with primary care settings. FQHCs have been identified as part of the solution at the local, state, and federal level (LaDHH, 2006, 2007; LaDHH/GHCRP, 2005). FQHCs are distinctively situated within local communities to provide need-based, community accessible, and culturally competent services focused on consumers' needs.

Louisiana's mental health challenges are exacerbated by the lingering effects of Hurricane Katrina. This hurricane hit New Orleans in 2005 and devastated the state of Louisiana. It was the deadliest hurricane in U.S. history taking 1,836 lives with the majority from Louisiana (Discovery Communications, 2010). However, because so many people remain missing, it is impossible to verify this number as complete (Discovery Communications, 2010). Kessler et al. (2008) conducted a quantitative study to evaluate mental health conditions of pre-hurricane residents in Louisiana, Mississippi, and Alabama between five to eight months after Katrina and again one year later. Utilizing a sample size of 815 participants, the researchers concluded that, contrary to other studies where post-disaster mental disorders decrease over time, the results indicated that mental disorders had actually increased over time for Katrina survivors. The study reported higher occurrences of Post Traumatic Stress Disorder (PTSD), mental illness, and suicidality even two years later, and the researchers signified these increases as a result of "unresolved hurricane-related stresses" (Kessler et al., 2008, p. 374).

In 2005, Louisiana conducted a statewide-needs assessment that was directed towards low income women and children, and mental health services were identified as a “top need” (LaDHH/GHCRP, 2005). The National Alliance for the Mentally Ill (NAMI) in 2006 “gave Louisiana’s mental health system an overall grade of D-” in a report card that evaluated conditions of the States’ mental health service systems (LaDHH, 2006, p. 7). This unacceptable evaluation highlights the obvious - changes are necessary in Louisiana’s mental health delivery, and consumers should be involved in improving these efforts.

Mental health care in Louisiana should be adjusted to increase availability and accessibility of behavioral health services for vulnerable populations, especially considering the outcomes resulting from untreated mental health conditions. The President’s New Freedom Commission on Mental Health reported that “more individuals could recover from even the most serious mental illnesses if they had access in their communities to treatment and supports that are tailored to their needs” (NFCMH, 2003, p. 3).

Summary and Justification for the Research

Mental health, in general, is a vital component of overall health and well-being. Risk factors, including poverty, place some individuals at an increased likelihood to suffer from mental health issues. However, despite the prevalence of mental health problems in the United States, a large proportion of mental disorders do not receive treatment, particularly among the low-income and racial and ethnic minority groups. This is problematic given the devastating impact of untreated mental illness and unmet mental health care needs, which can lead to suicide, physical problems and diseases, and

high expenditures as a result of lost productivity. Barriers to health care remain as major challenges to improve the Nation's health, predominantly for the poor and underserved. The stigmatization of mental health care appears to be the greatest impediment to utilizing behavioral health services, although not a sole deterrent. Collaborative health care, the integration of primary care and behavioral health care services in a co-located facility, offers a viable solution that removes many identified barriers to care, particularly when offered in the set-up of a Federally Qualified Health Center.

However, even in accessible, available, and consumer-friendly FQHCs, there remains an underutilization of behavioral health services. The research suggests this underutilization may be imbedded in cultural, contextual, and perceptual issues. In other words, the underutilization of behavioral health services may be due to meanings placed on receiving them by potential consumers. However, there is a dearth of research that explores the experiences, meanings, and beliefs of low-income consumers in relationship to mental health services, specifically in a collaborative health care framework. Qualitative research with this population could shed much-needed light on this issue.

This research study helped to address this gap in the literature. The study was unique in that it explored experiences of receiving behavioral health services in a collaborative care setting through the worldviews of consumers, as opposed to that of healthcare providers and experts reported in previous studies. This research project investigated the missing "voice" in collaborative health care – the voice of consumers. In addition, as the study was conducted with consumers of a FQHC, the participants were comprised of vulnerable persons from lower socioeconomic statuses, who traditionally have been silenced in their own healthcare.

CHAPTER THREE: METHODOLOGY

Focus of the Study

This study explored the real-lived experiences of low-income clients utilizing behavioral health services in a collaborative healthcare setting in a Federally Qualified Health Center (FQHC) in Northeast Louisiana.

Qualitative Research Methodology

Since a large portion of collaborative health care research has been conducted quantitatively and from the viewpoints of healthcare professionals, clients' perspectives are notably sparse and vastly underrepresented in the research literature. Qualitative research is conducted to seek a more detailed, composite understanding of some issue or experience (Bogdan & Biklen, 1998; Creswell, 2007; Maxwell, 2005; Moustakas, 1994; Patton, 2002). Additionally, qualitative research provides descriptive accounts of meaning and is more concerned with process than outcomes (Bogdan & Biklen, 1998; Creswell, 2007; Patton, 2002). For this reason, a qualitative research design was chosen, and, with its tenets, I was able to delve deeper into the research topic. Through this study, I helped to give voice to actual consumers of behavioral health services, received in a collaborative care FQHC, to understand these consumers' experiences and meanings created from these experiences. Too often, these vulnerable voices are marginalized and subjugated in the healthcare literature, and I sought to understand and describe these experiences. As Creswell (2007) stated, "let the voices of our participants speak and carry the story through dialogue" (p. 43).

Qualitative researchers center their concerns around the meaning, context, and process of situations to understand *what* something means and *how* things happen (Maxwell, 2005). As qualitative studies have relatively small sample sizes, especially

when compared to quantitative studies, these studies gain in-depth understandings of the inquiry explored and provide detailed descriptions of the participants' stories in their own words (Patton, 2002). Direct quotations and excerpts of participants are provided in the data analysis to exemplify these experiences (Patton, 2002). According to Creswell (2007), "Qualitative research begins with assumptions, a worldview, the possible use of a theoretical lens, and the study of research problems inquiring into the meaning individuals or groups ascribe to a social or human problem" (p. 37). Creswell (2007) described universal characteristics of qualitative research as: (1) occurring in natural settings; (2) the researcher as the "key" instrument; (3) utilizing multiple sources of data; (4) inductive data analysis; (5) understanding participants' meanings of experiences; (6) emergent designs; (7) viewed through a theoretical lens; (8) interpretive investigation; and (9) representing a holistic account of the bigger picture.

John Weakland (1967), an anthropologist and a prominent pioneer in the MFT field, believed that any exchange of information is best understood through interpretation, which, in essence, is the perception of experiences created in a reciprocal, relational context of meaning. In this regard, Weakland (1967) offered suggestions for research inquiry that are in alignment with qualitative traditions: (a) research should focus on directly observable communication, not presuppositions, including what the researcher sees happening; (b) the researcher should be aware that a larger context influences meanings and interpretations; (c) the researcher should be cognizant that "even the hardest 'facts' and the clearest messages are subject to differing interpretations" (p. 2); (d) the researcher should consider the complexities of perception, which can contain opposing interpretations of situations – "even if these can at first be characterized only

roughly, rather than inappropriate atomization and oversimplification to fit observational or statistical tools already available” (p. 2); and finally (e) the researcher should take a holistic approach in data collection and analysis, which includes the researcher’s role as a participant as well.

Qualitative research is an inductive process which progresses from specifics to more general viewpoints (Patton, 2002). According to Creswell (2007), it is not important whether these perceptions are called “themes, dimensions, codes, or categories;” however, what is important is for the researcher to move through a process of “multiple levels of abstraction, starting with the raw data and forming larger and larger categories” (Creswell, 2007, p. 43). Although a variety of qualitative approaches exist, the particular design chosen for a study should have the necessary characteristics that are most appropriate for the research in question (Creswell, 2007). Through pursuit of addressing the research problem proposed in this study, a phenomenological method of inquiry was chosen.

Phenomenology

Phenomenology seeks to understand everyday meanings in people’s lives, which are viewed as subjective and constructed through social interaction (Bogdan & Biklen, 1998). Researchers view phenomenology as “interpretive inquiry and emphasize the cultural and political contexts that influence the interpretation of meanings” (Dahl & Boss, 2005, p. 64). Phenomenologists study phenomenon in its context and recognize that perception is relative to this context (Dahl & Boss, 2005). In describing phenomenology, Moustakas (1994) stated “perception is regarded as the primary source of knowledge, the source that cannot be doubted” (p. 52). The principles of

phenomenology are congruent with my theoretical framework laid out in Chapter One, which acknowledges the intricate union of relationships, culture, social environment, and language in creating personal realities and understandings of self, world, and other. These are also the conceptual filters which guided my research inquiry. Due to the lack of literature describing the experiences of clients' utilizing behavioral health services in a collaborative care paradigm, a phenomenological method was chosen to understand the real-lived experiences of these clients and their meanings created from this phenomenon.

According to Creswell, research problems that are well suited for a phenomenological approach are those "in which it is important to understand several individuals' common or shared experiences of a phenomenon...in order to develop practices or policies, or to develop a deeper understanding about the features of the phenomenon" (2007, p. 60). This approach also believes that everyday knowledge is collective and shared throughout groups, which includes the researcher and participants equally (Dahl & Boss, 2005). A phenomenological approach focuses on descriptions of what participants have experienced and how they perceived that experience (Patton, 2002). Moustakas (1994) stated, "Descriptions keep a phenomenon alive, illuminate its presence, accentuate its underlying meanings, enable the phenomenon to linger, retain its spirit, as near to its actual nature as possible" (p. 59). In essence, I investigated consumers' frames of reference and social constructions about behavioral health experiences and their meanings placed on these experiences, which were influenced by their cultural and contextual environment.

Role of the Researcher

Researcher as the Instrument

In qualitative research, the researcher is the main instrument in the collection and analysis of data (Bogdan & Biklen, 1998; Creswell, 2007; Dahl & Boss, 2005; Lincoln & Guba, 1985; Moustakas, 1994; Patton, 2002). The researcher's inquiry is influenced by the researcher's worldview; therefore, the researcher cannot be separated from the phenomenon being studied (Dahl & Boss, 2005). In discussing the researcher as instrument, Creswell (2007) recommended that researchers acknowledge and discuss their experiences throughout their study's investigation because these experiences, inherently, shape the interpretation of results. He elaborated, "Researchers bring their own worldviews, paradigms, or sets of beliefs to the research project, and these inform the conduct and writing of the qualitative study" (Creswell, 2007, p. 15).

Lincoln and Guba (1985) asserted that human research is dialectical, and, therefore, the researcher needs complete cooperation of the participants to create meaningful results. In essence, the cooperation of the participants is inclusive of the reciprocal relationship with the researcher, and "it is the quality of the interaction" which provides the researcher the greatest possibility of responsiveness from the participants (Lincoln & Guba, 1985, p. 105). Therefore, the researcher should guide "inquiry in ways that maximize rather than minimize the investigator's interactions" (Lincoln & Guba, 1985, p. 107).

Moustakas (1994) referred to participants as co-researchers, which is indicative of the relational dynamics between the researcher and participants throughout their mutual process of influencing the other in data collection. Additionally, with a

phenomenological approach, this methodology does not denote any hierarchical stance between the researcher and participants about who is the expert (Dahl & Boss, 2005). As previously discussed, I view the world through a systemic and social constructionist framework, in which meaning is continually created, shaped, and re-shaped in language through interaction with others. These frameworks provided the perceptual lens through which I perceive and understand the world, which, in turn, shaped my understanding of the participants' stories.

Self of the Researcher

I am a doctoral candidate in the College of Human Ecology/Department of Marriage and Family Therapy at Syracuse University. I am a Caucasian female, who was reared, and is currently residing in Northeast Louisiana. I grew up in a professional, Catholic upper-middle class family and am aware of the countless privileges bestowed on me as a result of this context. In 2000, I completed my Bachelor of Science degree in Psychology at Louisiana State University (LSU), and I received my Master of Arts degree in Marriage and Family Therapy from the University of Louisiana at Monroe (ULM) in 2002. I am a Louisiana Licensed Marriage and Family Therapist (LMFT), Louisiana Licensed Professional Counselor (LPC), and Clinical Member of the American Association for Marriage and Family Therapy (AAMFT).

Throughout my doctoral training and time spent in Syracuse, my perceptions of the world changed drastically. Specifically, my understanding of oppression, marginalization, and subjugation of specific groups was overwhelmingly expanded. As a result, when I returned home, my surroundings and my understanding of those surroundings were different. I have worked at PHSC for almost four years as a therapist.

I am familiar with the many disparities that vulnerable consumers of the health center experience, which has evolved as a result of my work with them. I believe in multiple realities and describe my philosophical framework as postmodern with limitless and varying interpretations of the world. Also, I do not believe objectivity is possible, therefore, I believe that it is only possible to understand the world through one's own subjective experience. Consequently, it is impossible for me to be completely devoid of subjective meaning-making as a result of my personal life experiences. All of the aforementioned components influenced my perceptions and experiences, which, inevitably, influenced my investigation of the study and interpretation of the findings. Moustakas (1994) discussed this process as "intersubjectivity," in which the subjective worlds of the researcher and participants connect to create an understanding of the phenomenon in question.

As the research instrument in data collection, I maintained the practice of asking open-ended questions so participants could control what they wanted to share. Consistent with systems theory and the mutually recursive nature of the interview process, subsequent questions that I asked were informed by the participants' responses. I experienced emotional responses, which ranged on a continuum from happy to sad, as the participants shared their stories. For example, several of the participants disclosed very traumatic and painful stories about events that occurred in their lives, which played a part in their help-seeking behaviors. At times, they became highly emotional and teary-eyed upon discussing these situations. When these descriptions ensued, I felt empathetic, and I had to remind myself that my role was "researcher" not therapist.

I believe that my therapeutic skills helped me in successfully conducting the interviews, and, as the researcher, I purposely refrained from pursuing anything that was not relevant to my research question. For example, a challenge arose when one of the participants in the study wanted to use the interview as a therapy session. In particular, the participant wanted me, as a therapist, to provide him/her with my thoughts about his/her life from his/her conversations about personal topics that were not applicable to the study. As this occurred, I had to remind the participant that our interview was not a therapy session and reiterate the purpose of our meeting. I worked hard and successfully kept the interview focused and redirected the participant back to experiences connected to the research question. Verification procedures discussed towards the end of this chapter offer illustrations that I applied throughout data collection and analysis to most accurately present the research findings from the participants' worldviews and to keep my biases in check.

Research Procedures

Institutional Review Board

This research study protocol was reviewed by the SU Institutional Review Board (IRB) to evaluate the following: (a) the rights and welfare of the individuals under investigation; (b) appropriate methods to secure informed consent; and (c) risks and potential benefits of the investigation. The research study was approved and assigned IRB# 09-278, as the protocol was determined to be no more than minimal risk to participants.

Setting

Primary Health Services Center (PHSC)

The research study was conducted at Primary Health Services Center (PHSC), a Federally Qualified Health Center, located in Monroe, Louisiana. The health center has been established for over 11 years in the Northeast region of the state and provides services to low-income, poor, uninsured or publicly insured, and medically disenfranchised individuals. PHSC provides comprehensive healthcare services (primary care, behavioral health, and dental services) at two land-based clinics, plus an additional primary care mobile clinic. The health center's mobile clinic travels throughout Monroe and outlier communities serving the homeless, residents of public housing, and others who lack access to care. The mobile clinic also refers consumers to the land-based clinics if needed services are not provided on the mobile. PHSC also offers enabling services, such as transportation, case management, pharmacy access, social services, and outreach support to increase access and quality of care for consumers, whose economic disadvantages increase barriers to care.

The health center is located in an economically depressed area of the city, known as an enterprise zone. This designation means that the area is identified as needing economic growth due to downturn and recession, and businesses are granted tax breaks and incentives for establishment within this zone. Dilapidated buildings surround the health center, which is situated just off one of the city's busiest streets that extends centrally throughout the city and beyond. Additionally, the health center is conveniently located within the parameters of the city's bus line routes that provide public

transportation throughout the area to community residents. The organization is directly positioned behind a designated transport stop for these passengers.

PHSC has a consumer base of approximately 12,000 people. Consumers' racial profiles at PHSC include 76% African American, 23% Caucasian, and less than 1% other (more than one race or another race). Female consumers are double that of males with about 8,000 women compared to 4,000 men. Regarding poverty stats, 95% of consumers at PHSC are 100% or more below FPL. The health center employs 75 people, many of whom are members of the local community and representative of the population served at PHSC. Employees' demographics by race are 64% African American, 35% Caucasian, and less than 1% is another race. Women comprise 87% of the employee breakdown compared to 13% of men. This includes physicians (general medicine, an obstetrician/gynecologist, pediatrician, part-time psychiatrist), nurse practitioners, nurses, medical support staff, patient access staff, mental health professionals (marriage and family therapists, licensed professional counselors, social workers), behavioral health staff, dentists, dental staff, mobile staff, outreach staff, and the administrative and personnel staff. The organizational chart (see Figure 1.) demonstrates the managerial categorizations of the FQHC inclusive of various departments and employee positions.

PHSC's mission is "to provide quality, comprehensive, compassionate, and culturally appropriate primary and preventive healthcare services to residents in medically underserved Northeast Louisiana." The health center's philosophy of treatment is to empower consumers in their own healthcare through patient education to better self-manage and eliminate health disparities. The FQHC's employees also strive to embrace a spirit of humanity in treating consumers with dignity, humility, and respect,

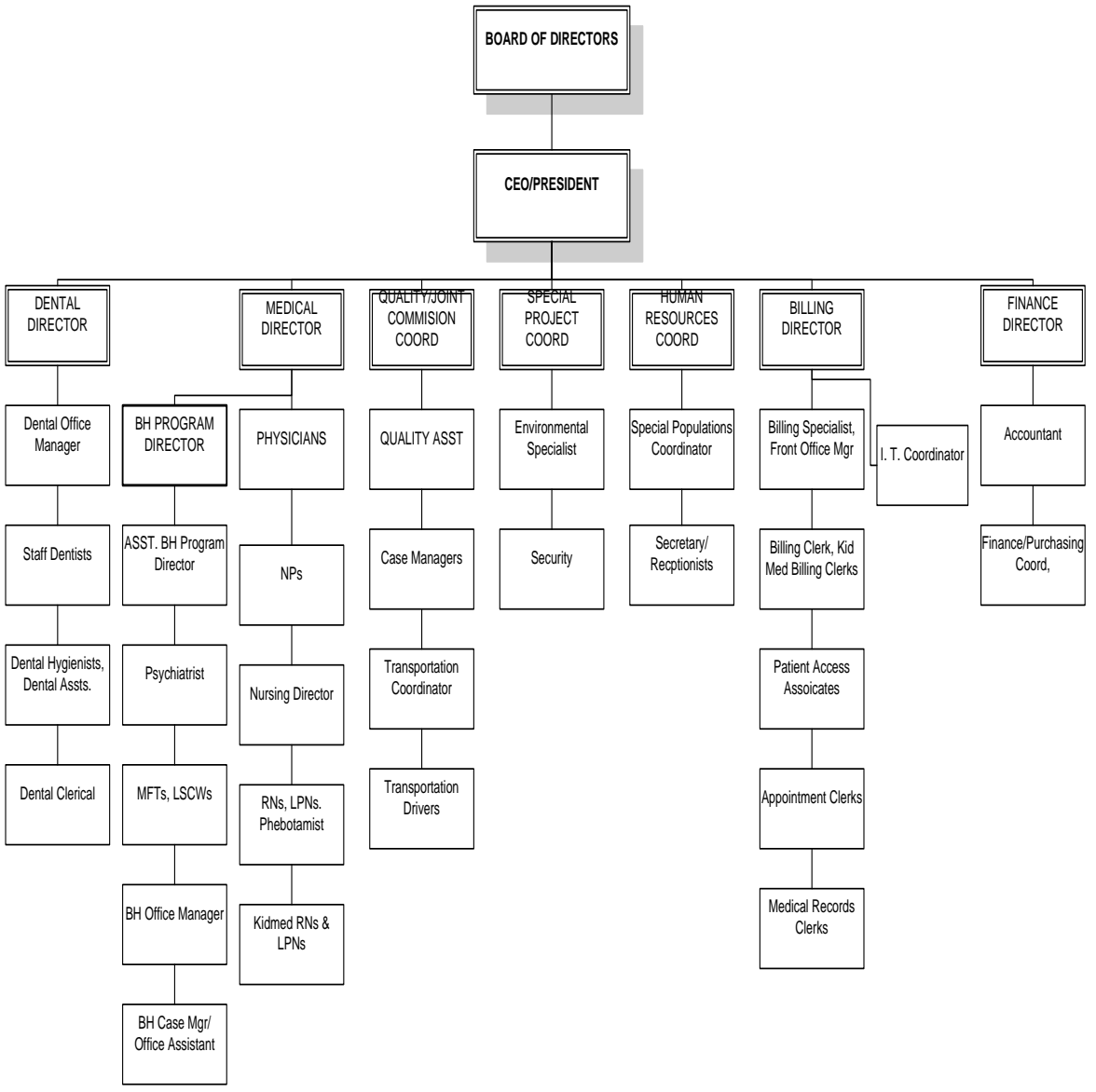


Figure 1. Primary Health Services Center Organizational Chart

specifically through commitment to the organization's mission and values in daily activities and attitudes towards those served.

PHSC Behavioral Health Program

The behavioral health program is located at the main land-based clinic, and the PHSC secondary clinic and mobile unit refer consumers from these sites to the program. Roughly 5% of PHSC's total consumers utilize the services of the behavioral health program. PHSC, like the majority of FQHCs in the country, is continuously developing and trying to improve its behavioral health program. Many of the challenges of providing collaborative health care at PHSC have been presented in Chapter Two as nationwide struggles. The collaboration employed at PHSC by the behavioral health and primary care providers is between level three and level four described by Doherty et al. (1996). Level three is *basic collaboration on site* and level four is *close collaboration in a partially integrated system* (Doherty, 1995; Doherty et al., 1996). PHSC's collaborative care level is a "blend" of these two levels, which could be described as *basic collaboration in a partially integrated system*.

To elaborate, the behavioral health and primary care providers appreciate the significance of the other and have some team purpose, but they do not fully comprehend the other's scope of treatment. The medical providers provide in-house referrals to the behavioral health program, and both types of healthcare providers correspond with the other about clients. The providers have access to the same system of scheduling, waiting room area, and some charting. For example, with the exception of small children, all consumers of PHSC complete comprehensive mental health screenings at their first appointment and every six months, thereafter, as a standard component of care. The

behavioral health providers include these screenings in the medical charts, and the primary care providers will generate referrals based on the results. Another type of shared charting includes the scenario of a behavioral health provider being requested into an exam room to converse with a consumer. In this situation, the behavioral health provider will write a short description in the medical chart, which the primary care provider can review. However, the behavioral health providers have separate charts for consumers who have scheduled appointments with them, and these charts are inaccessible to the primary care providers due to the legality and strict confidentiality requirements of mental health practice.

The behavioral health program is in a separate wing from the medical services at PHSC, although consumers share the same waiting room and sign-in at the same front desk. The program has three Caucasian full-time therapists: a licensed marriage and family therapist (LMFT), a licensed professional counselor (LPC), and a dually licensed LMFT and LPC. Two therapists are female and one is male. Other full-time behavioral health staff includes three African American women, the office manager and two case managers. Additionally, the program has a part-time psychiatrist, who is a Caucasian male.

The focus of the behavioral health program is to help clients with any challenges they may be experiencing, and treatment goals are established relative to each clients' unique situation and is a collaborative process between therapists and clients. The psychiatrist assists with evaluations of consumers who need more specialized services, including mental status examinations and medication management. The psychiatrist also consults with therapists about their clients, as the clients seen by the psychiatrist are

working with a therapist in the behavioral health program. The psychiatrist can also start a medication regimen for a client that can be monitored through use on the primary care side and re-evaluated by the psychiatrist at a later time. Sometimes, the primary care providers will defer writing psychotropic medications for a client until the psychiatrist has done an assessment to determine the best course of action.

The atmosphere of the behavioral health program is unlike the medical setting of the primary care environment at PHSC. The behavioral health area is calm and serene with tranquil music playing and fragrantly scented therapy rooms with big lush couches and chairs to increase consumers' comfort. One of the therapy rooms has an attached children's playroom with a television, DVDs of cartoons and animated movies, and toys. This setup was created specifically to help parents or guardians without childcare. While the children play in the playroom, the parents or guardians can watch them throughout the duration of the adults' therapy session. Additionally, a number of snacks and a "tea cart" with a variety of beverages are available for behavioral health clients. Clients are offered these items at their scheduled appointments upon entering the behavioral health program area. Appointments are scheduled for approximately an hour per therapy session.

Sample Selection Procedures

Participants

In this study, 11 consumers, who had utilized behavioral health services in a FQHC collaborative health care setting, provided the "voice" of this primarily unexplored phenomenon. Participants were identified as any person that was using or had used the behavioral health and primary care services at Primary Health Services Center (PHSC)

and met the inclusion criteria for the study. This phenomenological study employed purposeful sampling, which seeks “information-rich cases...which one can learn a great deal about issues of central importance to the purpose of the research” (Patton, 2002, p. 46). Therefore, by utilizing a purposeful sample, criteria for participation is established to find participants who have experienced the phenomenon that the researcher aims to explore (Lincoln & Guba, 1985).

Inclusion criteria for the study consisted of the following: (1) persons who were ages 18 and older; (2) a current or previous consumer of behavioral health services at the health center, who was simultaneously using or had used the health center's primary health care services during their treatment; and (3) persons who met the aforementioned criteria and were not my clients. Additionally, exclusion criteria for the study included the following: (1) persons who were under 18 years of age; (2) persons who were cognitively impaired and could not legally consent for self; (3) persons who were not using behavioral health services at the health center; (4) persons who were using or had used behavioral health services exclusively, without primary care services, at the health center; and 5) persons who were my current or previous clients.

Recruitment

I am employed at the health center as a behavioral health provider and was granted approval by the PHSC Board of Directors to utilize the facility and recruit willing participants for my dissertation project. I did not recruit or interview any of my own clients, as these clients were excluded from the study to minimize the possibility of any coercion or undue influence. I aimed to recruit 10-15 participants until data saturation

occurred. Data saturation occurred when no new themes or findings were appearing throughout the data, therefore data collection ceased after completing the 11th interview.

Participants were recruited through the following means: (1) I posted recruitment fliers (see Appendix A) in the behavioral health area of PHSC; (2) the health center's other therapists informed their clients about the study and gave them a flier, while reiterating that participation was voluntary; (3) the behavioral health receptionist distributed a flier to each client who presented for a scheduled behavioral health appointment that met the inclusion criteria. Additionally, I was prepared to mail a recruitment letter (see Appendix B) and, if necessary, a follow-up recruitment letter (see Appendix E) to current and former clients describing the study, but these recruitment efforts proved to be unnecessary as the aforementioned means provided the needed participants.

With the recruitment flier, clients were able to ponder their willingness to participate in the study and could contact me if interested. Clients were also given the option to leave their name and phone number in a secure, locked, and confidential drop box labeled, *research study*, in the behavioral health program area at PHSC, if they preferred that I contact them with additional information. Ten of the participants chose the latter option and left their contact information in the drop box. One participant was introduced to me by his/her therapist, as he/she expressed curiosity and interest in the study. Whether by phone or in person, all questions or concerns about the study were answered, and all interviews were scheduled within a week of initial contact. Three of the participants requested and were provided transportation to the FQHC for their interviews.

Data Collection Procedures

Data collection began with the first interview and was an evolving, emergent process (Creswell, 2007; Moustakas, 1994; Patton, 2002). All participants, who met the inclusion criteria, voluntarily participated in individual, face-to-face, audio-taped interviews with me. The interviews lasted 1 to 1 ½ hours and took place at PHSC in the behavioral health area, where participants were accustomed to and familiar with the setting. The interviews were in-depth and semi-structured by questions that guided the initial process (see Appendix D). These questions were open-ended to avoid imposition of premature categories. Dahl and Boss (2005) asserted that “phenomenological research questions are questions of meaning designed to help the researcher understand the lived experience of the participants” (p. 70). Creswell suggested for the qualitative researcher to ask open-ended questions, be curious about what the participants are saying, form questions after exploration, not assume the role of expert, and be open to the research process as it emerges (2007). Qualitative researchers understand that “our questions change during the process of research to reflect an increased understanding of the problem” (Creswell, 2007, p. 43). The questions served as a general guide, meaning they were flexible and could change from one interview to another, as a result of developing data.

At the time of the interviews, I introduced myself and thanked the participants for their interest in participating in the study. I tried to alleviate any anxiety by briefly chatting with the participants to help them relax and feel more comfortable with me and the research process. Moustakas (1994) reported “the interviewer is responsible for creating a climate in which the research participant will feel comfortable and will respond

honestly and comprehensively” (p. 114). With this in mind, I chose to gather demographic information about the participants in our initial “ice-breaker” conversation before the interview began, rather than have them complete a demographic form. I discussed the purpose of the study with participants and explained that their experiences may help provide information that PHSC could utilize to improve behavioral health services. Next, I detailed all components of informed consent (see Appendix C) to ensure that the participants understood the audio-taping, risks and benefits, their right to withdraw at any time without penalty, confidentiality, and all other aspects of informed consent. I answered any questions that participants had about the study and clarified anything that participants did not understand about the research process.

Additionally, I discussed confidentiality. Participants were informed that (a) nothing shared with me would be disclosed to their therapist, (b) nor would anything shared with me impair or interfere with the services they were currently receiving or would continue to receive, (c) nor did I know anything about their reasons for coming to therapy or anything they have shared with their therapist. Participants were reminded of the boundaries of confidentiality and that their therapist is bound by confidentiality, therefore could not disclose anything to me about them. Participants were informed again that they could drop out of the study without penalty, which would also not impact or affect the services they were receiving or would receive in the future. Participants signed and were given copies of informed consent, which included appropriate contact information if they had any concerns as a result of involvement in the study. I also discussed with participants the member check process (see p. 106) and explained that,

only if absolutely necessary, a brief second interview could take place for further clarification.

Compensation

Participants were compensated with \$25 gift cards to Wal-Mart upon completion of their interviews. No participants withdrew from the study, but if any participants had chosen to withdraw from the study after beginning, compensation would have been pro-rated to recognize their time and effort. In this occurrence, the gift card would have been mailed to participants, unless a participant stated that he/she would prefer to pick up the card at the health center, which would have been arranged. The pro-rated method of compensation was broken down to include \$5 for every 20 minutes of involvement in the study.

Data Management Procedures

At the conclusion of each interview, each participant was assigned a number and pseudonym, which were the identifiers used on audiotapes, transcripts, analyses, and documents. Each audio-taped interview was transcribed by a transcriptionist following the data collection. To ensure precision of the participants' words, I listened carefully to each tape while reviewing the accompanying transcript and, if necessary, made the appropriate corrections. For example, in one participant's interview, I changed the word from *candid* to *guided* to correct the transcriptionist's error. Each transcript was saved as a paper document, on a USB jump drive, and on my personal computer, which is password protected for only my access. All data was stored in a locked file cabinet at my private home. Additionally, this data included all correspondence with my dissertation chair - Dr. Linda Stone Fish, other committee members – Dr. Ambika Krishnakumar and

Dr. Wendel Ray, and all other professional colleagues involved throughout the collection and analysis of data. After successful completion of the dissertation defense, all data will be destroyed in compliance with the SU IRB's guidelines.

Data Analysis Procedures

With the transcribed interviews, data analysis began (Moustakas, 1994). Each participant's transcript was printed on a different color of pastel paper, in order to distinctly recognize each of their voices. I read and re-read the transcripts several times to familiarize myself with the descriptive data and to obtain a composite understanding and overview of the participants' experiences (Maxwell, 2005; Moustakas, 1994). Phenomenology applies the method of reduction in analyzing data, as Dahl & Boss (2005) described:

The investigator begins with a generalization or hunch, and peels away (like an onion) until he or she gets closer and closer to the essence of the phenomenon.

The investigator keeps rejecting *what is not* in order to get closer to *what it is*. (p. 69)

Additionally, reflection on the researcher's part is an important aspect of data analysis, which embodies the logical thought necessary to examine information in a way that allows the phenomenon to become visible through descriptions (Moustakas, 1994). Intuition is another important component of data analysis and is an imbedded process with reflection. Because phenomenology seeks to understand meanings and the researcher must reflect on these meanings, "all things become clear and evident through an intuitive-reflective process, through a transformation of what is seen" (Moustakas, 1994, p. 32).

As a phenomenological method was chosen, data analysis occurred through the procedures recommended by Moustakas (1994), which is broken down into four steps or processes. These include (1) epoche; (2) phenomenological reduction; (3) imaginative variation; and (4) synthesis of meanings and essences. Although utilizing this method appears to be a simple linear operation, the actual practice of this analysis procedure was rather complex and recursive. As I became more and more immersed in analyzing the data, the lines of distinction between these four steps blurred. The recursive intricacy of their interplay was not something that I could separate throughout the analysis. Below, I discuss the analysis process as described by Moustakas, along with my descriptions of how I utilized the method in this study.

Epoche

The first step in analysis was epoche. The process of epoche requires the researcher to suspend judgment, preconceived notions, and biased assumptions to see the data with new vision in a new light (Moustakas, 1994). Moustakas (1994) explained that epoche is necessary for the researcher to be open to new possibilities of meaning in hearing the participants' stories. To achieve this process, Moustakas (1994) recommended that the researcher:

engages in disciplined and systematic efforts to set aside prejudgments regarding the phenomenon being investigated (known as the Epoche process) in order to launch the study as far as possible free of preconceptions, beliefs, and knowledge of the phenomenon from prior experiences and professional studies – to be completely open, receptive, and naive in listening to and hearing research

participants describe their experience of the phenomenon being investigated. (p. 22)

With the epoche process in mind, I realized that my training as a therapist helped me in many capacities when interviewing the participants and analyzing the data. The epoche process was not something that was challenging for me because it is a daily practice with clients in my professional work as a therapist. I am open and able to understand other people's perceptions of the world being careful not to impose my own. Epoche is also congruent with the theoretical/conceptual framework that I described in Chapter One which influenced the study. I worked hard at being completely open and receptive to the participants' stories. In combination with epoche, I progressed with the phenomenological reduction of the data.

Phenomenological Reduction

The process of phenomenological reduction involves looking at the data to dissect a "point of focus" from the "whole," which is called bracketing (Moustakas, 1994). Bracketing is a continuous process of reflection that requires the researcher to continue examining the data by seeking clarity "aimed at grasping the full nature of a phenomenon" (Moustakas, 1994, p. 93). Simply, this process focuses the relevancy of the data on the research question being explored and requires the researcher to bracket the noteworthy, essential statements. Reading through the participants' transcripts, I asked myself the following question: What statements describe their experiences of behavioral health services? Next, I bracketed off the significant statements that were relevant to the participants' experiences of the phenomenon. After being bracketed, these statements

underwent the practice of horizontalization, which means that all statements have equal value and significance to the researcher (Moustakas, 1994).

Throughout horizontalization, the researcher focuses on the participants' textural descriptions, which include "thoughts, feelings, examples, ideas, situations that portray what comprises an experience" (Moustakas, 1994, p. 47). I asked myself these questions throughout the horizontalization process: What is the experience? What is the meaning of this experience? I made notes in the margins of the transcripts related to themes that began emerging, as I intuitively-reflected on the textural qualities of the participants' experiences. Statements that were extraneous, overlapping, and repetitive to the study were eliminated. Disregarding the irrelevant data left only the horizons or meaning units, which are "the textural qualities that enable us to understand an experience" (Moustakas, 1994, p. 95). Increasingly, I noticed similarities in the participants' stories. Five broad themes emerged, and each theme was assigned a primary color of construction paper. Next, I cut out all of the participants' horizons/meaning units, which were on pastel colors of paper, and I attached them to their coded, matching themes on the primary colors of construction paper.

Throughout this process, I practiced epoche, and I used intuitive-reflecting while being cognizant of intersubjectivity. In short, Moustakas (1994) summed up phenomenological reduction as "an uncovering of the nature and meaning of experience, bringing the experiencing person to a self-knowledge and a knowledge of the phenomenon" (p. 96). In combination with the phenomenological reduction process of investigating what meanings participants attached to their experiences, I utilized the imaginative variation process to explore how participants created their meanings.

Imaginative Variation

In the process of imaginative variation, the researcher examines the structural qualities of the participants' experiences and meanings and evaluates them from varying points of reference to understand the phenomenon in a deeper, more complex capacity (Moustakas, 1994). Moustakas (1994) explained:

The aim is to arrive at structural descriptions of an experience, the underlying and precipitating factors that account for what is being experienced; in other words the 'how' that speaks to conditions that illuminate the 'what' of experience. How did the experience of the phenomenon come to be what it is? (p. 98)

In this process, the researcher understands "there is not a single inroad to truth, but that countless possibilities emerge that are intimately connected with the essences and meanings of an experience" (Moustakas, 1994, p. 99). In this deeper exploration of searching for the participants' meanings, I asked myself the following questions: How was the experience experienced? How did this experience come to be what it is? This phase of analysis went hand-in-hand with the phenomenological reduction process; therefore, it was impossible for me to separate the interwoven elements of *how* the experience came to be without understanding its connection to *what* the actual experiences were.

Moustakas (1994) delineated the following steps for imaginative variation: (1) evaluate the possibilities of structural meanings that underlie the textural meanings; (2) identify the significant themes that describe the emergence of the phenomenon; (3) contemplate the common structures that lend descriptions of feelings and thoughts about the phenomenon; and (4) investigate the examples which demonstrate structural themes,

which assists in the development of the structural descriptions of the phenomenon. In this process, I examined the broad-themed horizons/meaning units and began further refining and narrowing the themes based on their essential structures and meanings. For example, the broad based theme, *therapeutic relationship*, became more narrowed by understanding how aspects of the therapeutic relationship were experienced as helpful versus unhelpful by the participants. As the broad themes became more clustered themes of meaning, I completed the synthesis of textural and structural meanings.

Synthesis of Textural and Structural Meanings

The synthesis of meanings is the final step in phenomenological analysis and “is the intuitive integration of the fundamental textural and structural descriptions into a unified statement of the essences of the experience of the phenomenon as a whole” (Moustakas, 1994, p. 100). This synthesis contains the general experiences of the study’s participants as a whole, comprised “voice.” In this process, the horizons/meaning units and the narrowed themes were further conceptualized and clustered by the common structures that were shared among participants, which became the core themes. By deeper investigation into the texture and structure of the participants’ experiences, the “essence” of the phenomenon became clear. The essence is the deepest meaning of personal truth that the participants have created from their real-lived experiences of the phenomenon as a group.

Six core themes materialized from the final analysis and will be discussed in Chapter Four. With a small sample size of 11 participants, core themes were addressed by all of the participants, subthemes were primarily addressed by the large majority, and sub-subthemes were addressed by two or more participants. Each core theme was

assigned a neon color poster board, and its corresponding clustered meaning units were attached. In sum, the synthesis of these core meanings is illustrated through thick, narrative descriptions of the participants' words, which exemplify the essences of their experiences (Moustakas, 1994).

Trustworthiness

Trustworthiness is an important component of qualitative research and asks the prevailing question: "How can an inquirer persuade his or her audiences (including self) that the findings of an inquiry are worth paying attention to, worth taking account of?" (Lincoln & Guba, 1985, p. 290). Due to the emergent data and biased perspectives of researchers as instruments in qualitative analysis, Lincoln and Guba (1985) have proposed four concepts for establishing trustworthiness of a qualitative study as compared to a quantitative study: (1) credibility, which is analogous to the quantitative concept of internal validity; (2) transferability, which is analogous to the quantitative concept of external validity; (3) dependability, which is analogous to the quantitative concept of reliability; and (4) confirmability, which is analogous to the quantitative concept of objectivity.

Credibility

Credibility denotes the accuracy in representing the meanings described by the participants in the study. With the subjectivity of researchers' biases inherent in phenomenological research, precautions and methods must be in operational practice for the researcher to effectively and efficiently support the study and show its credibility. Lincoln and Guba (1985) stated "credibility is a trustworthiness criterion that is satisfied when source respondents agree to honor the reconstructions; that fact should also satisfy

the consumer” (p. 329). Procedures used to verify credibility in this study were triangulation, prolonged engagement, peer debriefing, persistent observation, and member checking. These methods are described in detail in the following section, entitled *Verification Procedures for Trustworthiness*.

Transferability

Transferability signifies the replication of the study’s findings. Transferability in qualitative research weighed against external validity, its comparator in quantitative analysis, is more complex to attain. Lincoln and Guba (1985) concluded that a qualitative analysis cannot achieve external validity in the same manner as quantitative studies, therefore “can provide only the thick description necessary to enable someone interested in making a transfer to reach a conclusion about whether transfer can be contemplated as a possibility” (p. 316). In narrative format, thick description uses the actual words, phrases, and sentences of studies’ participants to illustrate their real-lived experiences (Moustakas, 1994). In essence, the researcher presents as much thick description as possible “to provide the *data base* that makes transferability judgments possible on the part of potential appliers” (Lincoln & Guba, 1985, p. 316). Purposeful sampling also adds to the transferability of findings (Lincoln & Guba, 1985), and I utilized this sampling criterion in the research project. Additionally, I included as much thick description as possible in the analysis results of Chapter Four, which offers narrations of the essences of participants’ experiences.

Dependability

Dependability is associated with the quality of the study and consistency of the findings. Because there is “no credibility without dependability” (Lincoln & Guba, 1985,

p. 316), dependability is an important component to establish reliability in qualitative studies. A detailed description of the research methodology used in a study lends to its dependability (Lincoln & Guba, 1985). Therefore, the comprehensive description of the phenomenological method described in this chapter contributes to the dependability of this study with behavioral health consumers. Additionally, the use of internal and external auditors is another process to substantiate the dependability of a study. Auditors will be described in the next section under the subsection, triangulation, including how they were applied throughout data collection and analysis.

Confirmability

Confirmability is an element which further establishes trustworthiness of a qualitative study. In short, confirmability is a larger process in the collection and analysis of data as it develops structure (Lincoln & Guba, 1985). “Confirmation is achieved by repeated looking and viewing while the phenomenon as a whole remains the same” (Moustakas, 1994, p. 47). Confirmability holds the researcher accountable for subjective biases that filter into the analysis, which requires procedural actions on the researcher’s part for his/her findings to attain confirmability. Moreover, this concept requires the researcher to be reflexive and write down thoughts, feelings, and experiences about the study from its inception through collection and analysis of data to the final, completed project with written descriptions and findings (Lincoln & Guba, 1985). Confirmability can be accomplished through the concurrence of auditors that examine the data and support the researcher’s results, which further increase the trustworthiness of the study (Lincoln & Guba, 1985). Selected procedures described by Lincoln and Guba (1985) for

confirmability are triangulation and reflexive journaling, which are discussed below and were used for establishing confirmability in this study.

Verification Procedures for Trustworthiness

The verification of trustworthiness is demonstrated through operational processes, which further add credibility to the study (Lincoln & Guba, 1985). Some of these verification procedures, which were employed throughout this study, are (a) triangulation, (b) prolonged engagement, (c) persistent observation, (d) member checking, (e) peer debriefing, (f) and reflexive journaling (Lincoln & Guba, 1985). These procedures also correspond with Creswell's description of the *rigor* needed in qualitative methods. Creswell (2007) elaborated, "Rigor means, too, that the researcher validates the accuracy of the account using one or more of the procedures for validation, such as member checking, triangulating sources of data, or using peer or external auditors of the accounts" (p. 46). What follows is a description of the verification procedures that were used throughout this study to obtain the methodological rigor needed to establish its trustworthiness.

Triangulation

Triangulation is a method to generate credibility for qualitative research. Triangulation of data is important "as the study unfolds and particular pieces of information come to light, steps should be taken to validate each against at least one other source" (Lincoln & Guba, 1985, p. 283). Triangulation can use a variety of sources, methods, investigations, or theories (Lincoln & Guba, 1985). In the present study, the dissertation chair, Dr. Linda Stone Fish, served as an internal auditor in reviewing all of the participants' transcripts to further triangulate the data. In addition, an external

auditor, Dr. Pamela Clark, who is well versed in qualitative methodology, was also used for triangulation and read all of the transcripts. Dr. Clark is the program director of a COAMFTE (Commission on Accreditation for Marriage and Family Therapy Education) accredited MFT program and a published qualitative researcher.

I maintained contact with both of my auditors during data analysis to discuss themes that were emerging and to ensure the accuracy of the findings. Through this method of triangulation, they concurred with my results. The agreement of these auditors lends to the credibility of my study and further confirms adherence to sound research practices.

Another source of triangulating the data in the study included the FQHC employees' perspectives of behavioral health services. To further contextualize the voices of the study's participants, I interviewed various employees of PHSC about their perceptions of behavioral health services in a collaborative care paradigm, and I took extensive notes of these interviews. Through assessing these additional viewpoints, I was able to understand and reflect upon supplemental information that illustrated cultural, contextual, and social narratives of behavioral health services from a broader perspective. In short, I attempted to gain as much information as possible that could inform the stories of the participants in the study. "Reflection becomes more exact and fuller with continued attention and perception, with continued looking, with the adding of new perspectives...through approaching something from a different vantage point, or with a different sense or meaning" (Moustakas, 1994, p. 93).

Prolonged Engagement

Prolonged engagement is another procedure to establish credibility for a qualitative study. Lincoln and Guba (1985) defined prolonged engagement as “the investment of sufficient time to achieve certain purposes: learning the ‘culture,’ testing for misinformation introduced by distortions either of the self or of the respondents, and building trust” (p. 301). This process further includes understanding the context that will give the participants’ stories their meaning. I have worked at the FQHC in the behavioral health program for almost four years; therefore, I am accustomed with the set-up and processes of the health center’s day-to-day operations. Because I have worked with the population that was recruited in this study, I had an understanding of the broader context of the participants’ lives. However, I worked hard to be as unbiased as possible to learn from the participants, assumed an active stance of curiosity to learn their worldviews, and attempted to build trust through treating the participants with the utmost respect as people and participants. The interviews lasted 1 to 1.5 hours, and, initially, I devoted time to socially chat with the participants to relax them, relieve anxiety, and increase their comfort with me and the process.

Persistent Observation

Persistent observation is also a process to create credibility for qualitative research studies. Lincoln and Guba (1985) stated, “If prolonged engagement provides scope, persistent observation provides depth” (p. 304). This process requires the researcher to concentrate on aspects that transpire as important to the research in question, yet sorting out aspects that are not. Lincoln and Guba (1985) described “the purpose of persistent observation is to identify those characteristics and elements in the

situation that are most relevant to the problem or issue being pursued and focusing on them in detail” (p. 304). Persistent observation was a continuous process throughout data collection and analysis, as I was reciprocally involved and immersed in exploring the participants’ experiences.

Member Checking

Lincoln and Guba (1985) described member checking as “the most crucial technique for establishing credibility” (p. 314). This process involves checking with participants in the study about information gathered during data collection and analysis to ensure accuracy of the participants’ voices and meanings. To confirm that I understood the meaning that participants were conveying in their stories, I employed member checking throughout the duration of the participants’ interviews. I achieved this by repeating back what I heard participants say, and they either validated or corrected my understanding of their experiences.

After their interviews, verbatim transcripts and researcher’s summaries were mailed to all of the participants to verify if the documents accurately described their experiences. I included a cover letter with directions (see Appendix F) and a self-addressed, stamped return envelope. Each researcher’s summary described the “essence” of what I found and was explained as an overview of the participant’s experiences. Participants were asked how the transcripts and summaries differed from their experiences and how they reflected their experiences. Participants were encouraged to make corrections as needed to inform me of any discrepancies and to contact me via phone, email, or postal mail. Three participants mailed back their transcripts and summaries without any changes, which confirmed that I was accurately interpreting the

meanings that they created about their experiences. In addition, two envelopes were mailed back to me from the postal office with the following stamped message: “Return to sender, undeliverable as addressed, unable to forward.”

One week after mailing the member check documents, I received a phone call from one of the participants, who stated his/her name and then replied, “I don’t want to do this.” I asked the participant if everything was alright, to which the participant replied, “I don’t want to do this, and I don’t want to talk about it” and abruptly ended the call. Immediately, I contacted my dissertation chair, Dr. Stone Fish, and we processed the situation. We both agreed that it was not clear if the participant did not want to participate in the member check, or if the participant was opting to withdraw from the study. At first, we decided that I should let some time pass and then call the participant back for clarification. Upon further reflection and processing, we agreed that as researchers our primary responsibility is to “do no harm” to the participants. We believed that the participant was conveying his/her wish to be left alone and wanted to cease communication; therefore, we agreed that contacting this participant any further could be harmful to him/her.

However, as chance would have it, I bumped into this research participant in the behavioral health program of the FQHC about two weeks after I received the initial phone call from him/her, and a brief conversation ensued. The participant proceeded to tell me that he/she has difficulty reading; therefore, he/she felt overwhelmed with the member check process and, literally, felt unable to review the documents. Through seeing the participant face-to-face and having dialogue, I was able to gain clarity that the participant was not withdrawing from the study, rather he/she did not want to partake in

member checking. I apologized to the participant for any stress and anxiety that occurred as a result of the member check process, and we ended our conversation on a positive note.

Peer Debriefing

Peer debriefing involves consulting with a peer, who is removed from the data collection, yet is considered a resource in challenging the researcher's biases, meanings, perspectives, and interpretations of the data (Lincoln & Guba, 1985). Additionally, peer debriefing is a "catharsis" to release the researcher's emotional experience involved in the data collection and analysis (Lincoln & Guba, 1985). I frequently debriefed with two peers in the field of Marriage and Family Therapy, who challenged me throughout the research process. Communicating with these two peers proved to be invaluable as I collected and analyzed the data. Their useful wisdom and insight all contributed to the quality of my performance throughout this project.

Reflexive Journaling

Reflexive journaling is a reciprocal process with epoche and can help the researcher become aware of biased perspectives that may interfere with the study. I kept a journal throughout the entirety of data collection and analysis. In journaling, I wrote personal memos for clarification of thought; ideas about the research as it emerged; and thoughts, feelings, and ideologies that ensued throughout the research process. I used reflexive journaling after each interview with participants, and I incorporated any notes taken during the interviews. As themes began emerging, my journal notes helped me make connections in the participants' stories and were an indispensable resource in the

study. I also used reflexive journaling as a personal/professional debriefing tool for the researcher as instrument.

Summary

I selected a qualitative, phenomenological method to explore the experiences of clients utilizing behavioral health services in a collaborative care FQHC.

Phenomenology is recommended for researchers who want to investigate the real-lived experiences of a phenomenon and understand the meanings that those experiencing this phenomenon have created as a result. This chapter detailed the following: (a) the focus of the study, (b) qualitative research methodology and phenomenology, (c) role of the researcher, (d) research procedures, (e) setting of the study, (f) sample selection procedures, (g) data collection procedures, (h) data management procedures, (i) data analysis procedures, (j) trustworthiness, and (k) verification procedures for trustworthiness.

CHAPTER FOUR: RESULTS

Introduction

This chapter presents the findings from 11 participants who voluntarily contributed to the research study and shared their real-lived experiences of receiving behavioral health services in a FQHC collaborative healthcare setting. The voices of the participants, in their own words, are illustrated throughout the chapter with rich descriptive statements that exemplify their experiences of the research phenomenon. This chapter unfolds an understanding of the phenomenon in question, aimed at providing a deeper grasp of the meanings and essences of participants' experiences. The following section introduces the participants, followed by the findings and results of the analysis.

Participants' Profiles

Ten women and one man participated in the study. Participants ranged in age from 27 to 56 years. Eight participants identified as Caucasian, two participants identified as African American, and one participant identified as African American/Asian. One participant completed tenth grade, eight participants graduated high school, and two participants graduated college with one obtaining a master's degree. More than half (six) of the participants were uninsured, and the remaining five had Medicaid coverage. Four participants were employed, two were disabled, one was retired, two were stay-at-home moms, one was not working, and one was a full-time college student. The participants' incomes ranged from no income to roughly \$45,000 a year with a mean of nearly \$15,000 annually. Eight participants in the study had previous experiences utilizing mental health care treatment prior to receiving behavioral

health care services at the FQHC, while the remaining three participants experienced behavioral health services for the first time at the FQHC.

Brief descriptions of the 11 participants are listed below, and demographic tables (see Tables 1 and 2) summarizing the participants follow their profiles. To protect the privacy and anonymity of each participant, numbers and pseudonyms were assigned, and any information that could potentially identify a participant has been changed or removed. All information was current at the time of the interviews.

Participant #1 - Molly

Molly is a 32 year old, Catholic, African American female. She is a high school graduate and is employed in retail sales, while she attends college. Her yearly income is less than \$10,000. Molly is in a long-term relationship and is expecting her first child. She is covered by Medicaid throughout the duration of her pregnancy, but, otherwise, she is uninsured. Molly has used the behavioral health services at the FQHC for 1.5 years, without any prior history of behavioral health usage.

Participant #2 – Georgia

Georgia is a 44 year old, Unitarian Universalist, Caucasian female and is engaged to be married. She is a high school graduate with some college coursework credits. Georgia is disabled and receives Social Security Income (SSI), which totals \$8,000 a year. She is insured by Medicaid. Georgia has used the behavioral health services at the FQHC for over a year and has a previous history of behavioral health utilization.

Participant #3 – Louise

Louise is a 27 year old, single, Caucasian female, and a non-denominational Christian. She is a high school graduate and a full-time college student. Louise is

uninsured and lives off of her student loans which average \$15,000-\$20,000 annually. She has used the behavioral health services at the FQHC for 1.5 years and has a prior history of behavioral health usage.

Participant #4 – Zahra

Zahra is a 34 year old, non-religious, African American female. She is in a long-term relationship and lives with her five children and significant other. Zahra is a high school graduate and obtained a medical assistant degree. She is a stay-at-home mom, who has no income, and survives with food stamps and Medicaid coverage. Zahra has used the behavioral health services at the FQHC for 2 years and has a previous history of behavioral health utilization.

Participant #5 – Penelope

Penelope is a 46 year old, Caucasian female, who believes in God. She has been married for 20 years with two children and is a high school graduate. Penelope is uninsured and does not work, although she helps her husband with paperwork for his contract jobs. Her husband's income varies year to year and averages \$17,000 annually. Penelope has used the behavioral health services at the FQHC for 1.5 years and has a prior history of behavioral health usage.

Participant #6 – Chrissy

Chrissy is a 29 year old, single, African American/Asian female, who believes in God. She is a college graduate and is employed doing clerical work. Chrissy's annual income averages \$23,000, and she is uninsured. She has used the behavioral health services at the FQHC for 3 months and does not have a previous history of behavioral health utilization.

Participant #7 - Betty Jane

Betty Jane is a 56 year old, Baptist, Caucasian female. She is married and has three grown children, in addition to grandchildren. Betty Jane completed her education through grade 10, and she is uninsured. She is retired and lives off of her husband's income in security maintenance, which totals \$40,000-\$45,000 yearly. Betty Jane has used the behavioral health services at the FQHC for 8 months, without any prior history of behavioral health usage.

Participant #8 – Dianne

Dianne is a 45 year old, Catholic, Caucasian female. She is separated from her husband and has three children. Dianne graduated from high school and is a stay-at-home mom. Dianne's annual income is less than \$2,200, which breaks down to \$180 monthly plus food stamps. She is covered by Medicaid. Dianne has used the behavioral health services at the FQHC for 5 months and has a previous history of behavioral health utilization.

Participant #9 – Edma

Edma is a 53 year old, Baptist, Caucasian female. She is separated and undergoing divorce proceedings from her husband. Edma is a high school graduate. She is disabled and receives monthly SSI payments, which totals \$8,100 a year. Edma is insured by Medicaid. She has used the behavioral health services at the FQHC for 3-4 months and has a prior history of behavioral health usage.

Participant #10 – Brad

Brad is a 51 year old, Baptist, Caucasian male. He has been married for 19 years and completed college with a master's degree. Brad has had a myriad of jobs and is

employed as a laborer. His annual income is \$20,000, and he is uninsured. Brad has used the behavioral health services at the FQHC for 2 years and has a previous history of behavioral health utilization.

Participant #11 – Stacey

Stacey is a 39 year old, Baptist, Caucasian female. She is in a committed relationship and has children. Stacey is a high school graduate and employed at a local plant. Her annual income is \$14,000-\$15,000, and she is uninsured. Stacey has used the behavioral health services at the FQHC for over a year and has a prior history of behavioral health usage.

Findings and Results of the Analysis

Through an exhaustive phenomenological analysis of the in-depth interviews, the essence of this phenomenon became clear. As the participants' meanings of their experiences were clustered, six core themes emerged. These themes were (1) Barriers to Care; (2) Breaking/Overcoming Barriers to Care; (3) Humanizing the Context of Care; (4) Evolvement through Relationships of Care; (5) Transformation through the Therapeutic Process; and (6) Advocating for Behavioral Health. These themes are presented in combination with the participants' voices to facilitate an understanding of the meanings that consumers attached to their experiences of receiving behavioral health services in a collaborative care FQHC. A discussion of these themes follows, concluded by the collective essences of the consumers' real-lived experiences of the phenomenon.

Table 1
Participants' Demographics of Age, Race, Gender, Religious Affiliation, and Relationship Status

Name	Age	Race	Gender	Religious Affiliation	Relationship Status
Molly	32	AA	Female	Catholic	In a long-term relationship
Georgia	44	C	Female	Unitarian Universalist	Engaged
Louise	27	C	Female	Non-denominational Christian	Single
Zahra	34	AA	Female	Non-religious	In a long-term relationship
Penelope	46	C	Female	Believes in God	Married 20 yrs
Chrissy	29	AA/Asian	Female	Believes in God	Single
Betty Jane	56	C	Female	Baptist	Married
Dianne	45	C	Female	Catholic	Separated
Edma	53	C	Female	Baptist	Separated & Divorcing
Brad	51	C	Male	Baptist	Married 19 yrs
Stacey	39	C	Female	Baptist	In a relationship

Note. AA = African American; C = Caucasian.

Table 2
Participants' Demographics of Education, Occupation, Income, Insurance, Duration of Behavioral Health Treatment at the FQHC, Prior Usage of Behavioral Health Services

Name	Education	Occupation	Yearly Income	Health Insurance Status	BH Duration at FQHC/ Prior BH Use
Molly	Graduated high school	Retail sales/ College student	< \$10,000	Medicaid	1.5 yrs / No
Georgia	Graduated high school	Disabled	SSI = \$8,000	Medicaid	1+ yrs / Yes
Louise	Graduated high school	College student	Student loans \$15,000 – \$20,000	Uninsured	1.5 yrs / Yes
Zahra	Graduated high school/ Med. asst.	Stay-at-home mom	No income/ Food stamps	Medicaid	2 yrs / Yes
Penelope	Graduated high school	Not working	\$17,000 (husband)	Uninsured	1.5 yrs / Yes
Chrissy	Graduated college	Clerical work	\$23,000	Uninsured	3 mo / No
Betty Jane	Completed 10 th grade	Retired	\$40,000 - \$50,000 (husband)	Uninsured	8 mo / No
Dianne	Graduated high school	Stay-at-home mom	<\$2,200/ Food stamps	Medicaid	5 mo / Yes
Edma	Graduated high school	Disabled	SSI = \$8,100	Medicaid	3-4 mo / Yes
Brad	Graduate degree	Laborer	\$20,000	Uninsured	2 yrs / Yes
Stacey	Graduated high school	Plant worker	\$14,000 - \$15,000	Uninsured	1+ yrs / Yes

Note. BH = behavioral health; SSI = social security income; med. asst. = medical assistant.

Theme #1 – Barriers to Care

In this theme, all participants described various situations and experiences that interfered with the process of seeking and obtaining behavioral health care treatment. One of the primary barriers that emerged was the stigma associated with mental health issues in general. Participants indicated common sources included their own perceptions, the perceptions of others, and their negative experiences with previous utilization of behavioral health services. In addition, participants articulated contextual factors that hampered utilization of behavioral health care, including difficulty with access to services and relational factors. The following discussion explores participants' shared experiences that presented barriers to obtaining behavioral health services and includes (a) negative preconceived notions, (b) previous negative experiences of behavioral health services, (c) lack of access to behavioral health services, and (d) relationships.

Subtheme #1 - Negative Preconceived Notions

Crazy. Prior to using behavioral health services, many participants had negative perceptions of what it meant to use behavioral health. Brad mentioned that “preconceived ideas” about behavioral health prevent people from accessing it. In describing their initial perceptions, several participants made associations that behavioral health was for people that were “crazy;” “had lots of really bad problems;” “suicidal;” “insane;” and “very sick.” The word “crazy” specifically had a negative connotation for participants, as their perception of crazy meant being chronically mentally ill. Although these participants' initial perceptions of behavioral health would evolve to become misconceptions after using the services, their descriptions were common held beliefs that delayed their help seeking behaviors.

Participants reported that hearing other people talk disapprovingly about behavioral health perpetuated their negative beliefs, which further added in postponing their mental health care utilization. Stacey responded:

...people talk about behavioral health. If you go there, you're crazy. You need to be drawing a crazy check, and this is coming from people that ain't even been. I guess its gossip on the street that made me...let's put this off.

Other participants discussed that viewing negative images of mental health care treatment via the media contributed to their preconceived notions. In describing her initial thoughts about mental health, Chrissy articulated "it's probably a lot with movies and stuff...you're in a padded room, you're locked up, and you're in those little white coats or whatever, and they've got you tied down." Molly also discussed that her initial impressions of behavioral health were influenced by television, which included a passive client "lying on a couch" needing a "fix" by his/her directive therapist.

Additionally, Betty Jane talked about an unpleasant encounter with a medical health care professional that largely shaped her perception and, thereby, attachment of "crazy" to behavioral health. Instead of treating the physical medical condition that Betty Jane presented for care, the healthcare professional insinuated that her problems were mental, and he recommended, condescendingly, that she pursue medications through a behavioral health treatment method. Betty Jane conveyed that she was offended and immediately asserted to him, "I'm not crazy." Although Betty Jane had no previous experiences with behavioral health treatment, this scenario played a part in creating her perceptions that behavioral health services were for "crazy" people needing medications.

She described how this experience influenced her thoughts when she went to her behavioral health appointment at the FQHC for the first time:

Walking in somewhere that I've never been before and probably in the back of my mind I'm thinking...I'm wasting my time here because medication is what I don't need because I've got enough medication, and that's not what I'm after.

Stigma and Pride. Participants also discussed the shame and difficulty that other people have in seeking mental health care treatment due to the social ramifications of stigma. Penelope explained, "I think it's like saying, 'I'm not normal. I'm not okay.' And, people have real trouble saying that as a whole." She elaborated by saying "Most folks are in denial of the problems being a problem...if they admitted that there was a problem, then they're not doing something right." Chrissy added:

...everybody's trying to show that they're fine, that they're okay, like a machoism. They don't want to show any signs of...people would probably think behavioral health was a weakness. Yeah, a weakness. Why can't you cope? or Why can't you do it on your own, by yourself?

In concurrence, Georgia discussed her beliefs about barriers that stop people from seeking help and responded, "Pride...their own pride. Getting behavioral health, well, I would never live it down."

Subtheme #2 - Previous Negative Experiences of Behavioral Health Services

Unethical Therapists. Several participants described some previous experiences utilizing behavioral health services that felt cruel, unconstructive, and even harmful. These experiences were disclosed primarily through depictions of the therapeutic relationship. Participants reported that they did not trust their therapists because these

therapists demonstrated a lack of professionalism through behaviors that appeared to be repugnant and unethical. Some of these behaviors included breaching the client's confidentiality, chastising clients for their problems, making snide comments, and not allowing clients to discuss things that conflicted with the therapists' personal beliefs, such as religious views. For example, Edma articulated "I've been to some places and had some experiences that they don't like me to talk about it...I couldn't talk about God. Some of them [therapists] were like different religions than me or didn't believe in religion." Louise revealed, "I've even had problems with therapists just being outright rude and horrible to me...I've had to quit going to clinics because they were just completely insensitive to issues, which is obviously beyond unprofessional, just outright mean." She further expressed:

I was having sexual problems with my boyfriend, and she [therapist] told me I needed to put out and shut up. And, she wasn't there to be my sex therapist, and I just needed to open my legs and get it over with and quit griping about it.

Other participants also detailed situations where they were ridiculed, taunted, and even mocked by previous therapists. Consider the following statement by Edma, where she narrated the dialogue between herself and a prior therapist:

I told her [therapist] I wasn't getting enough sleep, and she looked at me and she says that 'Well, I can tell by you that you're getting a lot of sleep.' I said, 'Who me? I'm depressed all the time. I cry all the time.' She said, 'Why does this crying spell got to keep on for?' I said, 'If I would know that I wouldn't be here, would I?'

Dianne recounted a similar “bad experience” with a therapist, who was callous and snide towards her, when she sought help after losing her sister to suicide. She stated:

And he [therapist] said, ‘Why are you here today?’ and I said ‘because my sister shot herself in my head.’ And he said, ‘Oh! Is she alive?’ I said, ‘No.’ He said, ‘Well what do you want me to do for you? She’s the one who shot herself.’ I said, ‘Not a f’ing thing,’ and I got up and walked out.

From a “kid’s point of view and not an adult,” Georgia discussed her early experiences utilizing behavioral health services at age 14 for the first time and the future impact of these encounters. She reported that she “did not trust” her therapist, believed that the therapist was sharing all the details of their sessions with her [Georgia’s] mother, and was angry that her therapist failed to recognize signs of abuse that she was enduring. Georgia replied, “I was angry because my counselor was bad...In fact, I think that is why it took me so long to go back to mental health.”

Textbook Therapy. Some participants also communicated various unpleasant experiences regarding their therapists’ approaches in regard to the actual process of therapy. These experiences were reported as mechanical, in that participants felt their care was non-personalized and directed by the therapists’ goals instead of their own. Louise stated, “I have had many therapists that have just gone by the book. And, I’ve even had to tell them, like, take your nose out of the book and treat me differently. I’m not a case study.” She defined these experiences as “textbook therapy,” in which therapists demonstrated a “lack of warmth” and stringency in therapeutic process. Louise elaborated:

Well, I just kind of sat down talking and they'd be like, no we need to work on this. And this is what I think, and this is what you need to do, and this is the course we're going to take. And, they were just very rigid. There wasn't flexibility in it. You know, just because we need to talk about this doesn't mean I'm ready to. Or, this isn't where I would like to take my therapy. Even though you're the professional, it's my life, and I feel like I should still be in control. If I'm not comfortable, if I'm not ready, don't push me before I am.

Stacey corroborated a similar story. She stated, "it was strictly by the book. She [therapist] already had stuff wrote down, not even knowing what was wrong with me that day."

Just a Number, Just a Job. Several participants described situations where they felt that they were treated as a number instead of a human being. Edma reported, "I was just a number or something, like a number you can call on. You just sit down in this chair, and she's typing on the computer and ignoring you." In some instances, this included have no choice in healthcare decisions and being silenced at times. Zahra mentioned, "In general, I don't think I had too many choices. I felt like I was being just shuffled with everyone else...I don't want to be flopped around all of the unfamiliar faces and unfamiliar areas." Another prior perception participants discussed was that behavioral health services were more about money than actually helping people. Dianne replied, "I thought it was all about money. It was big crock of crap, and they just were out for money." Edma described a previous therapist's work as "It's just for a job...just want to get paid."

All participants, who had previous negative experiences utilizing behavioral health services, also reported emotional responses that occurred as a result of these negative behavioral health experiences, such as depression, anxiety, fear, anger, annoyance, and isolation. Edma relayed that “I never felt that I could be open or happy or anything else over there at [name of agency] because every time I went to see my therapist, I’d get depressed just by going to see her.” Zahra communicated “I get flustered because I’m being demanded to do one thing, and I feel like I’m being, again, in a controlled situation.”

Client as Therapist (Role Reversal). Much to their dismay, a couple of participants discussed role reversals that occurred with their therapists during therapy sessions, where they felt as though they had acted as counselors to their therapists. In describing this scenario, Penelope articulated, “this man [therapist] had gotten divorced, and I thought that he needed it more than I did. It was almost like I was counseling him. It was really bad.” Georgia explained, “It was all about her [therapist]...we rarely talked about what I needed to talk about, but she was always talking about different things for herself.”

Subtheme #3 - Lack of Access to Behavioral Health Services

Waiting. Several participants discussed waiting time as a barrier to mental health care treatment and the need for immediate access to services. Georgia reported about a situation in which she was going into a downward spiral, and, without hesitation, she reached out for behavioral health services. She detailed:

Well, it took about two weeks before I could get in to see someone. I didn't know if I was going to make it. I made it clear this was not...I made it clear this was an emergency and it still took too long. That was a problem.

Molly, Chrissy, and Penelope all related frustrated stories about having to wait for a very long time just to be seen for behavioral health services. Dianne conveyed her frustrations with time, in referencing another agency, with the following statement:

You wait six to seven months for your intake appointment, and then the most you get to see somebody, if they decide that you do...which they don't...would be once a month for about 15 minutes.

Denied or Unmatched Care. A couple of participants reported about situations, in which they were deprived of mental health treatment. For example, Stacey stated:

I've already had two bad experiences. [Name of agency]...they don't want to deal with me because I'm not crazy enough, or I don't fit their profile, which I think that's bullshit. If someone is going somewhere for help and all, you help them...regardless. Don't say 'you don't fit the profile.' You know? 'You don't have enough of issues to be seen over here at our clinic.' You know? I think that's something else. [Name of agency] turned me down, so what's one of these little rinky dink clinics going to think about me. That kind of pushed me away there for a little while...

Zahra described a previous experience where she was placed in group therapy, as opposed to her preference of individual therapy. This ultimately led to termination of her behavioral health services. Zahra replied "the state insisted that I go through group

counseling. And, I don't work well with others, and they didn't understand that. So, they put me in an anger management class, and I ended up getting kicked out of it."

Subtheme #4 - Relationships

Family. Relationships with family members were described by a couple of participants as hindering factors in their utilization of mental health care. Dianne described an abusive relationship with her husband, whom she is now separated from, in which he tried to obstruct her behavioral health use and control her. She said "my husband was a huge road block" and narrated:

He didn't want me to get any kind of help whatsoever. You know what I mean? To be completely dependent on him and believe exactly what he says...that I am nothing without him, and I can't do anything or have anything without him, and that he does everything for me, and that I can't make it without him.

Dianne further discussed that she was lying to the therapist she was seeing at that time because she was still living with her husband and was "too afraid" to talk about it. In addition, she mentioned that both her mother and living sister were "discouraging and in denial," which also created difficulty in her pursuit of behavioral health care. Chrissy, who is half Asian and half African American, talked about her mother's Asian culture and the influence of her family's cultural norms on her help-seeking behavior. She replied:

Maybe it's a culture thing, too, like with my mom. She's Asian. She's like 'don't tell anybody.' She's that kind of person...Petrified. Keep it quiet because you don't want to make the family look bad. I mean, that's her culture and her side...the Asian side...They would probably think that the person is not right in

the head, or just like, there's something wrong with the person. I mean, how do you put it? I don't know. Just don't make the family look bad...that's the only thing I could say. It's not like the whole bringing shame to a family. It's not, but in a way it's...you don't want to do it. You'd rather other people just not know about behavioral health...Don't let people know about it.

In addition, Chrissy communicated that her mother's message was centered more around the social stigma of *don't let people know about it* rather than *don't do it*.

Theme #2 – Breaking/Overcoming Barriers to Care

In this theme, participants described ways that they were able to break down and, ultimately, overcome barriers to access the behavioral health care they needed.

Participants relayed their personal motivations and motivators for seeking help and discussed factors that facilitated entry into behavioral health services. The participants' collective stories about breaking/overcoming barriers to care include (a) their faith in the therapeutic process, (b) their personal motivations and motivators to seek help, (c) the collaborative health care relationship, and (d) additional factors that assisted in surmounting barriers to care.

Subtheme #1 - Faith in the Therapeutic Process

Acknowledgment of the Need for Behavioral Health Services. Regardless of barriers that created reluctance in their help seeking behaviors, all of the participants remained hopeful and had faith that the therapeutic process could be beneficial in helping them to work through their problems. Evidence of this hope was demonstrated in their actions of pursuing behavioral health services. In their journeys that led to utilizing

behavioral health services at the FQHC, all participants expressed a realization that changes needed to occur in their lives, and they could not do it alone. Chrissy remarked:

I just wanted to change. I wanted a change to be, for me, to be a better person.

Because after awhile you're running around in the same circle, and you're starting to see it and you're like, oh gosh, wow, you really do need help. Maybe somebody else can guide you out.

Zahra asserted, "I know I need it [behavioral health]. You know? And, they assure me that as long as I know that I'm trying, I'm going to get better." Dianne stated "...I know I need behavioral health. There's no doubt in my mind, and I'm not giving up on it. I'm not backing down." Louise narrated how she was able to overcome her previous bad experiences and have the courage to try behavioral health care again.

I'm very realistic with myself, and I'm hard on myself. I took a step back from therapy after those bad experiences, but it came to a point that I knew I couldn't do this by myself anymore...And, I knew I had to look at myself in the mirror and go 'okay, you can't do this alone.' It just either things are going to get worse, or you're going to have to be courageous, take the step, and get something done about it. And, I chose to go the healthy route. So, I started going back to therapy to deal with the abusive situation more than anything. Of course, we've dealt with many, many other things since then. But, that was the catalyst at the time that I was falling apart on the inside, and I just couldn't do it on my own anymore.

Previous Positive Experiences of Behavioral Health Services. In contrast to the many negative experiences with behavioral health services described by so many participants, two participants articulated previous positive experiences that served to

facilitate seeking help again. Georgia discussed that she had “no qualms about calling mental health” and that her faith and trust in behavioral health care were built over time from having good experiences. She explained:

I had five [years] with this excellent counselor and with an excellent psychiatrist in [another state] at mental health. And, I learned to trust mental health...And so how that relates to here is that because they worked so well at building my trust in them, I knew I could trust. Hopefully, I knew I could trust behavioral health and when they were able to help me, it again reinforced that...positive reinforcement.

In addition, Penelope reflected on prior satisfactory mental health care treatment, which served as positive reinforcement in her help seeking journey. In describing her high school counseling experience, she said “For the first couple of years, it was really good. I learned a lot, and I felt like I moved a little bit. It wasn’t extremely so over-processed...”

Penelope further reported about behavioral health care received as an adult with the following statement:

...the biggest help that I feel like I probably ever got was going through a program...where they really tried to show you that it was your inner child that got so destroyed, and it was almost like you had to re-raise them...that nobody else can raise them. It’s honestly helped me a lot because it’s definitely like, she’s separate from me. And, I have to take care of her sometimes.

Take a Chance. Several participants discussed that their initial use of behavioral health services at the FQHC was a trial test. They described having attitudes of *take a chance* and *nothing to lose*. For example, the following statements illustrate the participants’ openness and willingness to try mental health care treatment and

demonstrate their faith in the process. Betty Jane stated, “I am going to give this a try because this is one thing that could possibly help me. Believe me I needed help at that point...I was just desperate.” Stacey expressed:

Just do it. I ain’t got nothing to lose because I’m already at the bottom. If it don’t work out, I’m still going to be at the bottom. But, let’s try it one more time. This looks like the last shot. And if it didn’t work here, I was done. I’ll deal with it on my own, or I’ll go do my time.

Molly added:

I’ve been playing with the idea of seeing someone because I was on Lexapro and chocolate and just down, crying all the time. I was actually depressed. And, so I thought, why not? I can go once, and if I don’t like whoever, or if I don’t like it at all, I can just stop going, and here I am almost two years later.

A couple of participants relayed that their readiness, to take a chance with the behavioral health program at the FQHC, was God’s doing. Edma explained:

Just something in me that said ‘try it.’ But I went home, and I prayed about it. I don’t know if I should say it, but I’m a good believer in prayers and God and everything. It was like God just told me ‘Go there. This is where you need to be. This is where you got to go.’ Then I did it. I made the call and made me an appointment, and that’s how I started coming here.

Subtheme #2 - Personal Motivations and Motivators to Seek Help

Losing Control. Several participants described overwhelming experiences of losing control of themselves, which assisted in their utilization of behavioral health services. Georgia explained:

I really thought I was going crazy. I was at the point of when I got here to behavioral health, either help me or somebody lock me up in the insane asylum because I can't do it anymore. I'm losing my f'ing mind...I don't think I was suicidal at that point, but I did think I was going to go completely insane. I think I might have actually been afraid I would hurt myself and for once in my life, I didn't want to. Whereas, even 10 years ago, if I had reached that point, I would have thought nothing of okay, so let's just check out. And, this time, I wanted...I needed...I was desperate for help at behavioral health here.

In addition, Dianne acknowledged, "I don't like having panic attacks. I don't like not having control of myself. I don't like having phobias that control my life. I don't like living in fear. Who would?" Betty Jane also discussed having uncontrollable feelings that were overpowering her life. She expounded:

I can feel it start coming on...it's coming, it's coming, and there's nothing I can do about it...I just can't take it...I get in one of those moods and it's like I said...I don't want to hear nobody; I don't want to talk to nobody, not on the phone or anything. You know? It's just don't bother me, you know?

Interpreter that's not Family or Friends. Some of the participants discussed that venting to their family and friends was non-therapeutic, which motivated them to explore professional help. Betty Jane conveyed the following statement:

I have talked to some relatives or friends or say a co-worker that I was close to, you know, about it. And it's just like, you know, okay I talked to them...I talked to them, but I've got nothing out of it. You know? It's still, even though I'm releasing, relieving it, it still hasn't, it's still there.

Chrissy reported, “Sometimes, you don’t want to listen to friends, or you don’t want to listen to family, you know? And, sometimes that’s why you need somebody else to talk to.” Louise explained that “sometimes you need an interpreter” because “you can only lean on family and friends so much.”

A Mother’s Love. Several participants confirmed that their love for their children factored into their decisions to utilize behavioral health services. Diane disclosed that she had to “piece me back together,” and her “mother’s love” for her children was her motivator in help seeking. She stated, “They count on me. I’m their advocate until the day they tell me to go to hell or whatever, but I don’t love anything or anyone like I love my children.” Zahra articulated, “It’s because I want my kids to know...I don’t want them to be shamed...it’s something in our heredity...But, don’t be ashamed of it.”

Subtheme #3 - The Collaborative Health Care Relationship

All 11 participants confirmed that the collaborative health care approach employed at the FQHC was an enormous, precipitating cornerstone that helped break down barriers and open access to behavioral health care. The participants detailed their experiences of collaborative health care treatment, including how the collaborative processes influenced their utilization of the FQHC’s behavioral health program.

Collaborative Care Opens the Door. The majority of participants articulated that without behavioral health services being integrated with their primary care services they probably would not have used mental health treatment, nor would they have been aware of its availability as a health care option. For example, Dianne narrated:

I found the people on the other [primary care] side to be seriously concerned. Not passively...seriously concerned for me and my health, and not just my physical

health but my mental health as well...They started by making me aware that behavioral health was here and available, and that was basically all I needed to know. And then the ball was in my court, and I just kind of decided to mop it, as they [behavioral health staff] came in the room and as I met them. It felt like it was okay...On this [behavioral health] side and the other [primary care] side, I just felt like it was okay. I mean, it's not like I did it, and it was easy. I'm not saying that. I'm saying that they graciously opened the door, and I made a choice to walk in.

Chrissy also disclosed benefits of the collaborative care setup for consumers needing behavioral health care with the following statement:

I think that with most people...they wouldn't even notice...notice behavioral health. You know? Because more people, who are like hurting and stuff, they're going to a doctor...first...of course, everybody goes to a doctor. But they never...I think maybe a lot of people never think of going to another kind of doctor, you know? A mental doctor. I don't think people think about that, but since y'all are...you two are together, it's something to think about.

Whole Person Care and Team Work. Several participants discussed the benefits of collaborative care as “whole person care” and acknowledged that both the primary care and behavioral health providers make better connections in healthcare diagnoses.

Louise asserted:

I think it's where the whole person issue comes into play. Therapy is in the same building. The physical health people care about your mental health and the mental health people care about your physical health. And, they understand the

connection so they're going to try to get you healthy on both sides. They understand that one affects the other.

Penelope related:

If the doctor sees that you are maybe a candidate, that you need some help from the behavioral health part, then they can suggest that. They can help follow up on that. You know? Yeah, a person could just quit coming all together and not end up with the help, but it's like they care of 'Did you go see so and so?' You know? It's a good connection, I think.

Some participants also mentioned the trusting relationships that the healthcare providers have with each other, specifically regarding medications, helped them trust the healthcare decisions made by the providers as a collaborative treatment team. Dianne articulated:

I feel like the medicine that they have me on...I think I need it because they went to great lengths to find out what they thought I needed...if they prescribed anything. I've never had that. I've never had anybody take the time to sit down and listen, and then she [therapist] reports to Dr. [name]. And then I talk to Dr. [name], and then he decides whether I need to be on the medicine.

Louise also elaborated on the teamwork relationship of trust between the behavioral health and primary care providers. She detailed:

I think there seems to be a level of trust since giving certain medications. Since I've been seeing my therapist for a long time, they [primary care providers] can see if I have a documented addiction. They know not to give me certain medications. Or, they know that maybe they need to bring up this health issue because of something that is going on with my mental health.

Recruitment from Behavioral Health Screenings on Primary Care Consumers.

Some participants described their initial use of behavioral health services at the FQHC began from being recruited by the behavioral health program, when they presented for primary care visits. They explained that recruitment was launched by the results of their mental health screenings, which all the FQHC's consumers complete as part of the intake process. Molly expressed:

When I went over to the other [primary care] side because I had the cold and whatever, they [behavioral health staff] bring you that box and it has the questionnaire. Just, you know, part of their routine thing. So I filled out the questions and they called me back. And, they said that my score was a little on the borderline or whatever. I don't remember exactly what she said. She asked if I would be interested in speaking with someone. And I'm like, well, I could give it a shot.

Zahra also had a similar story, which initiated her behavioral health utilization:

...they [behavioral health staff] give us our little survey, and yeah they wanted to see me. You guys, you said sparked interest. Yeah, I sparked your interest, and you guys are like yeah, can we talk to you over here? Let's get you interviewed, and let's get you an appointment.

Additionally, Zahra discussed that the logistics of the small, hand-held, computerized tablet, which administered the mental health screening, provided the discretion she needed in obtaining behavioral health treatment. She revealed:

...my boyfriend was standing over me while I was taking it, but he couldn't see because of the way that the picture thing was made. So, you know, I'm answering

these questions, and it's embarrassing because it asked you 'within the last year, have you felt like hurting yourself? In the last six months, six weeks, have you felt like hurting yourself or others?' You want to answer, but you don't want him to know what you're thinking. But as soon as you push your answer, it disappears. And then it goes to the next one and it was...I was able to tell the truth to somebody, you know? And then, I was able to start getting the help that I need.

Behavioral Health Advertisement in Primary Care Setting. Several participants mentioned that their exposure to the availability of behavioral health care occurred as a result of advertisements within the health center. Brad communicated, "Well, we just found out about it from the signage outside when we came for the medical health, and just one thing led to another..." Some participants reported that the behavioral health brochures opened access to mental health treatment. Edma stated:

When I came here, I had an appointment with primary care, and then I was reading the little pamphlet like that, and then I saw in there behavioral health program. And it was just something that, you know, why don't you try this? It looks like they got a lot of things that they might be able to help you with.

Chrissy also discussed how the brochures created awareness about the program and broadened the possibility of using behavioral health care. She detailed:

Actually, I've been over on that other [primary care] side for quite awhile, and they have pamphlets out for this place [behavioral health]. I kept looking at it, and I'm thinking...I'm just pondering whether I'm going to take this leap...The pamphlets were out, and I'm thinking...yeah, maybe I should. Why not?

The Primary Care Referral to Behavioral Health. Participants explained that trust in their primary care providers, specifically with an in-house referral to behavioral health services, made a difference in their acceptance of mental health treatment. In discussing her referral to the behavioral health program, Betty Jane commented:

It's just like her [primary care provider] referring me here [behavioral health]. I knew that she knew...if she had referred me to some off the wall place...other, I would have probably not have gone. I'd probably hesitated and thought about it...But I had a feeling that by her doing that, that she had to know about it and what it was like, in order to refer me here.

Penelope also discussed her beliefs about behavioral health referrals from primary care providers. She added:

I think there's a lot of people out there that having the notes from their doctor is going to make all the difference...if these doctors and nurse practitioners strike that person as they care, it may be all they need to get them over here.

The Mind/Body Connection. Without exception, all 11 participants spoke of a connection between their mental and physical health. They articulated their thoughts about the connection, including examples of how their minds and bodies respond simultaneously with each other. Brad described them as "very definitely interrelated." Stacey expressed, "the mental and physical are related." Edma conveyed:

My mental health has a lot of effects to do with my physical health. Since I...I have high cholesterol, high blood pressure, diabetic, so it has a lot to do with who I am. And my mental health has a lot to do with that. Because if I'm sure to me...if you have mental problems, then you have more aches, more pains, more

this and that. It works against you. I have a lot of stress, and I know it does bad things for you too.

Molly reported, “There’s a very big connection.” She also remarked, “I have not had an emergency room trip because of my high blood pressure since I started coming here [behavioral health program].” Chrissy stated her thoughts about the connection of mind and body:

Everything. Everything. I mean, if you’re feeling bad, upset or depressed, your whole body feels it. There’s no doubt about it. You’re like all achy. Some of it just gets worse, you know, like you’re so depressed, you don’t want to get out of bed so it makes your body feel even worse. But, it’s all in your mind. There’s nothing wrong with your body. They’re both connected in so many ways.

Under One Roof Convenience. Participants declared their appreciation of having collaborative health care services under one roof for convenience, accessibility, and familiarity. Stacey replied, “I think it’s cool because you don’t have to go to one building in one part of town and then drive somewhere else. It’s all right here under one big roof.” Louise narrated the following:

I think it’s a fantastic idea. I think more places need to do this. I think it also creates a more willing experience in a patient because if it’s all right there...Why wouldn’t I take care of this? I don’t have an excuse. Well, I have to go all over town to this place and then I have to run to that place. It’s right there. You might as well take advantage of it.

Molly mentioned, “it’s actually very, very good...and it’s all together. I don’t have to be like, where’s that doctor’s office again?” Molly also provided an example of the

convenience and accessibility of collaborative care. She reported that she was being seen on the primary care side and needed to see her therapist, but she did not have an appointment on that particular day. She explained this scenario and detailed the call from the primary care staff to the behavioral staff: “Hey, Molly is here. Her blood pressure is up. She said she really needs to talk but her appointment is not until next week or whatever. Can you squeeze her in?”

Collaborative Care versus Stand Alone Behavioral Health Care. The majority of participants, with the exception of Brad, articulated that behavioral health services in a collaborative health care setting were easier to access and broke down barriers to care, thus increasing their likelihood to use, as opposed to stand alone behavioral health care. When discussing if she would use stand alone behavioral health, Molly asserted “Probably not. No, because one, I probably never would have known about it. Two, it wouldn’t be as easy.” Chrissy replied, “I’m saying if it was standing alone, by itself, I don’t think a lot of people would be going in, or they’ll be too afraid to.” In articulating her thoughts about stand alone care, Louise mentioned:

I wouldn’t feel as if maybe my therapist had as much concern about my physical health. I don’t know...both sides learn from each other, and you can see that. So, I don’t think that connection would be as strong. I think it would be more frustrating because my therapist recommended me to go see a doctor, and I’m like Well, now I’ve got to go sign up for another place. I’ve got to find another place, since I don’t have insurance, a place that I can afford.

Subtheme #4 - Additional Factors that Helped in Breaking Barriers to Care

Transportation (as a Service). Several participants stated that transportation services provided by the FQHC aided greatly in breaking barriers to care, due to their lack of mobility. Dianne commented, “Transportation...that alone...transportation. I mean, I have no transportation. Maybe one day I will start driving, I don’t know.” Georgia affirmed, “...the biggest thing that has been boom for me is the transportation. Cause I’m one of those, otherwise I would have to sit and wait for the bus.” Edma mentioned, “...a ride that is from over here...Yes, your transportation...that I’m able to come to my therapist and come to my doctors here.”

Help without Breaking the Bank Account. Several participants reported that without the FQHC, they would not have access to the healthcare services they were receiving due to being low-income and struggling to make ends meet. Molly discussed that she began using the services of the FQHC because “I didn’t have insurance and someone told me that they go based on your income.” She added, “as far as out of pocket expense for the patient, it’s very reassuring that there is help without, you know, breaking the bank account, I guess you could say.” Dianne expressed:

...Primary [PHSC] have nothing to do with money. They’ve never asked me for a dollar, and I don’t have one. And it doesn’t matter. It doesn’t matter what my socioeconomic status is. I mean, that’s the way it is. I don’t have anything, and it’s okay...I don’t have any money. I wouldn’t be having any services, at all, if it weren’t for Primary Health. I would have nothing. I would have no behavioral health place to fall back on...

People helping People. Five participants talked about how other people were influential and supportive in encouraging them to seek behavioral health care, which included family members and other community resource links. Louise explained:

...growing up my parents were always very open about seeking help. They were always there for you, but they were very honest about when to draw the line between professional help and family. They were very encouraging, but they always encouraged my brother and I to seek help in any situation. If you're having trouble in school, you get a math tutor. If you are struggling religiously, you go talk to the pastor. You know, anything. If your car breaks down, see a mechanic. They are very pragmatic that way, and, so we were raised to know that it's okay to ask for help, regardless of the situation. Asking for help does not make you weak.

Chrissy affirmed that her father's advocacy for behavioral health, in turn, encouraged her to take a chance. She replied:

I'm really recommended from my dad. My dad's the one that told me to come here. He was having issues and problems himself, and he was like, 'You know what? You need to come. Why don't you try it out?' And, I was like 'okay.'

Penelope revealed that concern from one of her high school teachers, who suggested counseling to her, was her opening into behavioral health. She disclosed, "My PE teacher...she had seen me lots of times just crying for no reason...And, she picked up on there was something really wrong with me." Penelope further narrated the teacher's impact on her decision:

Well, the teacher being loving and concerned and kind, too. You know, maybe ‘you ought to do this.’ I was really susceptible, real quick to the idea...it was nice to have that teacher’s concern. Somebody concerned about Penelope for a change.

In addition, one participant discussed being very open about her utilization of behavioral health services with other people in the community, which assisted her in getting the help she needed as she navigated her way to the FQHC. Georgia relayed the following account:

I don’t have a problem with people knowing. I have no qualms whatsoever about going up to the bus driver and saying I need to get to the behavioral health center at Primary Health Care. What bus do I take? Which, I did the first time I came by bus. And they’re like, ‘Oh, you just get on this bus, and you tell them exactly what you told me.’ I did and they’re like, ‘You sit right here. Ok. This is where you need to go. This is where you wait.’

Georgia added that her candidness about needing behavioral health was warmly received by others and even elicited another riding passenger on the bus to offer her additional assistance. She elaborated:

...the other people on the bus, if they were listening, I would usually get just a smile and once in a while, I would get somebody that would actually start talking to me that might not have otherwise...Yeah, I remember one person, and this was two years ago or about a year ago, when I said I was going to Primary Health Care for behavioral health, she sat down beside me and she said, ‘I’ve gone there, and do you know so and so?’ I said, ‘This is my first time going.’ She said, ‘Oh,

okay. Well, if you get a chance to meet so and so in there, they are really good if you need something.’

In addition, some participants also discussed hearing about the services available at the FQHC by “word of mouth” from other people. For example, Brad commented, “It’s just word of mouth that we found out about Primary Health anything.” Molly replied, “Actually it was a co-worker” that informed her about the FQHC. Another avenue that participants conveyed created awareness about the FQHC was from other local agencies and referrals, which had community partnerships with the FQHC. These examples provide additional insight into how other people in the community increased access to healthcare for other consumers, thus breaking down barriers to care.

Theme #3 – Humanizing the Context of Care

In this theme, participants reported about the environment of care at the FQHC. Participants discussed in detail their perceptions of the health center’s ambiance, employees, and physical settings. The environment of care was described as being humanizing by the participants, which carried significant meaning for them. These impressions impacted their experiences of the care they received at the FQHC. In addition, participants differentiated between their experiences of the primary care and the behavioral health contexts of care. The following subthemes present the participants’ shared experiences of (a) the environment of the FQHC, (b) the environment of the behavioral health program, and (c) two different worlds of care.

Subtheme #1 - Environment of the FQHC

A Refreshing Place. Based on having some previous negative experiences with other agencies, some participants reported trepidation about what to expect upon entering

the FQHC. They communicated that their concerns quickly vanished, and their first impressions of the health center turned out to be encouraging and uplifting. Edma replied, “The atmosphere. When I got here, I felt the presence. Like, I could feel something. Like, I was happy in their presence...the atmosphere, people will talk with you.” She expounded about her initial experience and said:

Here is a totally different experience...from day one. Like I said, when I made that appointment, and I came here. I had the most good feeling about this place right when I walked through the door...I was like...what is this? A refreshing place!

Physically describing the facility, Louise mentioned, “This is a very basic building, but it feels nice. It doesn’t feel very stuffy. It is welcoming. The décor or there’s lots of sunlight.” Dianne reported, “I like the fact that it’s clean, and that’s really important to me.”

Smiling, Happy People. All of the participants talked about the kind, welcoming temperaments of the employees at the FQHC, which they reported contributed to their positive experiences at the health center. Georgia remarked, “the people, in particular, make this environment.” Betty Jane discussed the staff’s dispositions as happy and elaborated:

This is a good place. I would refer this place to anyone that needed it because the people...what counts is when you walk through the door of any kind of business and what I got when I first walked through the door meant a lot to me...I was such a mess, and I’m thinking...why are these people so happy up here? Why are they so happy? Where is my happy pill you know? It’s honestly...I’m thinking

just keep watching, you know, and it just felt like they had smiles on their faces, and they didn't look like they was having a bad day or anything. And I'm like, why can't this be me? I really need this fast.

Chrissy commented, "Every time I come in they always say 'good morning.' I'm like 'Auggghh!' All the time, they're always saying hello to everybody. That's a good thing...that's a great thing." Molly added, "Everyone is friendly. I mean, that's always a plus." Louise described the professionalism of the health center's staff in the context of a "low-cost facility." For example, she explained:

I know when you run a low cost facility, you know, you're not typically getting high society clientele...to be PR about it. So, when you have people who are in more dire need of services, I know it can get hectic and it's busy constantly and it's unpredictable. I'm just impressed with the calmness. How collected it is. How people really seem to work together and still have a good attitude. I can't imagine it would be easy to constantly be upbeat when things get so hairy around here. It's definitely impressive that it runs pretty smoothly. And, I've never felt like someone was just brushing me off just to get through something or that I was just a number. I mean, I've never felt that, and I don't know how they do it.

Safety and Privacy. A couple of participants described feeling safe in the FQHC.

The security guard employed at the health center was acknowledged, in addition to the private waiting room for the women and children of domestic violence. Dianne stated:

It's safe. I mean, you've got a guy right outside that will walk with me and wait for the van outside if I want him to...So I like that...secure. I know it's safe, and there's no doubt about it.

Georgia also discussed safety operations employed at the FQHC. She mentioned, "... I did like that they had a waiting room for those of us that were in the battered women's shelter. That helped tremendously."

Additionally, participants discussed some operational practices of the health center, which served to protect their privacy. Zahra discussed her appreciation for "the privacy" and declared, "You guys do the tickets and numbers. No name calling. You know? The private rooms. The privacy inside." In agreement, Georgia expressed appreciation for the extra precautions taken at the FQHC and said, "I didn't want my name being put out because I didn't know who was here, and I didn't know where my abuser was. And so, I was thrilled when they went to numbers."

Subtheme #2 - Environment of the Behavioral Health Program

A Cozy, Comfortable Living Room. All 11 of the participants described the physical setting of the behavioral health program as comfortable, relaxing, and non-threatening, which created experiences that allowed them to let down their guards and open up about themselves. Chrissy replied, "It's just like going to somebody's house and talking to them." Stacey added:

The rooms are kind of cozy...It makes sense. It's not an office. You're walking into like somebody's living room. It's a more homey atmosphere, instead of a business atmosphere...I can actually get comfortable...if you want to lay down, lay down on the sofa because I know you been at work all day...With the rooms being like they are, it's not like an office. It's down to earth. I think the more comfortable and more relaxed a person is, the better you got a chance of getting up in their head.

Penelope reported, “I like the flowers. The comfortable couch...all of the furniture is pretty and relaxing. The colors are relaxing.” In addition, she discussed the impact of the setting and added:

...it’s a very comforting setting and comfortable and relaxing and unthreatening...So much of the world is very sad, conflicting, and you just don’t have that in this setting. You know? You walk in there, and I’m ready to go take a nap because it’s comfortable and it’s relaxing, and you don’t feel like anybody’s judging you and all of that kind of thing. So yeah, whoever decorated and does all of this, that’s very much part of it all working. I think it’s because you have to have a person in the right mind set and comfort zone to be able to talk to people.

I Matter, Somebody Cares. Participants described that the décor of the health center gave them a sense of mattering, and they felt cared for. They reported that even though the FQHC served low-income people, the environment did not suggest this.

Louise declared, “There are certain places for lower income people that the standards aren’t up to par. You don’t feel like you want to go there...maybe it’s not as clean or maybe the people just don’t care as much...” Penelope detailed the following portrayal:

I don’t know who decorated this place, but all the whole place, even out there in the lobby of the medical part is a very...even though I know that this place has tight budgets and all of that stuff, they’ve managed to make it be comfortable and pretty and just a whole atmosphere of a place a person would want to come, rather than oh, I’m over there at that dirty, running through cattle place...It feels like...it makes you feel like you matter. It’s like, we care enough about our patients and our clients to make it nice for them. You know? Instead of, here’s just a bunch of

plastic chairs and nothing else. You know? It really does...it makes you feel like it matters.

Brad replied, "I just feel like I really am in a professional atmosphere here [behavioral health]. I am definitely getting my money's worth. You know? So, yeah, that's all a very definite plus."

Snacks and Beverages. Some of the participants reported that the snacks and beverages provided to them by the behavioral health program were humanizing and meaningful. Edna asserted:

They offered you...if you wanted something to drink, if you wanted something to eat or snack on, or what not. You didn't go hungry...nowhere. That would shock me. What do you want to eat or snack on? You know? It's been like...they treat you like a human being.

Louise relayed, "I can get a snack or a cup of coffee and just kind of...It's more like, let's sit down and talk to one of your buddies over a cup of coffee. Not very doctor/patient."

Subtheme #3 – Two Different Worlds of Care

Not Another Doctor's Office. Some of the participants made comparisons between the primary care and behavioral health settings as "two different worlds," specifically describing the behavioral health side as "not clinical" and communicating "more warmth." Chrissy mentioned, "Like two different worlds in this place. It's weird. They're like two different worlds." In describing behavioral health, she expressed, "It's not like going to a clinic. It's not like going to a hospital." Chrissy went on to articulate the following statement:

I was thinking that this [behavioral health] side was going to be the same as the other [primary care] side. I didn't think it would be like this comfortable with the couches and décor and stuff...I thought it would be like the same as the other side with the little beds or whatever, or you're sitting in that chair. It's more like a desk, and you're sitting across the desk talking to somebody. Kind of like that...that's what I was thinking it would be like...It kind of surprised me on this side. I was like 'Whoa! Wow!'

Stacey commented:

Well, the behavioral health side, it's laid back. You're in an office building, but it's not even like you're at a doctor's office. It's more of a friendly environment...If all places could be like that, I think places could get a lot more business and people might actually come back for a second go around. I'm coming back.

No Therapy in Clinical Exam Rooms. A couple of participants expressed their apprehension about having a therapy session in a clinical exam room on the primary care side of the FQHC. Louise expressed this situation as a "horrible idea." She further elaborated:

And, I know since therapy is hard work, a lot of times your mind will key into something, even the tiniest thing to give it an excuse not to accept it and not to go forward with the help. And, so this [behavioral health] setting takes that away. I think it is just very difficult to open up to somebody if you feel like you're in an examination room. I mean, you wouldn't talk to your best friend in a place like that. I don't think you should talk to your therapist in a place like that.

Time. Several participants made comparisons of time differences spent with and waiting for behavioral health providers versus medical providers. Participants expressed shorter time frames spent waiting in the lobby, in addition to more quality time spent with behavioral health providers. Molly described that behavioral health “did not feel clinical” and discussed some time variations in the delivery of behavioral health care and primary health care. She elaborated on her perception of non-clinical, in combination with clinical, in the following excerpt:

Like medical. Like I’m going to another doctor. I go to enough doctors. I don’t want to feel like I’m going to another doctor... You go and you sit and you wait for 45 minutes for them to see you for two minutes and tell you ‘Well, I don’t know what’s wrong with you’ or, ‘I can’t find anything wrong with you’ or whatever or, ‘try this and if that don’t work in a week, call me back.’ This [behavioral health] is not like that. You come in. You might wait for a few minutes out in the lobby and they call you back. You see them for actually for more than five minutes, you know? Out of the two hours you’ve been here, or whatever. And it just to me, there’s a big difference in feeling like you’re going to the doctor’s office.

In addition, other participants also discussed time as it pertained to behavioral health appointments weighed against primary care appointments. In discussing behavioral health, Stacey expressed, “Because the wait time...I might wait five minutes, if that. I mean you can’t complain about the wait time.” Chrissy related, “the wait. The wait...It doesn’t take very long.” Edma said, “You don’t even have to wait that long for the therapist to come.”

Further underscoring the meaning participants placed on not only receiving timely services, but also the quality of time shared with behavioral health providers, was denoted by a participant when behavioral health care time is lost. For example, Georgia described frustration when her therapy session started late and was cut short, which she expressed felt disrespectful. Georgia acknowledged:

...just for instance, my appointment is at 2 o'clock, and yet it's 2:15 before someone comes to get me. And, then I'm out of here by a quarter till. I've got a problem with that. My appointment is at 2, five minutes before or five minutes after, I don't care. But, to have to wait for 15 or 20 minutes, and then have to leave so the next person can be on time.

Theme #4 – Evolvement through Relationships of Care

In this theme, participants discussed the impact of their relationships with a variety of the FQHC's staff, including the front desk employees, behavioral health staff, transportation drivers, and their therapists. They described the relationships as caring, kind, and accommodating, and, on a deeper level, they perceived these relationships as their alliances to overcome adversity. Furthermore, as a result of the quality of these relationships, participants reported personal evolvement that transpired in the context of being cared for and supported, rather than being judged and criticized for their present circumstances. The following discussion details the participants' experiences with the health center's employees and the meanings these relationships held for them, including (a) their relationships with staff and (b) their relationships with their therapists.

Subtheme #1 – Relationships with Staff

Everybody Knows Your Name, and They're Always Glad You Came. All of the participants acknowledged the friendliness of the health center's staff (both behavioral health and primary care) and indicated they established meaningful relationships with these employees. Evidence of the value participants placed on these relationships were supported through the participants' descriptions of being humanized and personalized as individuals, in contrast to feeling like "just a number," by the FQHC's employees. Some of the staff's actions and behaviors that participants reported as significant included the staff's remembering their names, understanding and accommodating their needs, demonstrating care towards them, and having personalized conversations about issues noteworthy to the participants individually. In addition, participants also addressed the staff members by name when reporting about their experiences, which further emphasized the strength and familiarity of their relationships. Stacey replied:

...like *Amy [all staff names are pseudonyms and marked with asterisks] that works at the desk, she'll come in 'Hey Stacey. How you doing?' Or it's different people that she knows by name. I think that's cool. It's not just sign in like most places, and they give you a number. She actually knows your name. I think that's cool because a lot of them around here are like, 'there goes Stacey.' Like *Allison, 'you can come in here. We are trying to get you a room and all. Just have a seat.' Man, I'm straight. I think that's cool. Somebody actually remembers my name after like the first or second time of being here. Yeah!

Congruently, Louise expressed that she felt a sense of “importance” with the staff, specifically with the amount of detail they remembered about her personally. She supplied the following statement:

...people remember things. They remember your name. They remember that, you know, you dyed your hair. Or, you know, how’s your mom and things like that. And, they take the time to get invested even if they’re not your therapist or your physician. They will take the time to get invested if you are open, and you allow them to, especially since I come here once a week, every week. I’ve gotten to know a lot of the staff. And, you know, I’ve been places where I’d go there for a length of time and nobody cares. They don’t remember my name. They don’t remember anything about me. And, so this is totally different.

Participants also reported that their relationships with staff gave them a sense of purpose and helped them in their journeys to work through challenges that brought them to seek help. Zahra mentioned, “I feel like an outcast when I’m not here. Here, I feel welcome. I feel like I’m wanted...There’s a use here for me. There’s something here for me.” She further explained that she felt understood and received nurture in her relationships with staff members. Zahra elaborated:

They know me. Everyone knows me. I don’t have to...it’s just like they...I know Ms. *Whitney don’t sit in the [therapy] room with us, you know? But, it’s the understanding of ‘Zahra’ even when I’m looking rough, and I’m feeling bad...‘How are you doing?’ And I’ll be like...(grunts). So, I don’t give an answer. She’s like, ‘That’s okay. That’s why you’re here. We’ll get better. You’re going to get better. We’ll get you together.’ You know? I don’t get the

pat on the back or the ‘okay, you going to be okay’ at home. You know? Kids don’t know how to do that. I do that to them. You know, ‘I stubbed my toe, oh mommy.’ ‘Oh God, go get the wipes first so I can wipe your foot, and then I’ll kiss your foot, and you’re going to be okay.’ I don’t get that from the kids. I have to give it. But when I come here, I get it.

The Little Things They Do. Many of the participants reported that they could count on the staff to help them rise above many of the barriers that would have otherwise deterred them from the continuation of care they needed. They also discussed a pattern of predictability with employees, where they knew what to expect and felt understood, which contributed to the participants’ feelings that the FQHC’s staff were “trustworthy.” Georgia explained, “...I guess it’s more of how I feel. In all of the times that I have been at the family care, they are very trustworthy, both behavioral health and the other [primary care] side.” In addition, she described a pattern of consistency in their relationships, which provided the refuge she needed to follow through with her appointments. She asserted the following statement:

...with Whitney, I know that she is always going to have my appointment ready, and I know I can always get chocolate out of her. I love you Whitney...And, with Amy, I know that even though she’s going to give me the little ticket, I know that she’s always got my thing ready so that I can sign it and immediately go outside and have a cigarette because she knows that I can’t handle sitting for very long in the waiting room. So there is the little things that they do, in particular, like Amy with that. Little things that they do that make it much easier for me to come here and not get completely stressed out at being around so many people.

Zahra talked about the security that she felt in her relationships with staff, and she described their ability to function on her behalf when she feels inundated. She narrated:

I get extremely overwhelmed when I walk through the door, and then I go to the receptionist...she smiles and asks how I'm doing. Sometimes I can't remember, I remember my name, I remember my address, I forget the phone number, zip code. I'll tell her 'I don't remember,' but she remembers me. She remembers where she needs to go to look for my information, and she takes care of it.

Louise also explained patterns of knowing what to expect in her relationships with staff, in combination with the staff's knowing what to expect from her, which she perceived as expediting the health care process to serve her best interest. She disclosed:

...half the time I come here, and Amy out front at the desk, she already has my paperwork and stuff filled out. She's ready to go. She's like, 'Here's your ticket. I'll call *Leslie [therapist] and let her know.' And, I just get back right away because she knows I'm not going to miss my appointment. She knows I'm coming, and she just takes care of everything so I won't have to go through as much of the red tape.

Transportation (as a Relationship). For the participants that used the transportation services provided by the FQHC, they described relationships with the transportation drivers that were beyond just a service in getting them to their appointments. These participants mentioned having mental health conditions that made them anxious being around others, such as agoraphobia and paranoia. The participants detailed scenarios in which the drivers' actions were steered by understanding them,

thereby meeting their needs in creating a safe environment that enabled them to receive the health care services they desired. Georgia articulated:

Cause I'm one of those, otherwise I would have to sit and wait for the bus. And well I, kind of sort of, might possibly maybe be a little agoraphobic. And so, getting on the bus is not easy for me to do, but I've come to this...I know when transportation is coming, and I know it is one of two people.

She elaborated further:

They [transportation drivers] have been beyond helpful. You know? They, it's like I always know what assembly line of transportation I'll be on. They know that unless I call and say 'I'm not going to be there,' that I am always going to be coming. And so, we both have our thing where they know I'm coming, and I know they're coming. And then, when I get into the van for transportation, they help me to kind of relax to...they help me relax before I go into counseling. They kind of get me into that mode of, okay we're headed there [FQHC behavioral health]...so we've been able to do this so it's literally that routine of...and then when I get done with counseling, again, there's transportation. And they help me to unwind, and I know they are always going to get me home.

Zahra also acknowledged that her relationships with the drivers championed her health care access, and she described their assistance in gratifying her needs so that she was able to obtain needed health care. She stated:

I get confused myself sometimes up in here [FQHC], and I don't know...but I know I am here, and that they're [transportation drivers] going to get me home. And they don't delay...they don't leave because I explain to them that I have

issues. Sometimes they try to pick me up without no-body in the van because I have issues and, well, they wait for me. They try not to have me waiting outside for them. They be looking for me to get me home immediately, and they don't leave until I get in the house upstairs. I'm scared to leave my house so that few minutes to walk from the van to upstairs to my apartment is a really, really, really, really big deal for me...and they don't leave. They wait, they wait. They don't have me wait outside for them to come. I'm supposed to wait in the house until they come, 'we'll call you.' They tell me exactly where they are...

We are Family, I'm Home. Several of the participants described their relationships with staff members as “family.” Participants reported that having these meaningful relationships with staff members created a sense of home, where they felt comfortable, respected, and could ask for what they needed. Additionally, throughout the interviews at times, participants appeared to report about the FQHC as a relationship, rather than just an agency. For example, some participants made reference to “y'all” or “you guys” when dialoguing with me, suggesting their perception that I was part of the institution they counted on, that I was one of “them.”

The following excerpts illustrate the meaningfulness of the participants' perceptions of their relationships with the FQHC. Georgia mentioned, “I think y'all are pretty much doing everything right.” Brad replied, “I love drinking up what you guys have taught me.” Edma stated:

I feel very happy when I come here. And when I leave, I'm very happy. I might be a little stressed out from the therapy or whatever, you know, but I'm still very happy about it and looking forward to coming back. And I feel that it's helped

me tremendously...a lot since the time I've been here. I guess that's what it is when you come into a place, and you feel like you're part of a family when you come here. You're not ignored. You can tell that from the people that work here and the therapists. You can tell that. Well, I could for sure.

Zahra additionally described her close relationships with employees at the FQHC as family. She said, "they [FQHC employees] actually treat me better than my family does. I don't have a family, but they treat me...you guys treat me better." She expounded with the following statement:

Like the Golden Girls... Yeah, it's just like you got the female companions... I love you guys. I mean... I don't know how people attest their feelings, but you guys give me butterflies... Because I don't have anybody. You know? And, it's really nice. I see people out here on drugs and stuff, whose moms, dads, cousins, and stuff still love them... I don't have nobody, and you guys are all I have. When I see Ms. Whitney, she's like my big cousin, you know? When I call her, I'll tell Ms. Whitney, 'I'm having issues right now. I need to talk to my therapist.' She'll tell me if Ms. Leslie is in session. She'll tell me. And, she'll ask me if I want to talk to someone else. You know? I don't have that. I can't call my mom and say, 'Well, mom, it's just been bad day. Can I get a pep talk?' I don't have that, you know?

Operational Practices. The meaningfulness of the participants' relationships with the staff was further evident in the meanings they created as result of the health center's operational practices. For example, some of the participants perceived these practices, such as getting calls if there were cancellations to be seen earlier and being mailed

reminder letters, as deeper confirmation that the staff cared about their well-being, understood their hardships, and were working in their best interests. Louise remarked:

The appointments are easy to make. They're pretty flexible. I get mailed out a reminder of my appointment every week. If something changes, I get a phone call. If there's an opening and I can get in sooner, they give me a call. So, I think it's very accessible. Everybody has always worked with my schedule and tried to make it as convenient as possible for me.

Zahra discussed the staff's proficiency and conscientious efforts to accommodate her when she missed appointments because she felt they understood her personal difficulties and wanted to help her. In addition, she specifically referenced the availability of the children's playroom in the behavioral health program, if lack of childcare corresponded with her therapy time. She said:

Like in [another state], I missed a few appointments, and they were like, 'if you keep missing your appointments, you're not going to be able to come. Please don't.' Sometimes shit happens in my life. You understand? Even though I have a man with me, I only have one child by him. I still have four other I have to take care of, and life is really hard for me. And here, I miss an appointment...it might be a month later because you guys are just getting everything kicked off really, really good, but, at the same time, when you have a called-in cancellation, I'm in here. You know? They get me in here because, again, life happens. And I'm unable to stop certain things, and I cannot leave the kids at home by their self. And, I cannot just bring them all with me. I mean I could, I ain't going to lie... Ms. Leslie told me anytime I get ready, I could...Like she say, 'if there's a

problem or whatever. We have a room over there. You can keep an eye on them. You can see them while we are talking. They can play around there.'

Staff Relationships as Resources. A few of the participants described the health center's staff as linking them to other resources in the community when they needed help. The staff's inclination to provide additional information conveyed understanding and support to the participants in struggles they were facing, which they further perceived as a collaborative mission to help them overcome obstacles and obtain the resources they needed. Zahra revealed:

At Thanksgiving, we didn't have food. My therapist found a couple of lists of people. Christmas, we didn't...like I say, I don't have an income right now. Christmas, we were struggling. They hooked me up with Salvation Army. I mean, there's really nothing. I don't know anything else that you guys could do. Because everything I've needed since I've been in Monroe, it hasn't been family or friends helping me...You guys are the only ones keeping me afloat right now. You know? I know now the Salvation Army sells Christmas toys every year. I know the food bank down the street from me. And, there's one on the south side, but I don't know where that's at. But, they're resources, you know?

Subtheme #2 – Relationships with Therapists

Expectations of Therapists. Many of the participants had expectations of their therapists, which informed both their perceptions of the relationships that became established with them and the meanings they placed on these relationships. Participants conveyed their need to have a therapist who would engage with them in a way to create relational freedom, where they could be themselves, not be judged, and could evolve in

the context of their meaningful relationship. Several participants described “trust” as a necessary component of the therapeutic relationship. Georgia affirmed, “It’s extremely important to me. Having been abused from really infancy on, trust is a major issue for me. And, I have to trust the counselor I’m working with. Well, I just have to.”

Participants also reported needing a therapist that was caring, kind, and accepting of them so they could work through their life struggles. Dianne stated, “I was just praying for somebody nice to crawl inside my head and help me find a light because I’ve looked for such a long time. I didn’t understand what I was doing.” Penelope highlighted the need to have caring therapists that perceived their level of work as more than monetary value. She reported, “I’d quit real quick...if I felt like they [therapists] was just drawing a paycheck then, you know?” Penelope further added:

I realize that therapists, they’re people too, and they have a bad day. It’s not like every therapist you have is always going to be just right there attentive to you, majorly, every time. But for the most part, yeah, that is important. They do this because they care about people trying to...they see a lot of things that I see. And they want to help people get straighter from the bad things that have happened to them in their life, you know?

In addition, Louise also commented about therapists as people in discussing her expectations of them. She discussed therapists having barriers around their own personal issues and placing them aside for the betterment of their clients. Louise asserted:

So, the people that work in this field I know have to be, even quote unquote bad therapists, have to be mentally strong. I know its taxing. And it amazes me how people in the profession, in general, are able to help others while separating

themselves and dealing with their own issues. Because I know even after going through something life altering, they [therapists] are still there for their patients and to be able to have that barrier is fascinating to me, and it's pretty amazing. I know it takes a special person to really give of themselves to their clients.

After having several former bad experiences with therapists, Louise further added that she needed a therapist, who could go above and beyond the textbook approach, to personalize behavioral health care treatment to her needs. She said:

Well I guess, you know, of course, every client is different. Their level of knowledge about mental health is obviously different...their perspective, their feelings on it. I mean, it's different since I have been doing this for quite a while, and I personally study it on my own...It's just, I'm like, okay, this is, they're [therapists] going to file this under this, and this is going to be the reaction. This is what the textbook would say about this. I can kind of analyze myself very well. So for me, it was a challenge of finding a therapist that would go above and beyond that.

Stacey expressed her position of needing a therapist who could speak her language, which therapists commonly refer to as speaking the client's language. For example, she remarked:

You want to get through to me, you better talk like you're on the streets or something. Just because we up in here [therapy room], don't get all professional on me...Put that in Stacey terms...Explain that in dummy terms to me. You know? Don't use these big ass long words or whatever. Put it down to where I can understand it.

Chrissy asserted that there is a “fit” between a therapist and client and described that a level of comfort in the relationship is necessary for the client to progress. She articulated:

Maybe you might not feel comfortable with like one counselor, right? So, get another one that you might feel more comfortable with. Maybe you, maybe as a female, you talk better with a male counselor, or if you’re a male maybe you talk better with a woman counselor, or maybe if you’re a female you talk better with a woman counselor. It just depends...There is a fit. Oh yeah.

In addition, Brad perceived therapists to be non-critical, which he attributed to their educational stature. He explained:

...I love, quite frankly, to talk to counselors because first of all they’re educated. And educated people seem to be less intimidated by me, and therefore less likely to put me down...and I know you could say across the board, counselors are generally well educated. They’re not going to put this fellow down, and so that’s another reason I like behavioral health.

Ultimately, the participants’ aforementioned hopes and expectations of their therapists impacted the constructive relationships that essentially developed with their therapists, which will be discussed next.

Therapist as a Person and Professional. All of the participants described their current therapists’ personal and professional traits that facilitated in the growth of their relationships. Some of these traits included being personable, objective, caring, loving, understanding, flexible, offering suggestions rather than directives, treating consumers like human beings, and speaking the client’s language. Molly said:

It's her personality...she is bubbly. She is very personal. She is not very...she doesn't feel like a therapist. She looks like a girlfriend. You know, one of those that are like, 'Okay, kick off your shoes. I'm having one of them days and you can just sit and listen to me whine.' It's kind of one-sided because I just never get to listen to her whine. But, you know, it just doesn't feel like therapy. And then, we have a lot in common.

Betty Jane articulated, "I found that my counselor was the kind of person that I could, you know, she had no objectives or whatever you want to call it. She didn't. You know? She would sit and listened to everything that I said..." Betty Jane further elaborated:

She seems to be a very...she's a very nice person. She's a very caring person. She doesn't...she doesn't tell you to do something if you don't want to do it. She just says 'okay, this is just a suggestion, maybe you might want to do this. And if you don't that's okay, but if you do okay.' And I took her up on some of them. That seemed to help me. So I mean she's really good, and she's brought me a long way, a real long way.

Edma stated, "he treated me like I was somebody, and not somebody insane or something like that. He treated me like I was a human being," which she perceived as freeing. She added:

...I feel comfortable when he's here. He's just that open air, just an open feeling. It's like...he knows me by my name, and that's what I think makes most things...that he remembers who I am. He don't have to look at his big paper, oh this is... He doesn't. He knows. He still remembers...I can come in a month from now, and he still, which I have, and he still remembers. You know? And I

find that so comforting and so happy inside of me that somebody remembers that my name is Edma. You know? My name is Edma, and somebody remembers who I am. Not just a number. It really makes me happy.

Louise described her therapist as “understanding and very loving, but also very, very realistic.” In addition, Louise talked about her therapist’s approach as being multi-faceted and adaptable to different clients’ needs. She conveyed:

She [therapist] takes each person as they are, on their level, what they need, instead of having kind of a general outline and trying to fit people into that. My mom started going to Leslie recently. My mom is, you know, she is different from me. She requires a very different approach, but she adores Leslie and she [therapist] is able to fit her approach to my mom.

Diane reported feeling understood by her therapist and discussed the therapist’s ability to speak her language, which provided the validation she needed to work through her troubles. She described:

She explains things in a way that I understand. I don’t feel crazy even though I get called neurotic and crazy and all of the above. I don’t feel any of that. I can identify with who I really am with her help, and what’s really wrong with me instead of all the stuff I’ve always heard...She gets me...She smiles...Sometimes I think she feels like crying with me, but she’s not. And I want to do that too. I don’t want to be sad forever.

Georgia talked about flexibility in her therapist’s approach, which played into the therapist’s meeting the client where she was in the therapeutic process. Georgia replied:

It's like this counselor and the one before her. Everybody has gone off the grid with me and kind of worked with me where I am. Rather than forcing me into a mold. And, I try not to take advantage of it, but everyone has realized that, well, I might not be your typical consumer. I'm scared of people. I'm scared of being out and everybody has been willing to work with and accommodate that.

Therapeutic Relationship. Many of the participants reported close, meaningful relationships with their therapists, which they perceived as being like "family" or "best friends." They described the strength of these bonds they felt with their therapist, which promoted their well-being. Louise discussed:

I feel just incredibly close to her [therapist] and even my friends all know her name. They know if I say, Leslie said such and such. They know I'm talking about my therapist... Yeah, or they'll be like 'what would Leslie say about this?' ... She's really, even though my mom, obviously, is the only one that's ever met her, she has become a part of my family and my friends because everybody knows about her.

Brad depicted his relationships with his therapists as "best friends." In addition, he indicated having a no-holds-barred attitude in greeting them in public settings. Brad narrated:

...counselors and the Christian counselors too, they are some of my best friends. Now, they may not feel that. It's like, if I saw this guy in public... it's like, whoa, he's one of these people I counsel. They may feel that way. But in counseling, I'm one of these... you fill in the blank. I'm one of these different people that

when I see my counselor in public, it's like, 'oh, hey! It's good to see.' I go up and talk to them, or they are welcome to come over and talk to me.

Betty Jane additionally described her relationship with her therapist as, "I feel like she's my best friend." Molly expressed, "It's therapeutic, but it's like we are best friends, and we are just sitting there talking. I'm not going to say best friends, well, yeah, because who else can you tell everything to? Your best friend!" In addition, Zahra explained the significance of her relationship with her therapist as follows:

To have somebody that you can conversate with, even though you don't hang out with them on a regular basis, it's kind of like having a friend...And, it's like my therapists are kind of like my friends because you can talk to them, and they're not going to tell nobody...So, it's kind of nice when you can talk to your therapist about things, and you don't have to worry about people looking at you cross-eyed the next time you see them.

Testing for Trust. A couple of participants described candidly interviewing their therapist at their initial meetings, as a means of testing for the trust they needed to establish a significant relationship, in which growth could be cultivated. The participants depicted these interviews as an exploration of their therapist's ability to work with their concerns by immediately, although apprehensively, divulging personal information about themselves. Georgia explained her first "interview" with her current therapist and narrated their conversation:

...I told her, I said 'well, there are a couple of things I want to talk about straight up.' She said, 'Okay.' I said, 'I am in a dominant submissive relationship BDSM.' She said, 'Okay.' I said, 'Alright. And, I have issues to deal with from

having been abused.’ She said, ‘Okay.’ I said, ‘And, I have dissociative identity disorder.’ She said, ‘Okay.’ That was how I knew I could trust. She had no problem with any of them. She didn’t freak out. She didn’t...it was just okay...Yeah. Having that little bit of time to talk to her. I guess you could say to interview her, and how she responded to what I felt were three things that were most important.

In addition, Stacey discussed her initial interview with her current therapist and detailed how her therapist was able to engage her. She stated:

I told her right off the bat, ‘I got kids. I’m a package deal. I got major issues and I cut.’ She’s like, ‘so.’ Hold up. ‘What do you mean so.’ That right there through me for a loop. You tell a doctor that you cut and they see all these marks on your arm, they usually want to try and get you to...and she’s like, ‘so.’ That right there got me...that one little word she said. She didn’t show no interest at all. But it’s the way Leslie talked, I guess. She’s not all professional. She’s like, ‘you want to cut...cut...I’m not going to tell you not to, and I’m not going to tell you to do it. That’s on you. But if you want to learn better ways of not doing it, then I can help you.’ I’m like, hold up. I got this woman telling me she don’t care if I cut. Hold up! Leslie is crazy. I think she needs to be up here using behavioral health. But that’s cool with me...reverse psychology. Apparently, she got me. Hook, line, sinker...the second day and all.

Creating Safety, Building Trust. All of the participants discussed feeling accepted and comfortable with their therapists, where they could be themselves and open up without filtering information they wanted to share. Participants also expressed they felt

understood by their therapists without judgment or criticism, and they confirmed their therapists were able to meet them where they were in the therapeutic process. In combination, these elements were described as creating safety and building trust in their therapeutic relationships. Stacey explained, “I don’t have any like real close friends because I don’t trust anybody. But with her [therapist], I trust her with anything and everything.” Furthermore, Stacey detailed, “I’m comfortable with her, especially with things that have gone on with me that some people will judge you whenever they find out.” Molly stated:

We could talk about anything, and you didn’t have to worry about being judged or it going anywhere for one. It just felt safe. I could say things. You know, you can say things to strangers that you can’t say to people you actually know. Well, with Leslie, I felt like we were just really good buddies, and I can tell her just about anything. You know, and still not be judged or feel like I’m sure she thinks I’m an idiot now. But you know, I never felt that way with her.

Betty Jane expressed, “...I was having a shield in the beginning until I got to know my therapist and build my trust up that I needed.” She declared:

Well I know that from the beginning, I went in there and she said, ‘I will never’...well, some part of our talking was just like ‘this is between me and you. It stays between me and you. I don’t tell anybody anything. I’m not talking about you to anybody else...it’s just client and patient right here.’...To start off with, she was a stranger. And then the more I got to talking to her, I guess I could get...I got that trust from her.

Self of the Therapist. A couple of the participants mentioned that learning about their therapists' personal lives helped build trust in their relationships. Chrissy said:

I'm giving you information about myself, so maybe you give me a little bit of information about yourself. You know? You don't have to give your whole life story or anything, but just to show, you know, stuff like that...I think that some people need more information than others do.

Stacey communicated, "...for starters I'm going to find out, Are you married? Do you have kids? What have you done?...So, how are you going to ask me questions if you ain't dealt with it?"

In addition, another participant mentioned that it was helpful to learn his therapists had personal struggles too, especially when their difficulties were similar and related. Brad reported:

I mean, like once in a blue moon, with *Shirley [therapist]...it's like she would share with me that she was down...personal things in her life. But in all honesty GinnyLea, I didn't mind that and often that actually helped me...when you hear that even the experts go through the mess too. It's kind of like the misery loves company thing. You know? It doesn't take you off my pedestal to learn that you're not perfect. Now many people it might, but it helps me...one thing I appreciate about one of the Christian counselors I've seen was that he wouldn't just dump everything on the table. But he would let me know personal life experiences that he had gone through, especially ones that related to me. And they were like extremely helpful. And it's not like, I'm giving you a reason that your problem is okay...you can continue it, but I'm just giving you a reason that

it's like, 'Hey, I've been there...right where you are, but this is something that maybe you can overcome.'

Therapists' Going Above and Beyond. Some of the participants described scenarios that included their therapists going above and beyond what they expected in their relationships. Participants talked about times therapists gave of themselves outside of scheduled therapy appointments, providing the determination they needed at times to overcome their struggles. For example, Louise discussed:

...she [therapist] has been there for me in emergency situations. When my grandfather was about to die, when he was on life support, I called her crying, and she said, 'I'll squeeze you in today.' Or, you know, other things like that. She's been there when I absolutely needed her. I was terrified one time that I was pregnant. I was freaking out. I almost didn't come to therapy. She said 'Go buy a pregnancy test, and take it up here.' You know? 'I'll help you.' She stood outside the bathroom while I took a pregnancy test, and she was there for me. While I was freaking out, she was like 'I'll be there' because that was a panic in my life. Thank God, I wasn't pregnant. But knowing that I could call her freaking out about that, and she would help me with something like that. I mean, that's extraordinary.

Stacey stated:

I can call her anytime. Call up here at the office and if she's busy, the minute she gets done with her session...bam...she's on the phone. I like that. That's cool. Most places and all, will say 'tell her I'll call whenever I get a chance.' I know within 30 minutes maybe, bam...she's on the phone. 'Girl, what's wrong?'

Louise mentioned, "...I can send her an email and she'll reply back. You know, here's what's going on. You know? Things like that." Zahra discussed an occurrence in which she was scared and hiding in her closet at home, as she waited for her therapist to return her call. Zahra detailed the following story:

Ms. Leslie called me back, but she was like 'are you okay? Are you in the house now? Is everything secured? Are you looking out your window? Do you want to look out your window? Do you want to peek out your door?' I was like, 'I don't want do anything. I don't want them to know that I am here'...But, she talked me through it because I was in the room, I was in the closet, I was scared.

Changing from Faith in the Process to Trust in the Process. Participants reported progression with behavioral health care treatment, which was built from trust in their therapeutic relationships. After participants established trusting relationships with their therapists, they described an evolvment which shifted from hoping in the process to trusting the therapeutic process. In addition, the meaningful relationships that participants established with their therapists helped them to inventory their self-worth and their perceptions that they mattered, which further helped them flourish. Penelope expressed this succinctly with the following statement:

You're not going to be okay until you help that little person inside of you. And, by talking and having somebody that will listen and give little pieces of different things to try...Leslie don't sit and tell me, this is what's wrong with you...It is a place where somebody that is trained to help people can really give you a little bit of advice. At a time that's going to help you pull yourself out of some of the demons that haunt you...that makes things run the way they run in your life that

you don't want them to run. So having an experienced ear to listen to you, somebody that's going to really care about you, and helping you because lots of people's problem is just never feeling like they ever mattered to anybody. And just the fact that you come here, and you matter to somebody is a huge, huge thing.

Theme #5 – Transformation through the Therapeutic Process

In this theme, participants described their advancements with the therapeutic process at the FQHC and discussed salient meanings they ascribed to receiving behavioral health services, including its impact and effectiveness in improving their quality of life and relationships. They reported shifting from *hoping* that behavioral health treatment could help them to *believing* it was helping them. Participants further explained that the relational freedom they experienced in their trusting relationships with their therapists, in combination with their therapists' abilities to individually personalize their mental health treatment, were paramount in their personal journeys of growth and self-awareness. All of the participants discussed transformative experiences that were perpetuated by their behavioral health utilization at the health center.

Throughout this theme, the recursive nature of therapeutic process and relationship is illuminated, as the therapeutic process additionally illustrates much of the therapeutic relationship, but the theme's focus is on the participants' experiences and their meanings of the therapeutic process and its function as it related to their personal development. The following subthemes present the participants' collective stories of (a) the significance and sacredness of behavioral health services, (b) trust in the process built from trust in the relationships, and (c) the impact of behavioral health treatment.

Subtheme #1 - Significance and Sacredness of Behavioral Health Services

A Safe Haven. All 11 of the participants described behavioral health services as an essential part of their lives that helped them gain deeper understandings of themselves. Several participants talked about not only the significance, but also the sacredness, of therapy being a place where it was their time to talk to someone safely, release their worries by venting, focus on themselves, and have no reservations about the consequences of their conversations. For example, Zahra asserted, “Coming here [behavioral health] is my venting, outing time, and it’s my time. I’m actually not as flustered...It’s like my saving.” She further elaborated:

...this [behavioral health] is my safe haven...I can’t, as much as I would want to, take time just for me. I can’t and that upsets me that I can’t. But I do know next week, I’m going to therapy. So, I can make it a few more days because I have somewhere to go, and I have somewhere to talk. And, I can tell her [therapist].

Molly perceived her behavioral health experiences to be “a big ole woosa every week,” which she described as a “completely helpful...very calming, very relaxing” experience where she relinquished stress. She added:

...it’s just the relief you get from venting, and I can vent safely with her [therapist]...sometimes it actually does feel like it’s my oxygen and sometimes it’s the best chance I can get to calm down good, to breathe, to relax.

Dianne described behavioral health as her safe place to express herself candidly and elaborated:

I can say anything I want. It don’t matter who it offends. I’m not at my sister’s house. I’m not at my mother’s house. I’m not at his [husband’s] house. I can

come here and just say exactly what I think, what I feel, and it doesn't really matter anywhere in this world but in that room with Leslie.

Edma articulated the significance of her behavioral health time at the FQHC as helping her find the value in her own self-worth, which meant she was worthy of help and was being helped. She stated:

It means a place where I'm comfortable coming, and that I'm acceptable to what I have wrong with me...I felt like I was not getting ignored. I was getting opened up to, and I was talked to like a human being. Not like I had a sickness or illness that kept me from being helped. You know? They [behavioral health] helped. That's the main problem...helping you without making you believe or making you think that you're not worthy of that help. You know what I'm saying? Or make you feel more dumber than you are. Some places, they do.

Talking and Being Heard. Several participants conveyed the behavioral health process helped them believe that positive changes were attainable and were developing, which they attributed to the relational context of open and honest communication with their therapists. For example, Dianne conveyed that behavioral health services helped her hold "hope" and work towards having a life of "prosperity." In addition, she detailed the freedom that she felt in the process to let down her guard and to truly express what she needed without filtering. Dianne said:

I can hide my pain in front of my children. I can go get in the shower and cry my eyes out. I'm good at it. I'm a professional at hiding what's really going on with me from my kids. But I don't even attempt to with Leslie. I don't have to. I can just be whoever I am, whatever it is, and it feels good.

Chrissy explained that discussing her life with her therapist and working together to put things in stride was advantageous for her growth. She stated:

I'm trying to improve myself. I'm trying to improve my life...A lot of times I do come here [behavioral health], and I talk to Leslie, and that's just because she helps me think. She does. She helps me put a lot of stuff in perspective and if I'm talking to her I get another view, another idea from somebody else...It's good to have a person to talk to.

Edma detailed that being heard by her therapist and conversing with him in the therapeutic process, in which he provided helpful feedback, were substantial in her growth. She revealed:

Being able to have a therapist that you can talk your problems to, and that you can share things with...a lot of things I don't understand, but I can talk to him [therapist] and he can make me understand it or show me a way to understand it. Sometimes it's difficult, but it makes me...I try to understand as much as I can. I feel that coming here [behavioral health] can make me grow more to be myself, have confidence in myself, and being able to adjust to things on my own...So, my therapist is helping me with that. That's an important step for me to do. You know? That's scary, a scary step.

In addition, Louise depicted the importance of honestly talking with her therapist and processing patterns of behavior that needed to be changed for her personal growth. She explained:

...I'm just trying to be the best me that I can be. And, part of that is therapy. A large part of that is therapy...one way it keeps me in check of making healthier

decisions for my life. She [therapist] helps me. She's really great about helping me see patterns of behavior that I can break, and just knowing that she's going to be blunt with me because I'm a blunt person. She's going to be blunt, and she's not going to let me get away with things. She's not going to, you know, the little things that we all do to kind of sabotage ourselves. She's not going to let me get away with that. Not in a mean way, but she's going to keep me in check.

Tangible Help to Reach Goals. Some of the participants described behavioral health care as a concrete option, with professional collaborators, to combat life's perils and "move forward" on your "own two feet." Georgia explained, "It [behavioral health] was a tangible...there were people here. So, I guess in a way it was a tangible way of reaching out and saying 'Please help.' And, they were willing to help." In addition, Stacey expressed:

Behavioral health to me is trying to unlock people's inner issues that they don't want to deal with on their own. They need help coping with something that happened...And coming here [behavioral health], if you are lucky enough to get the right one [therapist] that can unlock that door and help you deal with it and move forward.

Penelope portrayed her behavioral health experiences as providing the platform she needed to find solid grounding of herself as an individual. She conveyed:

...it [behavioral health] means trying to get my feet back under me to where I can be my own person. And, I have never been my own person. So, I am trying desperately to crawl up a rope to feel like okay, you stand on your own two feet. So that's where I'm trying to get. And, it's baby steps, but there's a lot. I've

come a long way over the last 20 years living, my independence level of knowing that I can do this. I don't know why, emotionally, I'm not there. That's where I'm trying to get. That's what it does for me...is trying to get closer to that.

Subtheme #2 - Trust in the Process built from Trust in the Relationships

Therapy: It's a Process. The majority of participants described therapy as a process that involved time and persistence in working to overcome their struggles. They perceived that the changes they desired were occurring slowly, but surely, throughout the therapeutic process. Participants also reported that the trust established within their therapeutic relationships encouraged them to stay motivated in believing these changes were possible. For example, Diane reported:

I have a life...living in despair. I want to hide. I do. I hide. I stay at home. If you want to see me, you've got to come to my house. If I get out of the house for about an hour, I've just got to go home. I mean, it's [behavioral health] been opening the door to living my life again because I trust her [therapist], and I believe her. There's no doubt in my mind that she's going to help me through this.

Stacey disclosed her therapeutic process as a slow progression to help her release past, step-by-step, and move forward with her future. She narrated:

In my case, it's like I'm stuck in a time warp or time zone, and it refuses to go forward and won't. It's just there in my mind. I guess, I don't know...that's how Leslie puts it. We're slowing unlocking one door and dealing with that little issue, talk it out, and move on to the next...I know that, as an adult, it's not my fault, but there's something that still refuses to let it go. It's not your fault, just

get rid of it. Everybody says ‘that happened 30 years ago. Let it go. Let it go.’ Easier said than done. Through coming over here to behavioral health, they’re helping me deal with that issue.

Betty Jane articulated her perception that therapy is a process and not a quick fix. She communicated that medicine could not take away her troubles, but instead she needed to “talk” through her concerns. She described this as follows:

you know if there was a pill...one little, teeny tiny pill that she [medical provider] could give me and all this [problems] would go away, I’d take it right now...but it does need some talking about. I know it’s not going to go away.

She further described behavioral health as taking time to resolve issues, and she reported that some people do not commit to the depth of the process. Betty Jane added, “well, it works for me. As far as, you know, some other person, it may not work for them, or they don’t stay there long enough to find out if it’s going to work for them.”

No Pushing. Some of the participants reported relief that their therapists did not push them to discuss issues they were not emotionally ready to explore. They described that their therapists were able to meet them where they were in the process, which was of notable meaning to them. For example, Molly articulated:

She [therapist] didn’t make me talk about anything I didn’t want to talk about...If I came in and was dodging the subject, she wouldn’t push it. She would just let it go...she was like, ‘we are not going to push it. Whenever you are ready.’ Sure enough, eventually I was ready and that’s when we talked about it. So, I was never pushed to talk about anything.

Edma also revealed the significance of her therapist's actions, which contributed to her feelings that her therapist understood her and further built her trust in the behavioral health process. She explained:

He [therapist] told me, 'Do not push yourself.' He made me understand that. He explained it to me and made me understand that if I'm not ready for something, I don't have to do it. I don't have to push myself until I'm ready for it. So, that made me glad that he was my therapist.

It's a Choice, Your Choice. A couple of participants described the therapeutic process as a path that can help a person grow on a deeply personal level, but they explained the process as an individual choice, in which one can choose to be fully present in therapy and work through the issues that plagued them or not. They also talked about the good feelings that are the reward of choosing to face their challenges. Louise revealed:

There are some days that I just don't think I have it in me, but I get here and I'm like, you know, I need to go ahead and do it. And, that's from what I've spoken to people about, that's one of the reasons that people are hesitant about it.

They're just not ready to deal with it. They say 'I don't have time to deal with the pain, or I don't have the energy to deal with it.' Sometimes, it's a choice between the energy to keep it down or the energy to work through it. And, sometimes you just don't feel like crying, and it's okay, but you have to make that choice for yourself. That's why coming to therapy can be very hard when you have to deal with things, especially if you've been holding something in for a long time.

In addition, Zahra talked about having choices in the actual therapeutic process with her therapist and psychiatrist in their collaborative team relationship, which were meaningful to her because her voice was empowered. She further explained that there was no right or wrong choice, only the one that worked for her. Zahra replied:

I usually don't make decisions. I get headaches just to think of a better way of something. And, it's a little easier now...because if you decide what to do, they [therapist and psychiatrist] ask you like, 'Zahra, you can do this, or you can do this, or you can do this.' And I had a choice, and, whichever choice I made, it was okay.

Speaking the Unspeakable. A couple of the participants reported that the behavioral health process allowed them the opportunity to discuss things they could not speak of elsewhere. They perceived this openness as liberating, which added to their trust in the therapeutic process built from their trust in the therapeutic relationships. Brad illustrated this with his statement, "I get along with counselors so much better than I do the general public. And it's because we can talk about the dark things of life." Zahra also revealed that because of her trusting therapeutic relationship, she was able to tell her therapist things she had been holding within for well over a decade and was finally getting the support she needed to work through those problems. She asserted:

I tell Ms. Leslie a lot. I see...I watch TV a lot...parents hurting their children. It's a very irritating conversation for me, but I feel flustered a lot around my kids. I haven't just started feeling this since I had the last baby, I've been feeling it for 14-15 years. I'm just now talking about it. To make me feel comfortable enough to talk about that, you wouldn't tell nobody in the world that sometimes you just

want to run away from your kids or put your kids out. I can talk to my therapist and tell her that, and she tells me ways...she tells me she's proud that I didn't...it's a good thing.

Knowledge is Power. Several of the participants described therapy as a process of guiding them toward a deeper understanding of their circumstances. Therapy helped normalize their particular responses to situations and gave meaning to them. Dianne described behavioral health as “better understanding,” “knowledge,” and “knowledge is power.” She added:

I need it, counseling, therapy, whatever you want to call it. I know that I need it. I just didn't know the names of what was wrong with me. I didn't know I had to change. I didn't know. You know? All I've ever heard is 'you're crazy, you're crazy.' And you come here, and you find out you're not actually crazy...that what you are has a name and a reason for being there.

In addition, she also talked about how her therapist's ability to contextualize her behavioral health problems informed her evolving perceptions of herself. Dianne imparted:

Like when I found out that I was going through depressive episodes, I didn't know they had a name, I didn't know that's what it was. I saw my mother do it as a child for days and months on end, and I had no idea it was even something. You know? I didn't have an explanation for it myself. I'd withdraw and go to my room, and I don't know why. When I got to talk to Leslie about it, she explained it to me, so knowledge is power.

Validation. Some of the participants disclosed that behavioral health helped them grow through the validation supplied by their therapists as they endured their difficulties and made efforts to prevail. Zahra described that through utilizing behavioral health services, it helped her become a better mother so that she could keep her children. She affirmed that with her therapist's validation and encouragement, the therapeutic process served a large purpose in her life. Zahra said:

Keep my kids and keep myself free because I don't want to go to jail. I don't go outside because I'm scared of what I might do to myself or others, and it's okay. She [therapist] tells me that it's okay. I'm not ready for group activities and all of that, but it's okay. I don't do the family night and all of that like I used to, but we're getting back there and it's okay...So, we're working on it. That's my favorite words, she says 'You're working on it. You're doing good, Zahra. You're working on it.' I like it...I'm like 'yeah.'

Edma confirmed that her therapist's validation and acknowledgment of her hardships made her feel understood, which further gave her inspiration for self-exploration. She mentioned, "I went through a lot, and he's [therapist] told me 'You've been through a lot.' And, that eases me a lot. You know?" Molly also discussed that validation from her therapist was meaningful to her and helped her move beyond some pain that she would not surrender. She reported:

Because there was whole lot of beating myself up and she's [therapist] like 'no.' My fiancé could tell me 'it was nothing you did wrong.' My momma could tell me 'it was nothing you did wrong,' and usually when momma says that, it's okay. But, it wasn't enough. But that constant reassuring from her and...it's nothing

you did wrong, you just need to get past some of this or whatever. And, she did that in like the most subtle way.

Talking About Nothing Can Be Therapy. A few of the participants explained that the focus of therapy did not always need to be intense, and sometimes just blasé conversations were more therapeutic and actually what they needed. They explained that, in working through the therapeutic process, flexibility and relaxation is necessary from time to time. Louise detailed:

Sometimes Leslie and I, we'll just chit chat. Oh, I did this to my hair. I went and bought me a new pair of shoes. Here's what's happening with my pets. You know, sometimes you just need to kind of b.s. And, you know, while there's an understanding with everyone I've seen here, that that's part of it. You don't just have to intensely dig into issues and do hard work. Sometimes you just need to relax and talk about nothing because sometimes talking about nothing can be therapy. And people here seem to understand that.

Stacey added, "I can come over here [behavioral health]...I don't have to talk about my problems." Molly also mentioned needing elasticity in the therapeutic process to meet her needs and replied:

I go in and we have a conversation, and that conversation might have been extremely productive for that day and then again it might not have meant anything because we did nothing but talk about baby beds and names. But that's also kind of helpful because I was having a hell of a time picking out a baby name. You know, so it just doesn't feel like therapy to me. You know? It's a conversation

with...I schedule an appointment to come in and sit and talk to a friend for 45 minutes to an hour or whatever.

Therapy is like a Vegetable. A couple of participants utilized a vegetable metaphor to describe their experiences of behavioral health services. Molly described the therapeutic process and metaphor as follows:

We [Molly and therapist] talked through this and talked through that and she [therapist] fixed me without it actually feeling like she was fixing me. So, it's kind of like one of those things, you will...it's kind of like kids. If they don't know they are eating vegetables, they aren't going to argue about eating vegetables. I didn't know if I was against being fixed, but she fixed me because I didn't know I was being fixed. It just felt like we were sitting there talking.

Stacey described the therapeutic process as something people are afraid to sample but utilizing it could actually be a satisfying experience. She utilized the following metaphor to illustrate:

Like when they tell you, when you are a kid, just taste of the vegetable even though it looks all nasty. Just don't knock it till you try it. Okay. Same thing over here, don't knock it [behavioral health] until you try it. Whoever comes over here, don't listen to all the bullshit and gossip out there.

Safeguarding the Therapeutic Process. Two participants portrayed therapy as an experience that was so personal and meaningful to them that only their therapists were privy to the details they shared in session. They described safeguarding the process as something that was private and their own, which they chose to keep separate from their personal relationships. These participants also mentioned receiving silent support from

their loved ones, in regard to their behavioral health utilization. For example, Betty Jane reported she told her mother, husband, and kids that she was going to therapy but with a stipulation. She replied, “I told them ‘Don’t ask! I have a therapist that I go to, but don’t ask me what she says, or what we talked about that day because that’s between me and her.” Additionally, Molly mentioned safeguarding the therapeutic process from her boyfriend after she began therapy, although he expressed curiosity. She narrated the following conversation with him:

I said ‘I’ll try a couple of sessions’ because he [boyfriend] really thought I needed to talk to somebody. And after that couple of sessions, he never brought it up again, but I’ve been coming back. After a while, you know...Now granted, he would ask ‘how did therapy go?’ or whatever. Sometimes, he’ll ask ‘what did y’all talk about?’ Well, I don’t want to tell you that. If I don’t feel like telling him then I can be like, ‘I don’t have to tell you that.’ He’ll say, ‘well, I’m curious.’ I’ll say, ‘we talked about you and that’s all I’m going to say.’ But, you know, after a while, he was like ‘I take it you like therapy?’ I said, ‘well, it’s been three months, I guess I do.’ And, he was like ‘good.’

Subtheme #3 - Impact and Effectiveness of Behavioral Health Treatment

Feeling Better. Many participants described that the therapeutic process simply made them feel better, and they could count on the experience to lift their spirits. Molly expressed, “Regardless of what I have to leave and go do. I always feel better when I leave.” Betty Jane asserted:

If I was having a really bad day by the time I walk out, I was feeling better. You know? Now if it’s just a normal day, where just something, you know, or just

something that I needed to talk to her about, that was a good day. You know?

But on my really bad days, it's like...when I walk through that door...it's

like...Yes! This is what I needed.

Dianne added, "I feel better about myself when I leave here [behavioral health] than I do anywhere else."

Seeing the Difference. Several of the participants expressed noticing differences in themselves as a result of their behavioral health utilization. They described positive, personal growth that evolved from the therapeutic process, in which they gained deeper understandings of how they were changing within themselves. Betty Jane described the impact of the changes that have occurred in her life, specifically in terms of how she addresses conflict when she is angered. She reported:

...there's just a lot of change in there. Whereas I had a lot of anger built up in me, I don't seem...there may be a little bit still there, but it's not nothing to where it was...I get upset with somebody, I'll let you know. I don't bite my lip or keep my lips tight, you know, it's coming out. I don't do that anymore. You know? Maybe, sometimes it comes to, like something happening, and I just let it just go by. And I sit down and think...hmmmn. There is a difference right there. Otherwise, I would have flew off the handle just like that. And see now, it's not bothering me. I mean it comes to my mind, but it's like...I was more amazed at that it didn't bother me than what it was to start with. So I've seen that difference right off.

Chrissy explained the difference in her outlook on life, gained from the therapeutic process, as "It's not as cloudy anymore. That's the best way to put it." Brad conveyed

he felt that behavioral health was educational for him in learning about himself, and from his experiences, it helped him consider new career possibilities and think differently. He additionally described his experiences of behavioral health by saying, "...it's just like the help has been phenomenal." He also added, "...it's almost like I consider it more schooling to tell you the truth. And I've even, to the point where I've wondered...do I want to go back to school and get a counseling degree?"

Penelope described that the therapeutic process was helping her learn how to take care of herself and her needs, in lieu of everyone else and their needs. She disclosed the following statement:

It was just like you were always supposed to take care of everybody else. So therefore, I never learned how to take care of me...But even as slow as it is, I know I've come a long, long way. You know, everybody else was the only ones that ever mattered before...I've learned to do that by Leslie really encouraging me to do for myself.

Eye Opening Experiences (Expanding Realities). Participants described that the therapeutic process contributed in broadening their perspectives of their lives, particularly with viewing situations through the lens of multiple possible realities, which added to their personal transformations of growth. For example, Chrissy explained some of her advancement:

After being here [behavioral health], I don't know what it is. It's like you just start to see stuff, I mean, little stuff...Being able to talk to somebody and looking at my life in a different light. I was like, 'Are you going to keep going to the

past?’ And sometimes you do...Then somebody else puts it in a different light, and then you start to remember, oh there was good times, not just all the bad.

Zahra also described her personal growth from expanding her perceptions through the behavioral health process. She stated:

I’ve been dealing with this all my life...It’s like now, it’s not too late, but it’s very scary...I’m just seeing it in a different way. After I talk to my therapist, she was like ‘yeah, not everything is one sided,’ and I am paying attention to the situation with open eyes.

Systemic, Relational Impact. A couple of participants described the relational, systemic impact of their behavioral health utilization on their loved ones. Molly communicated that the therapeutic process was improving her relationship with her boyfriend, and she tried to engage him in the process outside of therapy. She supplied the following statement regarding its impact:

...some days it’s almost like couple’s therapy without him [boyfriend] actually being here [behavioral health]...then when I’m done I’ll call him, and I’ll be like ‘Hey, maybe we can try doing or try this, you know, or try talking about this and see how that works or whatever.’

Zahra discussed therapy’s impact on her children and narrated the following description:

And, my kids even love you guys. ‘You going to therapy today, mom?’ I say, ‘Yeah.’ You know? Because we got the calendar, and my kids draw pictures and happy faces around therapy...Because when mom comes home, she’s a little less stressed. When I left home today, and for like the past week, I didn’t want the kids to touch me. It was a really bad feeling for me. But when I come home, I’m

longing now. When I get in, they're going to hug me, and they like that. Maybe by next week, I'll probably not want to be touched again, but I have another therapy appointment coming where I can vent again. And, I can take that hug coming through the door and the good night kiss. I couldn't function before. You know? But when I do my therapy, it's easier living on my children too.

Application of Lessons Learned in Therapy. Many of the participants discussed effective techniques and suggestions they learned in therapy, which were conducive for their particular circumstances. In addition, they reported utilization of this learned information in their day-to-day activities as needed. For instance, Zahra described:

...she [therapist] taught me the breathing techniques and to think of a happy place. And, my happy place is the beach with the nice water. And my happy place, it brings it down a notch. Yeah, it brings it down...I didn't learn that out there. They didn't teach me that out there...I only did one session with Ms. Leslie, the first session we did, I've been working with those breathing techniques, and it keeps me from jumping out of my skin.

Betty Jane also conveyed that using relaxation techniques and different ways of thinking were helpful in developing positive changes in her interactions. She affirmed:

Something can flare up or come up, you know, and I handle it in a different way, or I try to let it go...if I have to lay down and just sort of like relax or think of a better place...Different places to be, and I can tell a great deal of difference.

Molly talked about her application of meditation practices, which she learned from her therapist, to help her remain calm and relax when she feels overwhelmed. She said, "...sometimes I'll try the meditation stuff that we've talked about at home. Deep

breathing...It's like, okay, perspective. We are back inside of our box. Thank you very much." Edna mentioned the effectiveness of keeping a diary at the suggestion of her therapist, and Stacey explained that her therapist was working to help her release her aggression in positive ways and recommended, "get you a punching bag."

No Shame in My Therapeutic Gain. A few of the participants described the meaningfulness of their behavioral health experiences, specifically in reference to the stigma of mental health utilization, which they reported would not deter their treatment because they were transforming through the process. Chrissy mentioned that if other people found out about her behavioral health use, it would not dissuade her. She explained:

Right now, it wouldn't stop me from coming here to be honest with you. I'm just getting too old to care about what other people say. I need help for myself. I need to help myself so I don't care. And if everybody else, they find out...I'll say, 'Oh! And? Everybody has problems!'

Louise also reported no reservations in consuming behavioral health services and described the practicality of taking care of one's mental health. She articulated:

And, so I'm not ashamed when people are like 'oh, you go to therapy?' I'm like 'Yes, I proudly go to therapy.' It's not. It still holds a stigma. I know the stigma is less than it used to be. But still, it can have a stigma attached to it, and I think it's ridiculous. I think everybody could use therapy at some point in their life. It's just a way of taking care of your health. I mean you've taken aspirin when you have a headache. You have an issue? Talk to a therapist. I mean, it's just that simple.

She further described that some people have been humored by her openness about using behavioral health, to which she tells them, “You can laugh all you want. But, the difference between me and you is that I’m taking care of my business, and you’re still kidding yourself. I mean, that’s the way I feel.”

Theme #6 – Advocating for Behavioral Health

In this theme, participants reported about their support of behavioral health services from the perspective of being believers, due to its positive impact in their lives. They also offered advice, support, and activism for others to utilize mental health care treatment and presented recommendations to reach other community members. The following discussion presents the participants’ shared experiences of (a) advocating behavioral health for all, and (b) their recommendations to reach others.

Subtheme #1 – Advocating for Behavioral Health for All

Just Do It, It Helps. All 11 participants described evolvment and growth through their utilization of behavioral health services. In addition, they perceived that many other people could benefit from mental health treatment and advocated for others to take a chance. The participants offered their advice and encouragement for other potential consumers who were considering exploring behavioral health services, based on the positive and meaningful experiences that they each perceived. The following statements exemplify their support. In providing her suggestions to prospective clients, Georgia articulated:

Just do it. If you think you need help, at the very least call and ask to talk to someone. Tell them what you’re feeling. And tell them, ‘I don’t know that I really need help.’ Just, you know? Don’t be afraid to say, ‘do I need your help or

am I looking in the wrong place?’ because you might be looking in the wrong place.

Through her positive experiences in taking a chance with behavioral health, Chrissy promoted the same for others and acknowledged her belief of other’s misconceptions of therapy. She described:

I would say go for it. I mean, just try it out. Why not? Talk to a counselor just once...Just try it. It’s not as bad as what everybody thinks...like there’s a big lion in the room ‘Augghhhh!’ You know? Stuff like that. No...of course not!

In addition, Molly advocated pursuing behavioral health services with an open mind and exploring the possibilities of what it could offer. She declared:

Try it. What do you got to lose? It’s 45 minutes of your time...Try it...if you think it’s something that might benefit you, try it. Regardless of...take the time and try it because it might be the best thing that ever happened to you. And, it might be the biggest waste time. But you won’t know until you try it.

Penelope reported about her encouragement in inspiring others to utilize mental health care, regardless of the extremity of a situation. She depicted this as follows:

...everybody could use a little counseling. I mean, it helps tremendously.

Whether it’s just you need somebody to listen to you that day, maybe nothing major going on to you’re having a total meltdown, and you need somebody to help keep you from blowing your brains out.

Stacey corroborated the benefits of mental health treatment and asserted, “I think everybody needs to come over here [FQHC behavioral health program]. At least, try it.”

Edma also mentioned her advocacy of behavioral health for others and mentioned, “I would get them to seek it out...that they can really help you.” She further supported the FQHC behavioral health program specifically, due to her personal meaningful experiences, and explained, “I would definitely send other people here because I’ve had a good experience here, and I think they will have one themselves because of what I’ve been through here...good experiences.”

Get Them While They’re Young. A few of the participants believed that behavioral health services were so valuable and important for personal growth that everyone needed it, therefore starting younger was better. For example, Dianne stated, “I think if I was going to be an activist for mental health, that’s what I would stand for right there...Get them while they’re young. Get them in here while they’re 18.” Chrissy also confirmed that starting behavioral health care younger was better and described that it could be efficacious in dealing with growing pains, especially starting during the college years. She added:

I think everybody should have a counselor to talk to. Most definitely, I really do. I feel like...sometimes, I wish they had that in...they should assign each person a counselor in college. I mean a *counselor* counselor...a therapist counselor to talk to you about your growing pains and stuff, and maybe when they got older they wouldn’t...like me, I’m like 29-30...maybe it would’ve helped out later in life.

Don’t Be Afraid to Use Your Voice. Some of the participants advised potential behavioral health consumers to use their voices and simply ask for what they needed, which included speaking up to acquire needed mental health assistance and to underscore they had choices in their treatment. For example, Georgia conveyed:

...my beliefs about using it [behavioral health] are don't be afraid to use it. It is here if you need help, ask for it. Behavioral health is not a mind reader. They don't know who all needs help out in the community. So since they can't go to the community, the community has to come to them and say 'help, help, help.' So don't be afraid to ask for help.

Georgia also offered additional guidance regarding personal preferences with behavioral health services. She elaborated with the following statement:

First advice is if you are going to get a counselor, don't be afraid to interview the counselor. Ask them questions that are important to you. If you are wanting marriage counseling, find out if they do marriage counseling or couples counseling. If you're wanting, well, like for myself, being an abuse survivor of pretty much every form of abuse, my questions would be, 'Do you deal with abuse survivors? How do you deal with them? How do you, you know, what do you expect from them? Are you willing to have a little give and take with maybe things are usually run in a very strict way, but are you willing to have give and take with an abuse survivor.' Because you can't always run things like a book. Because our emotions just don't last. Don't be afraid to ask to see their credentials. You have a right to ask, and they need to be willing to show their credentials. This is something I haven't had to deal with, but if you're having to pay for the services, don't be afraid to ask how much it is and don't be afraid to ask can you get on a sliding scale or can some accommodation be made.

Molly further emphasized that behavioral health clients have options, including the selection of an appropriate therapist/client fit. She expressed, "If you don't like it or if

you don't like who they put you with, you can request someone else. And if you don't like them, don't come back."

Subtheme #2 - Recommendations to Reach Others

Advertisement: Go To Where the People Are. Many of the participants recommended advertising as an effective manner to elicit behavioral health clients. In addition, they offered suggestions that the FQHC could utilize to maximize their potential in reaching others in need of mental health care. For example, Chrissy said, "So maybe you guys could do more advertising, just to get yourself out there." Molly proposed getting the clinic's behavioral health brochures out into the community to inform people of its availability. She detailed:

Brochures outside of the office. And you might have them, I just haven't seen them. You could do like, information boards and maybe different doctors' offices, like different gynecologists...they also have information boards at Wal-Mart with brochures or ask a member of management at a Wal-Mart, 'Can I put some of these in your break room for your employees?' You know, just brochures just out there. Maybe some more around the campus at ULM.

Stacey also discussed the necessity of advertising with brochures to inform people about the services, but she also mentioned the fundamental importance of the brochures as educating and expanding the understanding of what behavioral health services are, in contrast to common misconceptions. She explained:

Like that pamphlet they have, I don't know of any other clinic that does that. Now if you could get that put other places...I don't know...like they have the money saver outside of convenience stores. If you could do this, put brochures

like in supermarkets or stuff like the ones they have over here. There's like a whole list of stuff that you wouldn't think that they could do over here. I was shocked, whenever I was reading those pamphlets. I was thinking...Damn, they deal with...if you got this kind of issue or....

Louise also discussed misconceptions and shame of behavioral health care; therefore, she recommended "If you do an advertisement, approach it from the helpful perspective not the clinical perspective." She elaborated with the following statement:

...if you advertise, just do it very lighthearted and warm. Just kind of get the word out, 'Hey, it's okay. We just want to help you. We know times are tough.' Not point at somebody and say 'You know what? You need help because there's something wrong with you.' People still think if I see a therapist that means I'm crazy. And it's like, No! Maybe approaching from the standpoint of *life is tough, sometimes you just need to talk to somebody*. Kind of approach it from that perspective...like somebody who is objective...maybe you just need an objective person and approach it holistically. I think that would help break it down.

Betty Jane explained that, "Word of mouth is the best advertisement you could ever have."

Clients Utilizing Their Own Real-Lived Behavioral Health Experiences to Reach Others. Several of the participants described that they were open about their utilization of behavioral health services with others, which they conveyed helped break down barriers to this health care for others. For example, Stacey reported distributing the behavioral health brochures at her job to notify her co-workers that help was available for them also. She described:

I would tell them...Here's a card. Here's a pamphlet. I've already brought a couple of pamphlets, of the yellow ones, up to work and left them in the break room by the time clock...People I work with, like the guys work in another part of the plant...like I can just walk in the building, and say to all the guys that work over there, 'why don't you put these out?' I even put Leslie's name and number at the bottom of it.

In addition, Stacey also acknowledged that because of her transparency about using behavioral health services, people have approached her after reading the brochures and have asked for her opinion. She stated:

Yeah. The girls I work with...they're like, 'you can really go over here for this?' I was like, 'that's what the paper says.' I was kind of shocked...They actually read them. I mean they are still on the table. I put them there months ago. So, apparently somebody is keeping them around. I don't know if they just read 'em during break or lunch to have something to read. They'll actually come up to me because they know I'm the only one that comes over here [behavioral health]...so, they'll ask 'what are you thinking?' I'll say 'You need to see Leslie.'

Georgia confirmed that she used her behavioral health experiences to help her boyfriend negate his shame about needing mental health treatment, which was meaningful and made a difference in encouraging him to seek help. She narrated their conversation as follows:

He [boyfriend] made the comment that he might need to go see someone about his depression. And, he was just bemoaning the fact. I said, 'Wait a minute. First

off, it's not a sin to have depression. It's not a sin to be on medications. The medication can help, and just because you're on the medication today doesn't mean you're going to be on it for the rest of your life. It's different for everybody.' I said, 'whether it's six months, a year, two years, three years consider it temporary.' He finally went off of it after a year. He went off of it just a couple of weeks ago, and he told me when he was going off of it. He said, 'the thing that made me feel good about it was I know if I need it again, you're not going to shame me. You're going to remind me it can be temporary.'

Summary of Findings and Results of the Analysis

The Essence of Clients' Experiences of Behavioral Health Services Utilized in a Collaborative Health Care Federally Qualified Health Center

The participants in the study experienced behavioral health services as an essential element in their overall health and well-being. In addition, they acknowledged a connection between their mental and physical health and provided examples to illustrate how one affects the other. They described their behavioral health experiences at the FQHC as meaningful, positive, and fulfilling. Participants also discussed characteristic services provided by the FQHC, such as transportation and the sliding fee scale, as critical means in helping them to gain access to their needed healthcare.

Participants described their initial beliefs about utilizing behavioral health services and the stigma associated with mental health care treatment. While some participants discussed the stigma as it related to their personal perceptions, others communicated an awareness of public perceptions of stigma, although contrary to their own. This stigmatization of behavioral health services surfaced as a barrier to care. The

majority of participants had previous experiences with behavioral health services, prior to their utilization at the health center, which were predominantly perceived as negative and degrading. Participants attributed these bad experiences to foul behaviors displayed by the therapists, in which the participants felt dehumanized and treated like numbers instead of people. In contrast to these negative experiences, some participants had previous positive experiences with behavioral health utilization, which served to reinforce their motivation to seek help again when needed.

Participants described reaching a point in which they realized that they needed help and found the courage to seek behavioral health services. Although utilizing the services was a personal choice, some participants described that encouragement from family and friends, thinking of their children, and referrals from the health center's primary care providers helped them make their decisions to seek out behavioral health care treatment. In addition, the collaborative health care model employed at the FQHC, inclusive of the behavioral health screenings and advertisements throughout the health center, helped break down barriers and opened access to behavioral health care for participants.

All of the participants conveyed faith in the therapeutic process and held hope that behavioral health could help them cope and work through their problems. For those who had bad prior behavioral health experiences, it appeared as if they had faith in the process, not the person, because it was situations related to being degraded by their former therapists that they found unsettling. In lieu of these negative experiences, participants still had hope in the process and decided to take a chance. In taking a

chance, the positive experiences that occurred as a result led to continuation of treatment for all of the participants.

The environment of care and the relationships established at the FQHC were powerful stimulants in the participants' journeys of evolvment. The environment of care was experienced as humanizing by the participants and created a sense of home and importance for them, which added to their meanings that they mattered and were cared for by the staff. They also felt they were treated like human beings by the staff's remembering their names, accommodating their needs, treating them with kindness, offering them snacks and beverages, and going above and beyond to offer the participants assistance with any of their needs, including providing information about other community resources. The staff appeared to have the ability the communicate with the participants in a manner in which they felt seen and heard, due to the considerable amount of detail and attention that participants were given as unique individuals.

The participants' relationships with their therapists were overwhelmingly the most productive and meaningful aspects of their experiences of behavioral health services. Participants described these relationships as "family" and "best friends" underscoring the closeness and intimacy that they felt in the security of their therapeutic relationships. They described trusting their therapists, feeling accepted, and feeling cared for by them without judgment or false pretenses.

In reference to the therapeutic process, participants described their therapists' abilities to meet them where they were in the process. For example, participants talked about their therapists not pressuring them in therapy, but allowing the process to occur in congruence with their needs. They reported that some days were very difficult to discuss

hard issues, and, therefore, the therapists would talk about lighter issues, which participants still perceived as therapeutic for their advancements. Furthermore, the participants reported about the meaningfulness of having choices in their mental health treatment, where their therapists' actions were driven by the direction of the clients' voices. These efforts by their therapists were perceived as meaningful and further solidified their positive experiences of behavioral health care treatment.

Participants acknowledged the therapeutic process as a "process," in that changes take time and occur slowly, but they described that growth and transformation were occurring. Regarding the participants' relationships with therapy, there was a sacredness expressed by the participants about their behavioral health time as something that was theirs and for them, in which they could focus on themselves and not worry about detrimental consequences of their actions. Participants reported being able to see differences in themselves and their responses to situations as a result of their behavioral health utilization. Participants described that their perceptions and experiences of behavioral health services evolved over time, as a result of using the services. From these experiences, they went from having faith in the process to trusting in the process, primarily through the trusting relationships established with their therapists.

Finally from their real-lived experiences, all of the participants believed that everyone could benefit from behavioral health services and advocated for its utilization. They offered recommendations to reach others and believed that the provision of competent behavioral health services could make the world a better place.

CHAPTER FIVE: DISCUSSION

Summary of the Study

This qualitative study investigated clients' lived experiences of receiving behavioral health services in a collaborative care FQHC. The goals of the study were to (a) allow participants to describe in their own voices their lived experiences of receiving behavioral health services at the FQHC, (b) understand the meanings clients placed on these experiences, (c) explore how clients' perceptions of behavioral health services evolved, if at all, throughout utilizing the services, (d) learn about clients' experiences of receiving behavioral health and primary healthcare services at the same health center, and (e) be informed of ways that behavioral health services could be changed to better meet clients' needs.

The data from interviews with 11 participants yielded six core themes that tell the participants' stories of their lived experiences utilizing behavioral health services at the FQHC. The themes include (1) barriers to care; (2) breaking/overcoming barriers to care; (3) humanizing the context of care; (4) involvement through relationships of care; (5) transformation through the therapeutic process; and (6) advocating for behavioral health. Understanding these themes through the theoretical/conceptual frameworks of systems theory and social constructionism gave recursive meaning to the participants' experiences; therefore, taking into account the interdependence of relationships and the broader social context further informed the results of the study. This chapter discusses the study's goals and compares and distinguishes the findings of this research project with prior studies. In addition, this chapter includes components of my interviews with the FQHC's staff about behavioral health services, which were also used to triangulate

the data during the analysis. Furthermore, the chapter presents a discussion of the clinical implications of the study, limitations of the study, and directions for future research.

Comparing and Distinguishing Findings of My Research with Prior Studies

The first goal of the study was to allow participants to describe in their own voices their lived experiences of receiving behavioral health services in a collaborative care FQHC. Participants in the study reported positive experiences associated with their utilization of behavioral health at the health center. They discussed the stigmatization of mental health care utilization, either from their own or public perceptions, and acknowledged it as a profound barrier to care. This finding is consistent with prior research that evaluated the role of stigma and its deleterious impact on help-seeking for behavioral health care (Schomerus et al., 2009; Vogel et al., 2006). In addition, these past studies explained that consumers with prior experiences using mental health treatment reported much less stigmatization about its utilization and, thereby, were more likely to seek out this care. The results of the present study support these findings. For example, the majority of participants in the current study had previous behavioral health experiences, and, regardless if those experiences were positive or negative, they all believed that behavioral health care could be advantageous for their growth. This belief reinforced their motivation to seek it out.

In contrast to Schomerus et al's (2009) findings that suggest self-stigma deterred help-seeking for behavioral health but public stigma did not, the current study found that participants referred to public perceptions of stigma, such as fear of being considered "crazy" by others, as more of a deterrent than personalized, internalized self-stigma. However, consistent with Schomerus et al's study, participants with prior behavioral

health utilization acknowledged the public stigma of mental health care treatment, but they did not allow it to hamper their utilization. In fact, several participants in the study were extremely open about their behavioral health utilization even in the midst of possible ridicule from others.

In addition, my interviews with nine staff members at the FQHC, which included a variety of positions such as the medical staff, behavioral health staff, clerical staff, and administrative staff, further added confirmation to the power of stigma interfering with behavioral health usage, as suggested in other studies and by the participants in this study. The staff discussed and confirmed the public stigma of mental health utilization in the local community, and they described the fear and ensuing consequences of being labeled “crazy,” which they believed inhibited many people from obtaining behavioral health care treatment. One of the nurse practitioners at the FQHC mentioned that she frequently tells people, who could benefit from behavioral health services, “It doesn’t mean you are crazy if you talk to a therapist, *it’s crazy if you don’t* when you have a problem.”

In discussing additional barriers to care, participants also described previous negative experiences with behavioral health services, in which their therapists demeaned them as people and did not assist them in productively working through their struggles. Prior research has demonstrated that some mental health professionals actually have negative ideologies about consumers needing mental health treatment and will engage with them based on preconceived notions that are stigmatizing (Nordt et al., 2006; Snowden, 2003). The dehumanizing experiences with former therapists described by participants in this study appear to support these previous findings.

Consistent with other barriers to care reported in the literature (Elliot et al., 2001; Politzer et al., 2003), participants identified costs, affordability, transportation, and access to behavioral health services as barriers. The FQHC helped break down these barriers for participants by providing needed services such as the sliding fee scale, transportation, and supportive staff relationships. Since these health center's services are catered to serving the vulnerable and underserved, they have an understanding of the struggles of low-income populations and are equipped to accommodate the needs of their consumers. Many of the participants asserted that without the health care provided by the FQHC, they would have limited, if any, resources to rely upon.

Research by Elliot et al. (2001) reported consumers' behaviors identified as non-compliant by healthcare providers are actually the result of real impediments due to circumstances related to living in poverty. In support of these findings, several of the participants discussed their hardships and their difficulties at times being able to attend their appointments, but they also reported believing that the FQHC was willing to work with them, understood their struggles, and made accommodations for them, rather than viewing them as non-compliant and giving up on their care.

The second goal of the study was to understand the meaning clients placed on their experiences of receiving behavioral health services in a collaborative health care FQHC. Participants described their experiences at the FQHC as meaningful and fulfilling. They talked about their constructive experiences at the health center, which they attributed to the caring relationships established with the FQHC's employees. These relationships with the staff and therapists were experienced as incredibly humanizing by the participants, in that they felt they mattered and were cared for as human beings.

Participants also described the emotional and personal investments they felt from the FQHC's employees, which were portrayed by staff's individualizing them as people in calling them by their names, being personable with them, understanding and accommodating their unique needs, and by the participants' knowing what to expect when they entered the FQHC. From the participants' stories, it appeared that their experiences at the FQHC began immediately upon entering the center, starting with the front desk, and the kindness and warmth they received proved to have a lasting impact on them and their perceptions of the care they received.

A finding of this study, that distinguishes it from other studies, is the extraordinary amount of meaning that participants created as a result of the environment of care at the FQHC. They indicated that the compassionate staff, comfort, and décor of the facility, which did not appear to be a low-income health center, were contributors to their sense of being cared for and meaning something as people. They also mentioned that the atmosphere of the behavioral health program, which felt like a comfortable living room, helped them relax and promoted the likelihood of them opening up as a result of the non-threatening, secure environment. The small courteous gestures of being offered snacks and beverages during their behavioral health visits added to the participants' positive experiences of behavioral health care and were additionally perceived as humanizing.

Because the participants in the study were low-income, I wondered if perhaps that, due to the subjugation of living in poverty, stressors of limited resources, and the maltreatment which often occurs as a result, things which may be insignificant for those living in higher income brackets, such as being offered snacks and being called by their

names, are incredibly meaningful to lower income people and adds to their sense that they are important and matter. In addition, from the staff's interviews, several reported that if people in the local community could see the environment of the behavioral health program at the FQHC, this would automatically give them a different impression of behavioral health care, which would shatter their misconceptions about the services, reframe their perceptions, and open access for their potential use. Furthermore, I was also astounded by the tremendous sense of refuge and solace that the FQHC provided for the participants in this study, especially with the gravity and depth in which they felt supported and cared for by the staff and its impact in their lives. I was also touched by the appreciation the participants felt towards the health center and their feelings that they could count on the organization to assist them with their problems and connect them to other resources, if needed.

The participants described their relationships with their therapists, coupled with their expectations of their therapists that were fulfilled, as the most meaningful facet of their behavioral health experiences. Participants additionally perceived therapy as a process, involving time and effort, in collaboration with their therapists to overcome their problems and live more gratifying lives. These findings support prior research that suggested clients who entered therapy with an open mind and committed to the process actually satisfied their wishes and developed productive relationships with their therapists (Patterson et al., 2008).

In addition to the meanings created as a result of their behavioral health utilization, several participants also spoke of the meaning they created from their involvement in this study. They mentioned their appreciation to have their voices heard

and contribute to the study's findings. For example, Georgia said, "Just how often do you get asked to voice? To lend your voice to possibly helping where you're already at. Girl, I say take advantage of it and do it." In a similar vein, Dianne added, "I'm glad to be a part of what you're trying to discover because I'm trying to discover things myself. So hand in hand, we go." These statements illustrate the participants' willingness to share their experiences and give back to others, as a result of their journeys of growth from behavioral health treatment.

Throughout my research interviews, I was amazed at the participants' openness and willingness to share so much detailed information about their personal experiences with me. This could be another example of how much this population of consumers wants to be heard. Another possibility is that their openness further suggested that I, as the researcher, was a part of the relationships they trusted because of my connection to the FQHC. Somehow, this emerged as though the participants' relationships with the staff and therapists have been so trustworthy that it also served to facilitate a relationship with the organization itself, which extended beyond their connections with employees. Further evidence of this was supported throughout their interviews when participants made numerous references to "y'all" and "you guys" in conversing with me about their experiences at the health center.

The third goal of the study was to explore how clients' perceptions of behavioral health services evolved, if at all, throughout utilizing the services at the FQHC. While eight participants had previous experiences with behavioral health services, three participants experienced behavioral health services for the first time at the health center. These participants, who were new to behavioral health care, definitely experienced an

evolution throughout utilizing the services, specifically in expanding their beliefs about behavioral health services and altering their misconceptions of behavioral health treatment. In addition, the majority of participants, who had previously utilized mental health treatment, reported negative experiences. Very few participants reported positive experiences.

Participants described personal evolution that emerged through meaningful and trusting relationships with their therapists. These relationships attributed to their feelings that they were safe to be themselves with honesty and integrity without experiencing persecution from their therapists. They evolved from having faith in the therapeutic process to trusting in the therapeutic process. Through this process, participants were proactive in their behavioral health treatment because they were encouraged to use their voices, felt heard by their therapists, and worked together with their therapists to create meaningful changes that they experienced as personal transformations of growth. In addition, elements of the therapeutic process were so intricately interwoven with the therapeutic relationship that their differentiation was challenging. This was largely due to the participants' experiences of the therapeutic process that became entrenched with their relationships with their therapists. Through deeper analysis of the participants' meanings, I found that the caring and trusting relationships established with their therapists created the context of safety and fortitude that the participants needed to efficaciously proceed with behavioral health treatment. However, it was the individualized therapeutic process of *working through their struggles* in the context of those meaningful relationships that allowed them to move towards the transformative

changes they were seeking. In essence, all of the participants became advocates for behavioral health utilization due to their powerful personal experiences.

The fourth goal of the study was to learn about clients' experiences of receiving behavioral health and primary healthcare services at the same health center. Consistent with prior research and the collaborative health care literature, the collaborative health care model emerged as instrumental in opening the door to behavioral health care treatment and breaking down barriers to care. Other studies have revealed that, due to the stigma of mental health utilization, the discretion in using mental health treatment provided in an integrated setting served to enhance its utilization (Guck et al., 2007; Roberts et al., 2008; Todahl et al., 2006). The findings from this study further confirmed the results of these prior studies. Participants described being recruited to the behavioral health program from the mental health screenings that all primary care users complete during the initial intake process, being referred from the primary care providers, and signing up for the services after being informed of its availability from signs and brochures in the health center's waiting room and exam rooms. Several participants mentioned that without the integrated setting, they would not have known about the services, nor would they have been as willing to seek out the services. The comfort, familiarity, and trust established with the providers and the FQHC itself served to facilitate their willingness to explore behavioral health services as an option, as reported in other studies.

Another interesting finding in this study was that every participant acknowledged a connection between their mental health and physical health, which further served to strengthen the collaborative health care model as advantageous and necessary for whole

person care. Participants were well aware of the impact of their mental health on their physical health and vice versa, even providing concrete examples of how one affects the other. They also discussed advantages of the collaborative care health care relationship, specifically the benefits and convenience of having a range of healthcare services under one roof. In addition, participants felt that both the behavioral health and primary care providers made better connections in factors affecting their overall health by attending to their mental and physical needs, which further encouraged them to take care of themselves holistically. Some of the participants in the study also talked about the collaborative health care relationships between the medical and behavioral health providers, which they experienced as a team effort to provide quality whole person care. One important aspect described was the effectiveness of the medical providers' referral process to behavioral health because participants had rapport and trusted these providers' recommendations, which further supports what is reported in the collaborative health care literature. I also found it fascinating that these participants perceived that both the primary care and behavioral health providers worked together at great lengths to ensure the appropriate medications were prescribed for them. It was an interesting finding that participants denoted and viewed the providers' collaborative team relationships as helpful, sound, and effective, but more research is needed from the consumers' perspectives to provide in-depth understandings of these relationships and their impact on the consumers' healthcare experiences in collaborative settings.

McDaniel et al. (1992) described the two major goals of collaborative health care as supporting *agency* and *communion* with consumers. Agency advocates for consumers to use their voices and have choices in their healthcare decisions without compromising

their personal dignity. Communion includes consumers' emotional connections with healthcare providers regarding their healthcare experiences, and its impact on consumers' relationships. The participants in this study described having meaningful experiences of agency and communion throughout their behavioral health utilization in conjunction with collaborative health care. They detailed their therapists and the FQHC staff's ability to meet them where they were in their processes and to accommodate their unique needs without shaming or judging them. They further mentioned positive changes occurring in their lives as a result of their healthcare utilization, and they experienced their therapists, staff, and the FQHC itself as part of their extended families due to the sense of "home" and comfort they felt within the health center. I believe the collaborative and supportive staff relationships, which included empowering the consumers to use their voices and make their own choices regarding their healthcare decisions, in contrast to many of their previous negative healthcare experiences at other places, added to the participants' experiences that they meant something and were important. Low income people are often marginalized in society, but the participants in this study did not feel this way from their experiences at the FQHC. In addition, I found the participants felt respected by the staff because the staff had an understanding of them as people and worked within the cultural and contextual "norms" of each consumer. These were obviously different experiences than those where they felt voiceless, dehumanized, and consigned to passive positions in their own care.

The fifth and final goal of the study was to be informed of ways that behavioral health services could be changed to better meet clients' needs. The participants reported satisfaction with their experiences of behavioral health services and, therefore, had little

suggestions for change. However, prior research has reported that vulnerable populations are at greatest risk for unmet mental health care needs and less likely to seek mental health treatment (DHHS, 1999, 2001; Wang et al., 2005). The participants in this study provided the voice of some of these vulnerable persons, who more often than not do not seek mental health treatment. The value of these participants' stories can be further recognized in their recommendations to reach other consumers and how they were able to overcome barriers to care.

Many of the participants described inadequate knowledge and misconceptions that most people have about behavioral health services. Because many people view behavioral health care as stigmatic and shameful, participants in this study acknowledged that understandings about exactly what behavioral health care is remain limited. They additionally described that many people perceive mental health treatment as being utilized only for extreme mental health problems and not necessarily for counseling and support with life's stressors. Participants advocated to better educate communities about behavioral health treatment, specifically to demolish fallacies, and to increase possibilities for other consumers to seek help. The staff's interviews also confirmed the participants' perceptions that many people are misinformed about mental health treatment and need more education that behavioral health care is a resource to help not hurt. The staff elaborated that common public perceptions were that using mental health treatment meant being committed to inpatient facilities, as opposed to working through problems.

The behavioral health brochures appeared to be informative for the participants, and one participant even placed them at her employment site to help reach other consumers. Several participants recommended widely distributing the brochures

throughout the community, especially at locations where large amounts of people frequent. From their positive behavioral health experiences at the FQHC, the participants were believers in behavioral health and advocated for others to take a chance, as they did, and just try out the services.

Participants also mentioned the effectiveness of encouragement from other people to utilize behavioral health services, including family, friends, and teachers, which fostered their initial use and helped them overcome barriers to care. Some of the participants described being very open about their mental health usage and encouraged others to seek the services as well, which can help break down barriers and open the behavioral health door for other consumers as it did for some of the participants in the present study. From one of my staff interviews, an employee described a time when she desperately needed behavioral health services for grief counseling but refused to go because of fear of what her co-workers would think. What I found intriguing about this information was that this employee, in particular, actively encouraged others to utilize this care, yet she would not due to fear of being labeled “crazy,” although she did not perceive others as crazy who used behavioral health care. However, this employee added that seeing other people use behavioral health makes it easier, especially people that she looks up to. For example, she mentioned, “If President Obama uses behavioral health, so can I!” This employee’s story further adds to the powerful influence that stigma has in dissuading mental health treatment but also shows hope in how people can make a difference for others. This provides more validation for encouraging people to be open about their behavioral health utilization, without shaming them, to make a difference for others who could advance from the services.

Clinical Implications of the Study

As most research on collaborative health care has been conducted quantitatively and from administrative and healthcare professionals' perspectives, the clients' experiences were an unexplored point of view that provided valuable knowledge about behavioral health services within this framework. The present study explored the meanings that clients placed on these experiences, and the findings have significant clinical implications for family therapists.

Some of the participants' reported that their previous negative experiences with mental health treatment at other agencies resulted in reluctance to seek out this help again. The therapists' behaviors that participants perceived as sarcastic, taunting, and degrading acted as barriers to care in their continuation of treatment. In contrast, participants that had previous positive experiences with mental health care treatment and had fulfilling relationships with their therapists reported positive reinforcement that encouraged them to utilize the services again when needed. Taken together, these experiences illustrate the impact of therapists' behaviors on clients' utilization of services. Negative, demeaning interactions by one therapist can result in a client choosing not to attempt behavior change or symptom relief through therapy again.

Participants in this study who reported negative experiences with their former therapists did not give up on their beliefs that behavioral health care could help them; however, many clients may. The experiences described by this study's participants suggest that there may be a large population of former clients who simply never return to behavioral health services based on their initial experiences with therapists. In addition, clients' behaviors that may be considered non-compliant to mental health treatment by

therapists, especially with low income clients, could actually be a result of therapists' inabilities to adequately provide the clinical care they are searching for and need. The implications for therapists are clear. Not only do their behaviors impact the outcome of the current therapy, they also influence whether or not there will be utilization of services in the future; therefore, all interactions with clients should be respectful and sensitive.

In contrast, participants described their current behavioral health experiences at the FQHC as humanizing and helpful, which they largely attributed to the meaningful relationships established with their therapists. These relationships began with the expectation that the therapists were kind, caring people who viewed their jobs as opportunities to help others and not just paychecks. In addition, participants mentioned trust-building behaviors that included learning more about the therapists as people, actively listening, being non-judgmental, speaking the client's language (metaphorically), and the therapists' abilities to contextualize and normalize the clients' problems. Hopefully, all therapists practice these principles, but, from the participants' prior bad experiences, this does not appear to always be the case. These findings further underscore how essential it is for therapists to show respect, engage with clients in a non-judgmental manner, and demonstrate care, as some clients disclosed that without being cared for by their therapists they would have terminated their behavioral health treatment.

Another interesting implication that arose from this study was the participants' descriptions of interviewing their therapists. Some participants described that in their initial meetings with their therapists, they were feeling them out to assess for a therapist/client fit. A couple of participants even conveyed that they instantly questioned their therapists as a means of testing for the preliminary possibility of trust. Participants

reported that if they did not like their therapists, they would have terminated behavioral health utilization. Over time, their therapists were able to create safety and build their trust in them. These experiences provide insight from the clients' perspectives that how they perceive their therapists as people and professionals can be the difference in keeping or losing them as clients. The information that clients enter therapy as a trial test and their continuation of treatment resides on the therapist's ability to pass their test of acceptance would seem to speak to the importance of establishing a therapeutic alliance quickly.

Another significant finding which has clinical implications for therapists is being able to meet clients where they are in the therapeutic process and allowing them to move at their own pace, without pushing them to be where therapists would like them to be. Participants described their therapists' willingness and ability to work collaboratively with them in this way was instrumental in their growth. Additionally, participants reported that sometimes in therapy they were not in emotional places to discuss tough issues, and, therefore, their therapists discussed lighter issues, which still served to be therapeutic. Participants described that being accepted for who they were and feeling comfortable with their therapists encouraged their growth, and the support of their therapists helped them hold hope and trust in the process that they would eventually reach their goals. These findings suggest that therapy has levels of intensity; therefore, knowing when to stay away from hard issues and engage at a less threatening level are essential skills for therapists. In addition, therapists should understand that these times of less intense interventions can be as beneficial and therapeutic as exploring the deeper issues depending upon where the client is emotionally.

Furthermore, all of the participants in the study reported feeling heard by their therapists as unique individuals. Their therapists' skills to move beyond the "textbook" approach truly made a difference in their care because they worked together collaboratively as a treatment team, and their therapists were able to meet their personalized needs. Collaborating with consumers about their care and truly listening to their stories and understanding their worldviews offers insight into their "positions," which provide therapists opportunities to gain their clients' partnership and collaboration in successful treatment outcomes (Fisch, Weakland, & Segal, 1982). The fact that participants called their therapists "best friends" and "family" demonstrates that participants did not view these relationships as hierarchical but collaborative. Participants discussed that encouragement from their therapists was meaningful and inspirational to them, especially in the midst of their destitution. In addition, therapists' behaviors that occurred outside of the context of the therapy room, such as promptly returning phone calls to participants and helping them calm down, were experienced as significant interactions that helped them progress through difficult situations. These examples serve to inform therapists that sometimes small things, like kind words of encouragement, calling clients back right away, and so forth, have a much greater impact in people's lives than they may be aware.

In addition, the participants' experiences of the environment of care at the FQHC and the collaborative care relationship have implications for clinical work. Participants described that the comfort they felt within the behavioral health setting created relaxation for them, which helped them let down their guards and open up about themselves. Because the environment was so meaningful to participants, administrators of agencies

and therapists should work hard to create an atmosphere that feels inviting and warm to their clients as a result of sensory issues that can promote the therapeutic process. The couches and living room décor were appreciated by the study's participants, in contrast to other experiences where they were sitting in chairs by their therapists' desks. The collaborative care relationship was experienced as highly advantageous by participants, specifically as they recognized the systemic connection of their mental and physical health. Therapists working in collaborative settings should be aware that some consumers do not want to open up about their problems in clinical exam rooms because the medical environment is not comfortable for them to discuss their problems. Although the co-location of behavioral health and primary care was appreciated, the dissimilarities in the "two-different worlds of care" were valued as well.

Another clinical implication of this study is the intense meanings that participants attached to their experiences of receiving behavioral health services and its impact in their lives. For the participants in this study, behavioral health treatment was a profound link to help them live more fruitful lives. For some of the participants, they described behavioral health as their only hope and help in overcoming their struggles, and they depended on the services. Consistent with the literature, these participants reported many hardships and struggles related to living in poverty, which negatively affected their health. Without behavioral health services, it is frightening to think of where these participants would be, and these experiences reinforce the power, impact, and effectiveness that behavioral health care treatment can have in people's lives. Because the participants in this study were low-income, they had additional stressors in their lives, which many times interfered with their therapy appointments, but their

therapists appeared to have understandings and worked with them to ensure they continued receiving care. Therapists should be mindful in working with low-income clients that behaviors perhaps considered uncooperative are a result of their day-to-day struggles and should be accommodated accordingly. Furthermore, from the interviews, I found that participants felt as though they were treated with respect from the employees and therapists at the FQHC, regardless of their low-income status. They did not experience being short-changed due to their financial setbacks. Perhaps feeling respected and a sense of mattering may be more important for low-income people than for middle or upper class people, who may get more respect in different areas of their lives than those who are in a lower SES.

Some participants identified themselves with mental health diagnoses, such as bipolar and dissociative identity disorder. Diagnoses such as these are often met with stigmatized behavior from mental health professionals. Participants repeatedly stated that they appreciated that the health center's staff and therapists did not respond or interact with them as pathologized labels or treat them as labels. Instead, the staff and therapists treated them as human beings and were sensitive to their problems, and participants experienced these particular behaviors as helpful and humanizing, which added to their beliefs that they were receiving the personal care they needed. In particular, one participant in the study detailed the meaningfulness to her that she was not treated like she had an illness, but instead she was treated like a human being, who was worthy of being helped. Due to hardships of living in poverty, low income clients may be diagnosed more with labels of pathology. This study underscores the importance of

normalizing and contextualizing their problems, while validating and relating to them as people in lieu of diagnoses.

Limitations of the Study

One limitation of this research study was the purposeful sampling that I utilized in recruiting participants. With this sampling method, participants were limited to those who were utilizing both behavioral health and primary health care services in a FQHC in a small urban community in Northeast Louisiana. Although the study was made available to all of the FQHC's behavioral health consumers, participation was restricted to those who fit the study's established criteria. The participants of the study were also self-selected, in that they actively chose to participate in the study. Therefore, the findings of this study are representative of the 11 participants who contributed their voices and may not reflect the experiences of other consumers utilizing behavioral health services in a collaborative health care FQHC. In addition, the participant sample was living in a homogeneous region in the Deep South, which may illustrate viewpoints of the particular area, but these viewpoints may not be representative of other areas of the U.S.

Another limitation of the study was related to the diversity of the participant sample regarding race and gender. Two participants identified as African American and one participant identified as African American and Asian, while the other eight participants identified as Caucasian. In addition, the sample was primarily comprised of women with only one male participant; therefore, the male voice was underrepresented in this study. I believe this study was well advertised within the behavioral health program, and all consumers had knowledge of the study and the opportunity to participate, if they chose. Fliers were posted throughout the behavioral health program, and the program's

therapists and receptionist also distributed fliers to clients when they presented for their scheduled therapy appointments. The resultant participant sample was comprised of those individuals who responded to the fliers and requested to participate in the study. The majority of those that responded were Caucasian and female. In the interest of respecting both the privacy and the decision of the consumers who elected not to participate, I did not attempt to actively solicit persons who did not indicate interest in the study, regardless of their race, ethnicity, or gender.

The small representation of African Americans in the sample was noteworthy, especially considering that this was not an equal representation of the FQHC's ratio of 76% African American consumers compared to 23% of Caucasian consumers. However, research indicates that members of minority populations are less likely to utilize behavioral health services, and therefore could also be less likely to participate in research about its usage. Gary (2005) discussed the double stigma of behavioral health utilization for racial and ethnic minorities, specifically in relationship to the mental health system's failure in treating these populations adequately when compared to their Caucasian counterparts. Additionally, the FQHC's consumers are predominantly female, which could also explain the high proportion of women in the study compared to the one man. Furthermore, I am a Caucasian female, which may have kept more people of color and males from participating in the present study.

An additional limitation of the study is my involvement and association with the FQHC. Although none of the participants in the study were my clients, they were informed that I was employed at the FQHC in the behavioral health program, and they relied on the FQHC as their fundamental source of healthcare. As a result, participants

may have edited their remarks, were more complimentary than they would have been had I not been affiliated with the health center, and perhaps held some things back in fear of unfavorable consequences, such as losing services, to name a few.

Directions for Future Research

Participants in this study discussed some issues that were beyond the scope of the current study but should be explored in future studies. For example, although this study did not focus on the consumer's experiences of the collaborative team relationship between their behavioral health and primary care providers, some participants discussed these relationships primarily regarding referrals and medications. Future studies should investigate more closely the nature of the collaborative team relationship between these providers from the consumers' perspectives.

Future research could also focus on participants' experiences of receiving behavioral health treatment in clinical exam rooms. Although many behavioral health providers participate in this practice in the setting of collaborative health care, some participants in the current study reported disadvantages of this approach. Other studies should explore the impact and outcomes for consumers having therapy sessions in the medical setting.

Future studies could also focus on the experiences of racial and ethnic minorities receiving behavioral health services in integrated healthcare practices, whose voices were underrepresented in this study, to provide more in-depth knowledge. It is also recommended that future studies should investigate the behavioral health experiences of males in collaborative settings.

Although this did not surface in the participants' interviews, several of the staff's interviews suggested a clear distinction between their perceptions of behavioral health and mental health services, with mental health care having a negative connotation as being "mental" or "crazy" and behavioral health care having less stigma because it was perceived as "counseling" and "just working through day-to-day problems." These meanings appear to be influenced through social constructionism and language, and future studies could explore how the languaging of behavioral health versus mental health impacts consumer outcomes in terms of their utilization and willingness to seek the services.

Conclusion

This study gave voice to consumers' experiences of utilizing behavioral health services in a collaborative health care FQHC. It also helped to address a gap in the research literature and provided insight about a primarily unexplored perspective. It is important to acknowledge that my training and focus as a MFT heavily impacted my perspective and findings of this study. I hope that other scholars will continue with this vein of research and focus on empowering the clients served by the mental health care system. Wholeheartedly, I believe that if all therapists' visions of mental health practice could be built with their clients' voices, clinical outcomes would surely demonstrate behavioral health care's impact and effectiveness in improving quality of life, health, and relationships.

It is also my hope that other therapists will take knowledge learned and problems identified in their clinical practice with clients to become "citizen-therapists" and work towards surmounting those challenges in efforts to promote their community's health and

well-being, especially in regard to breaking the stigma of mental health utilization. As part of my citizen-therapist responsibilities, I feel an obligation to take the information that I learned in this study and help break the stigma of mental health in the community that I serve. With the consumers' voices providing my vision, I hope that my efforts will have an impact in reaching others, including those who have been previously victimized and marginalized by the mental health system and feel voiceless.

On a final note, I found the participants' stories inspiring and motivating, and I am grateful for their trust in me to tell their stories. I also found inspiration in that I am part of an organization that has impacted the lives of the study's participants and has truly made a difference in their lives. As one participant in the study described "the ripple effect of working together" is the difference that makes the difference. The participants' stories reported throughout this dissertation also reminded me that there is no substitute for human kindness and care and its impact in the world, all of which have the power to transform lives.

APPENDIX A

RECRUITMENT FLIER

Hello. My name is Ginny-Lea Tonore, and I am a doctoral candidate in the Marriage and Family Therapy Program at Syracuse University. I am conducting a research study that will be exploring clients' experiences of behavioral health services, who are also receiving primary care services, at Primary Health Services Center (PHSC). I am inviting you to participate in the study. I have worked as a therapist in the Behavioral Health Program at PHSC for almost three years, and I am very interested in learning about your experiences of the behavioral health services provided here. The information gathered from the study may be used to improve these services.

To participate in the study you must: (1) be using or have used behavioral health services and medical services at PHSC; (2) be 18 years of age or older; and (3) not be a client of the researcher. Participation in the study is completely voluntary. Your decision to participate or not participate in the research will not interfere with the services you are currently receiving or will continue to receive in the future at PHSC. If you decide to participate, you will receive a \$25 gift card to Wal-Mart after completing an interview with me, which will take place at PHSC and last 1 to 1½ hours.

To learn more about the study, call me at (318) 325-7740 or (315) 569-1497 and simply state that you are calling about the research study. You can also email me at gltodore@syr.edu for more information. Additionally, if you would prefer that I contact you, you can provide your name and phone number on a sheet of paper and place it in the secure drop box, labeled research study, by the receptionist's desk in the behavioral health program.

I look forward to hearing from you, or if you leave your contact information in the research box, I will contact you. I will discuss the study in more detail at this time. If you are interested in participating and meet the study's inclusion criteria, I will schedule a confidential one-on-one interview with you. Thank you!

Ginny-Lea Tonore, M.A.
MFT Doctoral Candidate
Syracuse University

APPENDIX B
RECRUITMENT LETTER

To Whom It May Concern:

My name is Ginny-Lea Tonore, and I am a doctoral candidate in the Marriage and Family Therapy Program at Syracuse University. I am inviting you to participate in a research study that I am conducting for my doctoral dissertation. You are being asked to participate in the study because you have received both behavioral health and primary health care services at Primary Health Services Center (PHSC). Your involvement in the study is voluntary, which means that you make the decision to participate or not. Your decision, either way, will not affect the services you are receiving or will continue to receive at PHSC. I will discuss the study in more detail below.

I am interested in learning more about clients' experiences of receiving behavioral health services in a health center where they also receive medical services. I am curious about your perceptions of the services you have received at PHSC. If you decide to participate in the study, you will meet with me individually for a confidential one-on-one interview, where I will ask you questions about your experiences. I will also encourage you to share anything that you think is important for me to know about your experiences of receiving behavioral health services at our health center. This interview will take approximately 1 to 1½ hours of your time and will take place at PHSC. To participate in the study you must: (1) be using or have used behavioral health services and medical services at PHSC; (2) be 18 years of age or older; and (3) not be a client of the researcher.

You will be compensated for participating in the study by receiving a \$25 gift card to Wal-Mart after completion of the interview. Information gathered from this study may help PHSC provide better services to you and other potential clients in the future. Most research has been conducted from the viewpoints of healthcare providers, but I am interested in learning what you think, as someone who is using or has used the services.

If you are interested in participating or would like to contact with me with any questions or concerns about the study, I can be reached at the following phone numbers: (318) 325-7740 or (315) 569-1497, or by email gltonore@syr.edu for more information.

I look forward to hearing from you. Thank you!

Ginny-Lea Tonore, M.A.
MFT Doctoral Candidate
Syracuse University

APPENDIX C

INFORMED CONSENT

Project Title:

**Co-Creating Collaborative Health Care in a Federally Qualified Health Center:
Exploring Clients' Experiences of Behavioral Health Services**

My name is Ginny-Lea Tonore, and I am a doctoral candidate in the Marriage and Family Therapy Program at Syracuse University. I am inviting you to participate in a research study that I am conducting for my doctoral dissertation. You are being asked to participate in the study because you have received both behavioral health and primary health care services at Primary Health Services Center (PHSC). Your involvement in the study is voluntary, which means that you make the decision to participate or not. Your decision, either way, will not affect the services you are receiving or will continue to receive at PHSC. I will discuss the study in more detail below. You are welcome to ask me any questions about the research study or anything else involving the study that you do not understand. I will be happy to explain the research process in more detail and address any of your concerns.

The purpose of the research is to learn about clients' experiences of receiving behavioral health services in a health center where they also receive primary care services. I am curious about your perceptions of the services you have received. Information gathered from this study may help PHSC provide better services to you and other potential clients in the future. In addition, your experiences may help guide other behavioral health and healthcare professionals to create services that are more culturally appropriate to clients' needs, preferences, and desires. Through sharing your experiences, you may help increase awareness and knowledge that could be utilized to improve quality and accessibility of these services.

If you decide to participate in the study, you will meet with me individually for a one-on-one interview. The interview will take place in a private therapy room in the behavioral health area at PHSC. This interview will last approximately 1 to 1½ hours. You will be compensated for participating in the study by receiving a \$25 gift card to Wal-Mart after completion of the interview. The interview will be audio-recorded to ensure accuracy of the information you share and will be transcribed for future data analysis. After your interview tape is transcribed, I will provide you with a copy of the transcript, where you can make changes and corrections if necessary. Only if absolutely necessary, a follow-up interview may be arranged for further clarification of information shared or to discuss additional data.

All information will be kept confidential and locked in a secure place that only myself, and, my dissertation advisor, Dr. Linda Stone Fish, will have access. No identifying information will be connected with the tapes, transcripts, or any other documents

produced as a result of the study. A number and pseudonym will be assigned to all data, which protects your confidentiality and privacy. The tapes and transcripts will be destroyed after completion of the research project. If any information obtained in the study is used for publications or presentations, your confidentiality and privacy will remain protected by removing or changing any identifying information.

A benefit of participating in the study is that your experiences could provide an opportunity to inform healthcare providers about what has been helpful and unhelpful for you, as well as what improvements could be undertaken to enhance behavioral health services. Most research has been conducted from the viewpoints of healthcare providers, but I am interested in learning what you think, as someone who is using or has used the services. You may also enjoy discussing and offering feedback about your experiences. Your risk for participating in the study is anticipated to be minimal. However, it is possible that during the interview process, information you share with me could create feelings of emotional difficulty, such as anxiety, stress, anger, frustration, and so forth. To minimize this possibility, I will be asking very open-ended questions, which allow you to decide how much information you share with me. Should you need additional assistance, I am a licensed therapist, who can help you process your feelings, and other licensed therapists are available at PHSC. I can also make an appropriate referral if necessary.

You may refuse to take part in the research. If you decide to take part in the study and then change your mind, you can withdraw at any time without penalty. Your participation is voluntary and optional. Should you choose to withdraw after beginning the study, your compensation will be pro-rated to recognize your time and effort. The pro-rated method of compensation will be broken down to include \$5 for every 20 minutes of involvement in the study. In this situation, the pro-rated gift card will be mailed to you, or you can arrange a time to pick up the card at PHSC.

If you have any questions, concerns, or complaints about the research, you may contact me by phone: (318) 325-7740 or (315) 569-1497 or by email: gltonore@syr.edu, or my faculty advisor, Dr. Linda Stone Fish, by phone: (315) 443-3024 or email: flstone@syr.edu. You may contact the Syracuse University Institutional Review Board at (315) 443-3013 if (a) you have any questions about your rights as a research participant, (b) you have questions, concerns, or complaints that you wish to address to someone other than the investigators, Ginny-Lea Tonore and Dr. Linda Stone Fish, or if (c) you cannot reach the investigators.

All of my questions have been answered, I am 18 years of age or older, and I wish to participate in this research study. I give permission to be audio-taped in the interview. I have received a copy of this consent form.

Signature of Participant

Date

Printed Name of Participant

Signature of Researcher

Date

Printed Name of Researcher

APPENDIX D

QUESTIONS GUIDING INITIAL INTERVIEWS

1. Tell me about your experience of receiving behavioral health services at this clinic.
2. What is your experience of having primary care/medical services and behavioral health services in same place?
3. What does it mean to you that you are using behavioral health services? What are your beliefs about using behavioral health services?
4. What were your perceptions of behavioral health services before receiving services, and what are your perceptions now?
5. What helped you make the decision to pursue behavioral health services?
6. What, if anything, made it difficult for you to pursue behavioral health services?
7. What has been helpful about receiving services here? What has been unhelpful?
8. What advice would you give someone who was trying to decide whether or not to receive behavioral health services here?
9. How did you hear about the behavioral health services offered here?
10. What would you say this program is doing right, and what would you recommend we change to provide better services and reach more people?
11. What are your thoughts about the connection between your mental health and physical health?

APPENDIX E

FOLLOW-UP RECRUITMENT LETTER

To Whom It May Concern:

Hi! Recently, I mailed you a letter inviting you to participate in a research study about your experiences of receiving behavioral health services at Primary Health Services Center (PHSC), where you also receive primary care services. I am very curious about your perceptions of the services you have received. I believe that you may make a big difference in how these services are provided through sharing your experiences. Your voice may guide PHSC, as well as other healthcare professionals, in the appropriate direction needed to work together as a team and improve healthcare services available to you.

Please contact me if you are interested in participating in a confidential interview. I can be reached by phone at (318) 325-7740 or (315) 569-1497. You may also contact me through email at gltodore@syr.edu.

I look forward to hearing from you. Thank you for your consideration!

Ginny-Lea Tonore, M.A.
MFT Doctoral Candidate
Syracuse University

APPENDIX F

RESEARCHER'S COVER LETTER TO PARTICIPANTS (MEMBER CHECKING)

Dear Research Participant,

Hi! Thank you for meeting with me in an interview and sharing your experiences of receiving behavioral health services at Primary Health Services Center (PHSC), where you have also received medical services. I appreciate your openness and willingness to share your unique, personal story with me about these experiences. I have enclosed 2 documents for your review: (1) the verbatim transcript from our interview and (2) a researcher's summary, which is a brief "overview" of your behavioral health experiences from the interview. Would you please review these documents to ensure that I am accurately capturing your experience?

{Please note: As we discussed in our meeting, in order to protect your privacy and confidentiality, your name is not on the transcript or summary, instead you were assigned a participant number. Any other identifying information (names, locations, etc) in the transcripts will be changed or removed in the final analysis to maintain your privacy and confidentiality.}

After reviewing these documents, please tell me:

- Do the transcript and summary reflect your experience?
- If the transcript and summary do reflect your experience, is there anything you would like to add to your experience? [Please feel free to make any additions, if necessary, on the transcript and/or summary.]
- If the transcript and summary do not reflect your experience, how do they differ from your experience? [Please make any corrections and/or additions as needed on the transcript and/or summary to inform me of any inconsistencies/differences that can help me better understand your experience.]

I have also included a pen and an additional, blank comment page where you can further elaborate on your experiences if needed. Your experience is what is important, therefore please do not edit for grammatical changes. When you have reviewed the transcript and summary and have had an opportunity to make changes, additions, or further comments, please return these documents to me in the stamped, addressed envelope. You may also contact me by phone (318) 388-2128 or (315) 569-1497 or by email: gltonore@syr.edu to discuss your comments, or if you have questions or concerns.

It was a pleasure meeting with you and learning about your experience. I greatly value your participation in this research study and the contribution you have made through sharing your story. I look forward to receiving your feedback!

With warm regards,

Ginny-Lea Tonore

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