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Exploring the Implications of Culture in Integrated Primary Care: Perspectives of Behavioral Health Consultants

Shane J. Gill[1] & Carine Kambou
Thomas Jefferson University, Philadelphia, PA, USA

Brooke Mauriello
Atlantic Prevention Resources, Absecon, NJ, USA

ABSTRACT

Cultural adaptations to Integrated Primary Care (IPC) models have impacted behavioral health outcomes in Black, Indigenous, and People of Color (BIPOC), with varying results. However, researchers have yet to determine which culturally sensitive approaches in IPC have the greatest impact. Furthermore, no study has explored culture in the context of IPC or how cultural context shapes behavioral health processes for BIPOC patients, who are overrepresented in behavioral health diagnoses and underrepresented in services in the United States. This phenomenological study used semi-structured interviews to explore Behavioral Health Consultants (BHCs) definition of culture and how culture shaped screening, assessment, and treatment of behavioral health conditions in BIPOC patients in IPC settings. Thematic analysis revealed endorsement of White male cisgender heteronormative and use of White authoritarianism in medicine, both of which reportedly contributed to poor conceptualization of BIPOC patients' symptoms. Use of culturally sensitive and responsive frameworks in IPC, tailored to contextual factors that shape behavioral health outcomes in BIPOC patients were encouraged. Themes support an ongoing need to identify how culturally-sensitive and responsive frameworks are defined in IPC settings and the efficacy of these frameworks in reducing structural barriers across all levels of health systems. In doing so, cultural adaptations to existing models and interventions can be made to improve behavioral health outcomes for BIPOC patients.

KEYWORDS: Integrated Primary Care, Cultural Humility, Person-Centered, Socioeconomic Factors, and Americanism

Integrated Primary Care (IPC) has become increasingly widespread over the past three decades, incorporating behavioral health services into primary care (Vogel et al., 2017). Despite having common characteristics, differences in IPC integration impact patient health outcomes across populations. (Kwan & Nease, 2013; Vogel et al., 2017). Studies have examined whether these models improve mental health outcomes for racially and ethnically marginalized populations (Blackmore et al., 2022; Holden et al., 2014; Hu et al., 2020). Hu et al. (2020) conducted a systematic review exploring the effectiveness of the Collaborative Care Model (CCM) on improving depression outcomes for racially and ethnically marginalized populations. Researchers

[1] Corresponding author; is an adjunct in the Department of Health Sciences & Clinical Practices at Thomas Jefferson University and the CEO/Founder of the Center for Racial & Health Equity LLC. E-mail; shangil@mail.regent.edu

found that most randomized control trials implementing a culturally sensitive approach to depressive symptoms yielded positive outcomes for patients. Compared to the conventional CCM, a culturally sensitive CCM integrates patients' language and "messages" (Hu et al., 2020). The aforementioned approach allows providers to identify and understand patients' attitudes and beliefs about treatment (Hu et al., 2020). The CCM has also improved engagement rates and clinical outcomes in low-income persons (Blackmore et al., 2022; Hu et al., 2020). In a study measuring the impact of the CCM on depression and anxiety among low-income racially and ethnically marginalized patients, Blackmore et al. (2022) found high attrition (25%) after the initial treatment visit with a behavioral health clinician despite provider availability, provisions for psychotherapy, and scheduling accommodations. The authors noted that for racially and ethnically marginalized populations, cultural and socioeconomic factors previously identified were also reported by behavioral health clinicians in the study, warranting a targeted and assertive approach to address patients' needs and to promote patient engagement (Blackmore et al. 2022).

Although data on CCM demonstrate favorable outcomes in improving mental health across populations, research on target culturally sensitive approach and efficacy for racially and ethnically marginalized populations is lacking. These populations have a higher prevalence of mental health diagnoses, with persistent disparities in access to and engagement in mental health services (Mental Health Disparities, 2017). In an earlier study on their role in mental health treatment, Primary Care Physicians (PCPs) treated approximately 30% of patients who had mental health concerns (Faghri et al., 2010). However, recent studies have shown a rising trend in patients seeking mental health treatment from PCPs, accounting for nearly half of all PCP encounters (Caspi et al., 2024; Rotenstein et al., 2023). Despite this increase in treatment, treatment engagement and symptom improvement for racially and ethnically marginalized patients vary by provider type and characteristics (Eken et al., 2021; Huang & Zane, 2016;). CCM and Primary Care Behavioral Health (PCBH) are the most well-studied models in IPC (Vogel et al., 2017). Several studies have explored improved outcomes associated with adaptations to existing IPC models that address targeted mental health conditions (Kwan & Nease, 2013). Holden et al. (2014) proposed the use of *culturally centered integrated care,* a framework that emphasizes delivery of comprehensive quality care with an understanding of clients' cultural context (e.g., values, attitudes, beliefs, and identity), views the patient-provider relationship as a partnership, fosters cultural humility among providers, empowers patients, and embraces diversity (Holden et al., 2014). Researchers have previously investigated the impact of cultural adaptions to IPC models for racially and ethnically marginalized populations from physicians, nurses, and case coordinators perspectives (Blackmore et al., 2022; Henry et al., 2020; Hu et al., 2020; Manoleas, 2007). However, perspectives on the impact of CCM are limited to physicians, nurses, and care coordinators. Overrepresentation of these professions in studies on IPC limits our knowledge of other providers' perspectives on contextual factors that impact the efficacy of IPC and specifically, PCBH.

To date, no study has explored the definition of culture in primary care settings that use PCBH models; perspectives of how cultural context influences behavioral health screening, assessment, diagnosis, and treatment (hereafter referred to as behavioral health processes) in PCBH; and differences across racial and ethnic groups. Furthermore, studies on IPC and CCM have focused on primary care physicians (PCPs) and patients' perspectives, with few studies reflecting BHCs' experiences in IPC settings (Poghosyan et al., 2019; Toal-Sullivan et al., 2024; Woodward et al., 2024; Wrenn et al., 2017).

Thus, we aimed to answer the research question "*How do BHCs describe the role of culture in screening, assessment, and treatment of Black, Indigenous, and People of Color (BIPOC) patients with behavioral health concerns [in IPC settings]?*" Our aims were as follows: (1) explore BHCs' perceptions of the reasons that BIPOC patients seek counseling and assessment of

presenting issues, (2) identify BHCs' therapeutic approach in developing rapport and assessing racially and ethnically marginalized patients' concerns beyond universal screening, and (3) identify and evaluate the impact of BHCs' biases and their cultural background on understanding BIPOC patients' behavioral health concerns.

Methods

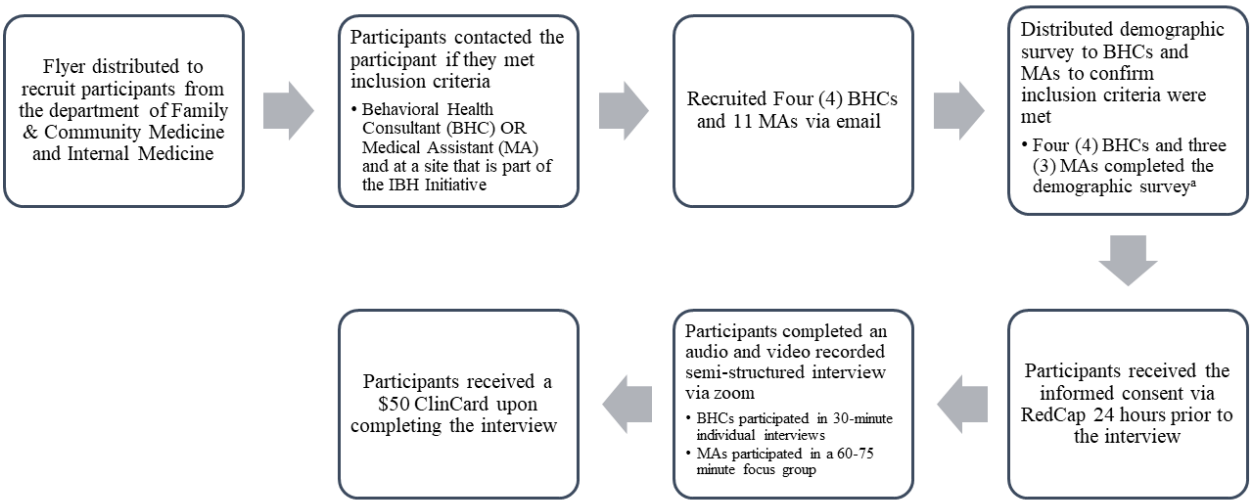
Study Design

This study applied the existential phenomenological framework (hereafter referred to as phenomenological framework) to investigate the phenomena of culture in IPC. Phenomenology is both a movement and approach in qualitative inquiry that explores the essence of a phenomena (defined as an object, subject of interest, or experience) relying on language to communicate the richness and vastness of ones' experience of the phenomena in question (Davidsen, 2013). Phenomena are described from the perspective of those who experience it, with intentional exploration of meaning persons given to their experiences, also referred to as the essence of a phenomena (Carel, 2011; Collingridge & Gantt, 2019). To study the phenomena of culture from the perspective of BHCs immersed in diverse, multi-, and inter-disciplinary primary care settings that implement IPC, we applied intersectionality theory, allowing us to explore identities that generally constitute culture, with deepening awareness of social identities, demographic characteristics, and multi-level structural factors that influence behavioral health processes and outcomes for racially and ethnically marginalized patients (Atewologun, 2018; Wilson et al., 2019).

Recruitment and Participant Selection

Participants were recruited from the study site's Department of [blinded for review] and Department of [blinded for review] within the [blinded for review]. An amendment to the original protocol was submitted to expand recruitment and increase the sample size following completion of qualitative interviews with PCPs. The recruitment process and selection of participants for this study are illustrated in Figure 1.

Figure 1
Study Design for Participant Recruitment



Note. This figure illustrates the process for participant recruitment, inclusion criteria, enrollment. The final number of MAs is three. Eight of the 11 were nonresponsive to the follow up to schedule and participate in the focus group.

Interview Protocol Pilot

The interview protocols for BHCs and MAs were developed using piloting, a method to increase rigor for qualitative and quantitative studies (Chenail, 2011). Piloting the sample interview questions was conducted using a group of four experts at [blinded for review] in the Department of [blinded for review]. Experts were defined as administrators, faculty, or clinicians within a primary care setting implementing the Integrated Behavioral Health (IBH) model, with familiarity with the duties and responsibilities of BHCs and MAs within that model, and experienced conducting qualitative research. Semi-structured interview questions were written as *open-ended* questions. The researcher adapted questions for BHCs and MAs using the original protocol developed by this PI for the first phase of this study for PCPs that was developed for the first half of this study, which explored PCPs' perspectives of how culture shapes screening, assessment, and treatment of patients who are BIPOC with behavioral health concerns (Gill & Mauriello, 2025). Experts reviewed questions independently to address issues related to bias identified by Chenail (2011): creating consistency in administration of questions; identifying ambiguous or difficult questions; removing questions irrelevant to the study's aims; and rewording questions to allow for diversity or range in responses and to mitigate researcher biases that may be inherent in questions. The interview protocol was revised and piloted on two occasions prior to approval.

Participants completed a semi-structured interview or participated in the focus group based on their role in IBH. Interview questions were based on a comprehensive literature review and designed to explore their definition of culture and the role of culture in screening, diagnosing and treatment recommendations for BIPOC patients with behavioral health concerns. Interview protocols were validated using piloting; members of the IBH team reviewed each question, identified potential outcomes of questions as written, and modified questions if necessary to align with the research question. All interviews were recorded using the audio and video feature on Zoom. Interviews were transcribed using an experienced professional transcriber through Rev.com.

To confirm their accuracy, transcriptions were compared against the audio and Zoom-produced transcription at the end of each interview.

Research Team, Positionality, and Reflexivity

The research team consisted of a postdoctoral research fellow (PI), research coordinator (Co-I), and student (study personnel). The intersecting identities of research team members and personal interests in racial and health equity in primary care impacted collaboration, data analysis, and perspectives on the implications and utility of the study in addressing contemporary approaches in behavioral health and medicine. Our perspectives include intersecting racial and ethnic and national identifies (African American/Caribbean (Jamaican ancestry), African (Cameroonian/Burkinabé), and White/Italian/Southern European), lived experience (history of mental health diagnoses by primary care and other mental health providers), and discipline (counselor education and supervision, mental health counseling, public health, health sciences and medicine). All parties identified as born female and cisgender, with two verbalizing experiences of being considered part of a minority group due to race and ethnicity. Positionality was explored, including definitions of minority and majority, and how a perceived position of power could have impacted interactions between the researchers and participants. The research team engaged in an iterative process of self-disclosing general reactions to the data to promote present-awareness and objectivity throughout data analysis.

All investigators were encouraged to engage in reflexive processes throughout the duration of the study using analytic memos (Saldaña, 2021. Investigators maintained a record of their reaction (defined as investigators 'attitudes, beliefs, assumptions, and biases) using annotations in NVivo; Process annotations were based on their positionality relative to the research and social identity by highlighting relevant text in each transcript and adding their reaction as comments in the margin section. Reactions to and understanding of the data were explored prior to and at the conclusion of each coding session with the investigator's partner. All investigators were trained in the use of bracketing, open-ended questions, probing, and challenging to engage peers in exploring how their reaction could influence coding patterns.

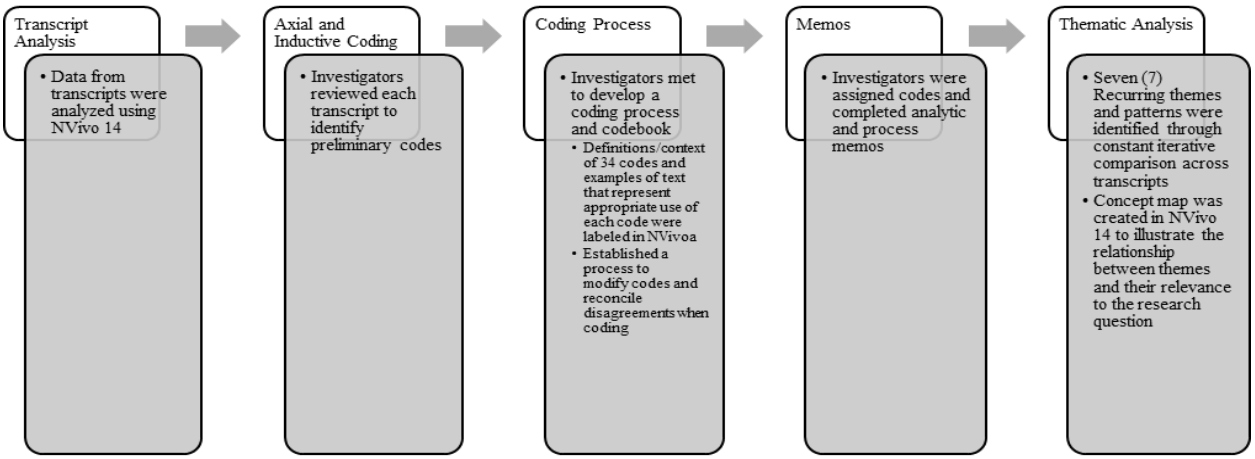
Data Exclusion

Prior to assigning memos, the PI determined that an interviewer deviated significantly from the interview protocol for MAs. Deviation from the interview protocol jeopardizes internal and external validity, and consequently, the degree of transferability for this population (Malterud, 2001). The IRB was notified of the finding, and discretion of excluding the data was given to the PI. As a result, data for MAs was excluded from thematic analysis.

Thematic Analysis

All investigators met for a thematic analysis session upon completing memos. Reflection occurred during thematic analysis, with team discussion of reactions to the data. Investigators explored the relationship between codes, with similar codes being classified as a theme. Figure 2 illustrates the data analysis process and development of themes. Themes were named and defined using a concept map to illustrate how each theme related to the research question.

Figure 2
Data Analysis Process



Note. This figure illustrates the five phases of qualitative data analysis with constant comparison and reflexivity occurring at each stage of analysis.

[a]31 codes were organized into seven themes. Three of the proposed codes were excluded as there was no data to support their use or relevance to the research question.

Results

Participants' Characteristics

We interviewed four BHCs from three sites across [blinded for review]. BHCs were encouraged to describe their racial and ethnic identity. Three BHCs self-identified as White and one self-identified as Black. One BHC who self-identified as White, described their ethnicity as Eastern European. The sample consisted of one male and three females, with three BHCs describing their gender identity as cisgender. On average, BHCs were employed at [blinded for review] for 4.3 years; however, they had significantly more years of experiencing in clinical practice and providing behavioral health treatment (12.3 years and 12 years average respectively). Due to the homogeneity of the sample, pseudonyms and other labels were not used to protect the identity of participants. Sample characteristics are represented in Table 1.

Table 1

Characteristics of Behavioral Health Consultants (BHCs) within Co-Located Primary Care Behavioral Health (PCBH) Sites at Jefferson Health

Characteristic	Family & Comm Medicine (DFCM)-Center City (n =1)	Internal Medicine-Center City (n = 1)	Jefferson Health Abington (JHA) (n = 2)	Total (n = 4)
Mean Age (Y)	Declined	32	44.5	40.3 (32-53)
Men	----------	32	----------	32
Women [a]	Declined	----------	44.5	44.5
Sex				
Male	----------	1	----------	1
Female	1	----------	2	3
Gender				
Cisgender	----------	1	2	3
Prefer Not to Say [b]	1	----------	----------	1
Race				
White	----------	1	2	3
Black or African Amer.	1	----------	----------	1
Mean Years in Practice [c]	No Response	2	17.5	12.3
Mean Years Providing BHC Treatment	11	2	17.5	12
Mean Years in Practice at Thomas Jefferson Univ.	6	2	5	4.3

Note:

[a] Characteristics of the sixth participant are not represented in the table due to non-response to the survey

[b] Average age for women does not include data from one participant that self-identified as female. The participant declined to answer the question pertaining to age in the survey

[c] Average years in practice does not include data from one participate

Themes

Seven unique themes were identified surrounding this worldview: Eurocentrism-Americanism, cultural alignment, structural inequity, relationship dynamics, patient-first wellness-centered approach, cultural framework, and systemic outlook. The definitions of themes and full quotes to illustrate these themes are illustrates in Appendix 1 Table A1 and A2.

Theme 1. Eurocentrism-Americanism

Participants defined culture as the intersection of multiple identities (i.e., race, ethnicity, religion, financial status, and language). These identities were described by BHCs as being shaped by the interaction between one's family, neighborhood, and community. One BHC elaborated on this definition, stating that culture is comprised of "customs" and "values" that are agreed upon and inform how people present and behave.

> "I define culture by commonalities that are identified by language, commonalities and shared experiences that others may not be familiar with. I also define culture by how people do life, how they show up and how they do life, and that these are agreed upon values and mores and customs... You can take two couples, put them in the same room, and they're different." (Interview 4)

The intersection of the factors reportedly influenced patients' "cultural framework." Cultural frameworks were defined as perspective of self, others, systems (e.g., the healthcare system), and the world. One BHC reiterated that differences in cultural frameworks influence how mental health is defined and the presentation of mental health concerns across cultures. "...Mental health I think is so nuanced... talking about cultures, maybe different countries or places in that regard may have a different relationship in terms of what mental health is or what mental health care looks like" (Interview 1).

One BHC described reductionism, or the use of quantitative "data" points, as the current approach used by providers in screening and assessment of behavioral health concerns. From her perspective, quantitative measures are necessary; however, they should not be relied on as the sole source of information when assessing patients.

> We have always and historically tried to align medicine with white cisgender care, and that's not right... So, I really do think that it's up to individual providers to use the tools that we currently have that we need to use, and using them in a way that is filled with cultural humility, that is filled with conversation and clarity, and not taking a number as the only data point... So, I think that those single data points that we use, it is a point, I get it. We need some form of measurement to do good work, but that shouldn't be the only form of measurement... (Interview 2)

Overall, provides described culture as multifaceted and commonalities or shared characteristics among groups of people. These characteristics shape behavioral norms with variation across groups. Eurocentrism-Americanism, a cultural framework that aligns white cisgender persons as the standard in medicine, limits use of other forms of measurement that promote cultural humility.

Theme 2. Cultural Alignment

BHCs labeled and described the intersection of their identities, demonstrating awareness of what these identities may represent to patients. From their perspective, representation contributed to real and perceived bias and discrimination experienced by patients. One BHCs reported being hyper-aware of her identity in cross-cultural interactions, which she described as a "conscious bias" of "what [she] represents." When asked about how patients' race and ethnicity influence how BHCs assess and understand patients' symptoms or concerns, one BHC expressed awareness of White authoritarianism in social services—consequently, the experiences of BIPOC patients with social providers as a driver of fear in this population.

> But to me, sometimes my conscious bias is that I'm representing white authoritarian medicine. I think I have an unconscious... Not an unconscious. I have a very conscious bias that I also represent, and when people hear social worker specifically from the BIPOC community, that that can be very scary... I could represent something that's very reassuring to the BIPOC community, but I tend to take the lens that I represent kind of what's wrong with these systems. (Interview 2)

Race and ethnicity were dominant identities in the discussion of factors that shape BHCs' understanding of behavioral health concerns in BIPOC patients. However, one BHC acknowledged that knowledge of social determinants (e.g., exposure to poverty and trauma) and other identities important to patients (e.g., faith, language or English proficiency, phonological speech characterized as an accent, and personality traits (such as emotional intelligence, etc.) also enhanced self-awareness of personal triggers that can impact BHCs preferences and interaction with patients.

> God's working on me...I remember this one really showed me my bias. So, an elderly woman from a Latin country just arrived in America a few years ago after her husband passed away... She didn't speak English at all. So, her son was there and he was translating or interpreting... And I said, 'Well, can I ask what caused you to come?'... "[She said] 'and I think maybe on that day I was feeling a little down, but I'm fine. I don't really need your help.' And then she just was so adorable and Latin and full of laughter. And ...it was like shame came over me. I just said, "I cannot believe I was so", and I think I couldn't connect with her. (Interview 4)

When asked to identify and name their conscious biases, most BHCs prefaced their self-disclosure with statements about intentionally not making assumptions and treating all people equally to foster empathy and respect. For one BHC, lack of empathy or care was a driver to exploring shared experiences with patients.

> I try to check myself about this, but I think maybe there's empathy that may be potentially missing, and it's not like I go out of my way, I don't care, but it's just our lived experiences are different. So maybe I have a hard time understanding what it's like to be a Black person or what it's like to be an Indigenous person because that's just not my lived experience. But I try to find overlap or commonality, I guess, to foster that empathy. (Interview 1)

BHCs elaborated on the impact of perceived racial incongruence in cross-cultural interactions. Patients' assumptions about providers' Race contributed to some patients' assumptions about BHCs lived experience and ability to relate to unique experiences of BIPOC patients. For example, one BHC who self-identified as a cisgender White and Jewish woman, described an encounter with an African American female patient and the impact of racial tensions stemming from the deaths of George Floyd and Breonna Taylor on patients' provider choice.

> This actually just triggered a whole [other] memory of a patient I worked with through the pandemic, through the murder of George Floyd, Breonna Taylor. And she said to me... At the end, we had worked with her PCP, who's also white, cisgender female. And she had said, "I had almost stopped seeing all white providers. But the way that you and the other provider just talked to me, tried to understand where I was coming from, even though you knew you could never understand it, helped me through. (Interview 2)

In addition to race and ethnicity, language, religion, and spirituality shaped interpretations and meanings of patient experiences. These factors impacted alignment with Western medicine and how conditions and experiences are understood. One BHC detailed the implementation of universal screening tools, such as the PHQ-9 and GAD-7, and differences in how patients interpret questions, resulting in different meanings across languages. Awareness of differences in translation was described as crucial when communicating with patients, suggesting that one must take caution not to assume sameness in assigning meaning.

> Well, I'm thinking of screeners that I administer, like the PHQ-9 and the GAD-7 and the PCL-5. I don't know. I guess I'm thinking about, I have one patient and they're Portuguese-speaking and I have to be mindful of how certain things are translated and received, and so I'm thinking about language differences and maybe leading to certain language barriers. (Interview 1)

Most BHCs reported that patients' choices in providers vary; some patients are intentional about choosing a provider who "looks like [them] while others seek providers that are "different," with an assumption that the BHC has different life experiences. Perceived racial congruence is one of many factors that influence patient-provider interactions. Most expressed taking the initiative to assist in submitting referrals based on patient preferences.

Theme 3. Structural Inequity

BHCs described their experiences with the IBH model at their institution as “in a major flux” and “not under one roof” while also admitting that they “don’t know a lot of the people who are referring to [them].” They detailed a model of care within the practice, departmental, and institutional levels that is fragmented, depersonalized, and reliant on outsourcing referrals, hindering the care of marginalized patients. These experiences were widespread despite variations in practice size and structure, satisfaction with the IBH model, and differences in the referral processes across practices. BHCs stated that simplification and [destigmatizing] behavioral health services would improve marginalized patients’ ability to navigate their care, yet this is often not the case in many healthcare systems. When how the department uses social work teams to meet the unique needs of their marginalized patients, BHCs discussed limited cohesion within the team.

> I don't work under one roof, and there's so many different services. It's more of a splintered experience here...We're kind of all splintered, and so it's not as easy to just refer someone to a social worker, to be honest with you. (Interview 3)

Lack of a centralized and structured system reportedly led to inequality in care for racially marginalized populations receive. They reported that the current inequitable system has worsened due to the following factors: high turnover, lack of staff, limited funding, unmet role expectations, and minimal departmental support. Views on the scope of their role and levels of integration into the patient care process varied. Differences in perspectives about duties and obligations to patients impacted their ability to provide them with proper treatment and access additional services to address unmet needs. When asked how they help BIPOC patients receive additional support services and what they tend to recommend, BHCs mentioned the systemic hardships these populations face when seeking these services. One BHC stated, … "I also know that those systems are very difficult to navigate, and they're historically difficult to navigate, again, for systemic, conscious and unconscious, racist and bias forming of it. Who should receive services and who should not receive services?" (Interview 2)

Notable structural factors at the structural and institutional level were drivers on inequitable care for racially and ethnically marginalized patients. Overall, BHCs differed in how they perceived their role and duties, widening inequity in treatment.

Theme 4. Relationship Dynamics

BHCs reported that all aspects of patients' identities shape how patients express their culture. Patients' attitudes and beliefs about mental health and customs influence their openness to sharing mental health concerns. For some groups, BHCs reported that expressing mental health concerns may lead to stigma and disparities.

> ...Certain cultures believe that it's a stigma to receive mental health...if you're disenfranchised or on the margin, just that anxiety about being seen, having to unpack. I think that if certain individuals come in with that mindset, you may not get accuracy because those agreed-upon terms and customs and ideas can influence how a person shows up in the session and even answers. (Interview 4)

BHCs reported that values and recognition of mental health concerns in some populations influence engagement in mental health counseling. Other populations endorsed culturally acceptable alternatives recognized in their communities. BHCs' identities impacted how they conceptualize behavioral health and engage with diverse patients. One BHC reported that Whiteness and masculinity, for example, were identity factors that patients may associate with knowledge or power. Being perceived as a "knowledgeable source" or having power was described as advantageous in some circumstances. For other patients, this BHC indicated that differences in identity impacted trust and openness.

> ...I think, and maybe I'm overthinking it, but I think socially speaking it's like, oh, you're a white man and there's a lot of privilege attached to that, and I think it's kind of sometimes it can be like, okay, well I'm going to trust you as this knowledgeable resource. Maybe not knowledgeable is the right word, but as this person because of the power association, and other times it's like—you don't share my identity, so I can't trust you or I can't open up to you. (Interview 1)

Patients' identities shape attitudes and beliefs about traditional approaches to counseling. For some populations, mental health was not widely recognized which influenced help-seeking behavior. In some instances, BHCs identity afforded them power in the relationship, with patients trusting in their knowledge. For others, perceived differences lessened trust and openness in relationships.

Theme 5. Patient-first Wellness-centered Approach

The Person-Centered (PC) therapeutic modality was endorsed by all BHCs and recognized as their primary clinical approach. Challenges related to race and ethnicity were not identified as drivers of help-seeking in patients. one BHC elaborated on how she identifies social determinants that impact patients' welfare and how she introduces additional clinical recommendations to address these needs. She described herself as a mediator, assisting in the referral process for additional services to address presenting concerns that impact treatment.

> ... I am that mediator for them. So, if they're virtual, I put them on a three-way, and I'm that bridge for them to help them get comfortable speaking to entities they don't know... I do the referral during the session, and I let the

> patient know the social worker will be reaching out to them within 24, 48 hours so that they know that there's a team that they're being heard... (Interview 4)

Two BHCs denied differences in their clinical approach with BIPOC patients. For example, one BHC stated, "I hope...that I'm giving the same amount of time, attention, and respect to everybody equally, no matter where they come from or their experience..." Sameness and equality were described as the "universal we" by one BHC. She reported using the universal we to acknowledge true differences between groups and avoid "[ignoring] the obvious."

> ... And when I use things, I use universal we. I use a universal we. I use a very humanistic approach. So even if we are coming from different backgrounds and cultures, and that can be seen, again, right off the bat by the color of my skin or by my gender, that I still go back to the fundamental principles of our physiology, and how we are always trying to cope and manage different situations. And I explore that through that way, using a contextual interview. (Interview 2)

Despite having a shared treatment approach, BHCs differed in the use of universal screenings. Patients receive the Patient Health Questionnaire (PHQ-9) and Generalized Anxiety Disorder (GAD-7) during intake and routine appointments. BHCs varied in their selection of additional screening tools and informal means of collecting patient information; interventions went beyond the PC approach, such as contextual interviews, incorporating an array of skills (e.g., SMART phrases and open-ended questions) to foster a relationship with patients that would allow them to probe further to understand symptoms and explore discrepancies in symptoms reported on screening tools and the contextual interview.

> ... I'll give different measures, like the PHQ-9 for depression, the GAD-7 for anxiety, PCL-5 for trauma. Those are the ones I mainly give. And then we have an intake, I guess smart phrases... And so, we have what brings you here, what are your presenting issues, what are your goals? And so based off of all those questions, both quantitatively and qualitatively, like I said, I usually make an assessment. (Interview 1)

BHCs unanimously endorsed the PC approach for counseling but differed in using universal screening tools. BHCs described deviating from enumerating symptoms and solely relying on the total or composite score of universal screening tools. Clinical interviewing skills were necessary to identify the cultural context of behavioral health concerns. Patient concerns and perhaps the "root" of their symptoms may be due to reasons not specified on referrals, which often reflect medical conditions. The presence of medical conditions may cause or exacerbate existing behavioral health concerns. Failure to validate situational factors and, ultimately, context could result in what one BHC described as “demonizing,” perpetuating racism and discrimination.

Theme 6. Cultural Framework

Whiteness and authoritarianism in medicine, an approach in which the provider is the expert in helping relationships, was described as influencing BHCs understanding of patients’ cultural framework and presenting problems. One BHC asserted that providers must intentionally dismantle this framework and belief system to create safety for BIPOC patients.

> ...When I think about historical traumas within healthcare of the BIPOC population, how many times has a white person said, ‘I'm the expert, you are not. And I am going to not tell you X, Y, and Z’? And it still happens today. So, trying to dismantle that authoritarian approach is actually

> probably something that I'm quite intentional about, and more so with BIPOC patients. (Interview 2)

According to one BHC, Whiteness and being a cis-gendered male shape how BHCs are perceived. When asked how culture shapes current screening, assessment, and treatment practices, he described "mindful[ness]" as key due to cultural differences that influence diverse patients' recognition of and meaning given to experiences widely known and accepted in Western culture.

> ...I guess I'm thinking about just my identity and maybe how it's being received as a white cisgender man and working with patients... I see religion comes up a lot and faith and spirituality, and so I think one question is—have you had thoughts about killing yourself or harming yourself, and how in a religious way that could be seen as maybe potentially insulting or like—I would never do that because of my faith-based practice. And so, I think being mindful of that. (Interview 1)

Two BHCs reported that minimal efforts to understand diverse patients impacts patients' help-seeking behavior and engagement with providers. BHCs asserted that cultural humility, endorsing the belief that "I am not the expert in you," shifts to a value-based approach, with providers becoming aware of culturally-bound factors that are important to patients. This sentiment was echoed, with another BHC describing cultural humility in practice; seeking education from patients about their culture, inquiring about culture references and terms, customs, and identifying patients' preferences allowed this BHC to incorporate aspects of what is unique and important to patients in sessions and overall treatment.

BHCs shared that language influences patient engagement during behavioral health screening and assessment. With most screening and assessment tools available in English, BHCs relied on third-party translators when assessing persons with limited English proficiency. One BHC reported experiencing mistrust in using the language line, stating that information can be misinterpreted due to linguistic differences, impeding translation for patients with limited English proficiency and non-English-speaking patients. For this same reason, some BHCs would adapt their approach when administering universal screeners; BHCs reported completing screeners during sessions for patients who had difficulty in reading and comprehension, educating patients on language to use when describing their current emotional state, and modifying language to describe the frequency of symptoms (e.g., small, medium, or large) to more familiar terms.

> ... So, before they became available in Epic, we used to just have the screening tools as papers, and I would give them to the patient. And I noticed some of them would struggle, and I used to be a school teacher, so now I ask... So, in terms of the administration, when they're with me and I administer to them, I use language such as small, medium, large, or not at all, rather than whatever it is. (Interview 4)

The cultural framework used to screen and assess patients is White, male, and cis-gendered. Cultural humility was an approach demonstrated when making cultural adaptations in treatment.

Theme 7. Systemic Outlook

Some BHCs described the first step to creating system-wide change as the development and indoctrination of the current white, heteronormative male system, centered around power imbalances and healthcare providers being "taught that they're the expert" not the patient. Thus, BHCs recommend a shift of power towards more marginalized communities, along with a change in their early education and training that incorporates the needs of these communities. When

discussing what can be done to improve current behavioral health processes and better engage BIPOC patients, reforming the current system was at the forefront.

> I do think that there needs to be an intentional dismantling of white, heteronormative, cisgender male culture…But you have to give power. When we think about power and control, if the people in power aren't sharing the power, then it doesn't matter what happens down below. (Interview 2)

A few BHC mentioned an inequity among who is being given the opportunity to become healthcare workers and how the current system is "now promoting people who can pay for it versus people who should be doing it." They also elaborated on biases, racism, and power dynamics within this system that contribute to limited representation and reflection of marginalized communities in the healthcare system, a lack of humility in patient care and interactions, and professionals who are not trained on "how to be a human" and address their bias and prejudice when treating patients. She stated, but to me, a good medicine program would be like, 'Yeah, we can train you how to do all your facts, but let's actually train you how to be a human. Let's do that and let's really confront those things. (Interview 2)

On a micro level, when addressing patients' social determinants of health (SDoH), some participants critiqued the IPC model for its inability to cater to the needs of diverse populations, including access to language and translation services; help navigating their insurance and associated benefits; and help with other housing and transportation needs that BHCs place in the "case management-esque category" and that are handled by an outside collaborator such as a social worker. A BHC recommended their institution identify patient needs and cater resources and partnerships to these needs to improve health outcomes for underserved persons.

> Definitely researching I would say how [my organization] could begin to partner with entities within Philadelphia who want to provide upliftment in these particular populations…So I would say maybe one [preventative protective factor] is to just kind of check the pulse and maybe get some surveys about patients specifically with that in those needs. (Interview 4)

Discussion

The present study was able to define culture and characterize its elements. Our findings suggest that culture does impact behavioral health screening, assessment, and treatment of BIPOC patients in IPC settings. The most important conclusions from the study are that White, cisgender, male, and heteronormative culture in medicine, hereafter defined as Eurocentrism-Americanism, is embedded in our healthcare system and can be a driver of differences in BHCs' approach in screening, assessment, and treatment of BIPOC patients with behavioral health concerns. Within this culture of medicine, Eurocentrism-Americanism describes both a philosophy of normalcy and a framework, that influences institutional policies and departmental approaches. Furthermore, in the absence of cultural humility at the provider level, this philosophy and framework maintains an authoritarian approach, with providers failing to acknowledge the power differential created in patient interactions (Ranjbar et al., 2020). Cultural humility is essential to create safety and reduce the risk of exacerbating trauma resulting from a limited understanding of sociocultural context that shapes patients' experiences, contributing to unintentional discrimination, and driving inequity in behavioral healthcare for racially and ethnically marginalized persons (Franks et al., 2021; Ranjbar et al., 2020).

The patient-first wellness-centered approach described in our data deviated from the idea of race and ethnicity being the most important cultural factor, with BHCs endorsing the importance

of intersectionality and empowering patients to explore identities that define and impact them (Fisher-Borne et al., 2015). BHCs advocacy for eradicating Eurocentrism-Americanism echo a call and efforts to declare racism as a public health crisis in Western medicine (Johnson-Agbakwu et al., 2022; Paine et al., 2021; Sexton et al., 2021). This declaration warrants the following: accountability on the part of providers to acknowledge the mechanisms by which inequity is created and maintained systematically through perceived White superiority and White supremacy (Paine et al., 2021); adopting race-conscious practices in which race, identity, and weaponization of race in medicine are acknowledged as drivers of adverse outcomes for persons of color (Paine et al., 2021; Soled et al., 2021); and the necessity of populations impacted by these systems to be included in mobilization efforts to determine the use and allocation of resources to effect change across systems (Paine et al., 2021).

Current practices in psychiatry used to evaluate and conceptualize behavior are founded on a European-American framework (Atdjian & Vega, 2005), with many mental health professionals and psychiatrists endorsing the belief that biological determinism is sufficient in describing the etiology of diseases and disorders (Malott, 2007; Shim, 2021). Rooted in scientific racism, this belief ignores social and environmental factors that influence behavior, with ethnocentrism contributing to overvaluation of one's own cultural values, attitudes, beliefs, and biases (Malott, 2007; Schouler-Ocak et al., 2021). One BHC in this study labeled the contemporary approach of defining behavioral norms and assessing mental health according to the European-American framework, identifying the intersection of identities (i.e., White, cisgender, male, and heterosexual) to describe the ideal or model patient in America. Two BHCs elaborated on social, economic, and environmental factors that could be ignored with the traditional approach and speculated that reliance on universal screening and the Diagnostic and Statistical Manual for Mental of Mental Disorders, 5th Edition (DSM-5) contributes to limited knowledge of SDoH, also referred to as contextual factors, that are drivers of and exacerbate mental health conditions and symptoms in racially and ethnically diverse populations (Braveman et al., 2011). Overreliance on universal screening tools impacted BHCs awareness of contextual factors associated with patients' behavioral health concerns. Existing frameworks on culture are designed to define and provide guidance on implementing strategies to promote cultural competence and awareness of contextual factor that impact patient health outcomes within and across healthcare organizations (Betancourt et al., 2003; Castillo & Guo, 2011).

Inadequate access to health-related materials such as assessments that are culturally or linguistically inconsistent with the patients' identity pose a structural barrier due to unnecessary complexity of the system and a system that does not reflect the diversity of its patients (Betancourt et al., 2003; Handtke et al., 2019; Peréz-Stable & El-Toukhy, 2018). Despite access to translation services and interpreters, one BHC expressed concern about interpreters' knowledge of mental health conditions cross-lingual translation and interpretation of phrases in the screening tools words or phrases that could not be translated and how these factors influence patients' behavior on response items. Prior studies support the benefit of using interpreters to enhance communication between patients and providers, increase satisfaction (Ferguson & Candib, 2002), and improve overall quality of care (Al Shamsi et al., 2020). However, systematic reviews on cultural and language concordance reveal several limitations that impact health outcomes in racially and ethnically marginalized populations (Aggarwal et al., 2016; Ferguson & Candib, 2002; Hsueh et al., 2021). In settings that implement CCM to treat mental health conditions, cultural context (patients' use of language and vocabulary used to narrate their history and describe symptoms) is an aspect of medical communication that influences topics of discussion during patient encounters and shapes patients' concerns about physicians' use of power and control due to intercultural differences with patients (Aggarwal et al., 2016; Alkahamees & Alasqah, 2023). Consistent with

earlier findings, BHCs acknowledged patients being the expert and the need to shift the power differential in the patient-provider relationship. However, our findings do not support the differences in communication style between providers and patients during intercultural encounters. Evidence of cultural humility during patient-provider encounters was a consistent finding among all participants and described as crucial in rapport building with vulnerable populations.

Relationship-centered care in primary care emphasizes cultural safety and whole-person care (Fletcher et al., 2021), empathy, healing, and continuity of the relationship. Continuity of care (COC) has multiple dimensions. The first dimension is the duration of the relationship, and the second dimension is trust and responsibility, which can improve physicians' understanding of symptoms, use of diagnostic testing, and shared decision-making (Fiscella et al., 2004). BHCs generally reported using a PC approach, emphasizing this modality as allowing them to understand the universal experiences of all persons, regardless of race, ethnicity, sex, gender, and other characteristics. Although the brief-solution-focused approach is typically used by BHCs in IPC (Mann et al., 2016), BHCs reported using the PC modality for all patients and contextual interviewing to understand the whole patient and how patient characteristics impact wellness. Exploring the "root" cause of patients' concerns and identifying situational factors that cause symptoms allow providers to develop meaningful relationships with patients and make appropriate referrals for treatment (Davis et al., 2018).

Barriers and facilitators of IPC have been identified across multiple levels within the health system, having unique effects on different populations (Maruthappu et al., 2015; Threapleton et al., 2017; Wakida et al., 2018). Concerns about processes for outsourcing referrals for behavioral treatment echo a need for standard practices in healthcare systems [blinded for review] health system. Standards of practice that enable providers to identify patients' needs and risks are essential to improving equitable outcomes for patients throughout the continuum of care across healthcare systems (Maruthappu et al., 2015). BHCs' identification of departmental and institutional contributors to structural inequity mirrors earlier findings including instability within the health system (e.g., turnover); lack of funding for integration; lack of joint training in the IPC model and its integration for all providers; providers not being co-located; and time and staffing constraints (Beacham et al., 2012; Threapleton et al., 2017; Wakida et al., 2018). Shared values are essential to overcome these systemic barriers, warranting new or revised policies to promote a culture that supports the integration of IPC (Maruthappu et al., 2015; Threapleton et al., 2017).

Some BHCs described cultural humility as necessary for change in education and training to disrupt the continued impact of Eurocentrism-Americanism on patient health outcomes. At the macro- and micro-level, cultural humility and structural competence must be present to disrupt Eurocentrism-Americanism and cultivate an inclusive and equitable culture (Metzl & Roberts, 2014; Shim, 2021). Mechanisms that impact the effectiveness of IPC across the [blinded for review] health system were identified in the study, however, the infrastructure to support a centralized system and how it could improve efficacy to deliver services and health across populations was not explored. Change Teams (defined as teams that consist of multi-racial and ethnic members that represent all levels of the healthcare system as a whole and the institution) are necessary to create an infrastructure that supports changes in policies and practices (Griffith et al., 2007). Teams determine how resources are allocated and conduct ongoing assessments of contributors to racial and health inequity (Griffith et al., 2007). Consistent with BHCs' statements on co-location, decentralized services contribute to uncoordinated communication and care (Wakida et al., 2018). Alliances must be created between interdisciplinary professionals who serve marginalized patients to address complex needs and increase collaboration between services (Metzl & Rogers, 2014; Wakida et al., 2018).

Co-location or a centralized system is the infrastructure that strategically places key members and stakeholders near to increase planned and intentional communication, professional, knowledge, and shared information, strengthening relationships across all levels of the health system (Griffith et al., 2007; Threapleton et al., 2017; Wakida et al., 2018). This interdisciplinary, collaborative, multi-level, systems-based approach gives health systems and providers a global perspective and opportunity to opt out of reductionism. A reductionist philosophy assumes that biological factors and race or ethnicity are the primary determinants for adverse health outcomes (Braveman et al., 2011). Although race was identified as a contributing factor, BHCs reiterated the use of race and historical racism as contributors to inequitable systems that prove to be disadvantageous. However, geographic location, education, employment, and access to economic opportunity were also notable in BHCs comprehensive assessment of contributors to presenting problems, impacting their ability to make choices that reduce health-related risks (Braveman et al., 2011). Physicians and other team members are vital for accessing and allocation of funding; funding efforts should be targeted to promote incentives for stakeholders and tailored to the health needs of the patient population to improve total health outcomes in IPC (Maruthappu et al., 2015; Threapleton et al., 2017).

Limitations

There were several notable limitations for this study. Sampling was restricted to three of the nearly 100 primary care centers at [blinded for review], limiting generalizability. Our sample was not representative of all parties in the IPC and PCBH model. With BHCs being the only group represented, external validity of our results to other behavioral health providers in the IPC and PCBH was affected. The small sample size limits the scope of our understanding of the complexity of culture and how it impacts behavioral health processes. Due to the homogeneity of staff and BHCs, diverse perspectives of BHCs with varied identities (e.g., race, ethnicity, gender, age, etc.) was not captured. Lack of representation in the sample could have led to unintentional sampling bias. Members of the research team disclosed their identities, with the PI facilitating dialogue on the impact of these identities through the research process. Although identities were named and disclosed, researchers did not engage participants in exploring how their identities shaped responses during the interview. Inclusion of persons that identify as non-minorities and collaboration with non-clinical personnel on interpretations of data could improve reflective practice and allow for robust discussion on exploring the role of identities in cross-cultural interactions in research. Interview effects must be taken into consideration when analyzing participant responses to sensitive questions.

Semi-structured interviews are appropriate to answer complex questions using an open-ended format to probe directly for biases. However, this interviewing structure hindered exploration of how patient characteristics impact BHCs understanding of symptoms and influence decision-making. A structured interview using standardized questions could allow for direct assessment of biases due to differences in identities and outcomes in IPC and PCBH settings. This approach would reduce bias, improve reliability and validity, and allow for direct comparison across participants. Purposive sample was used to recruit participants; however, we did not inquire about differences between participants and non-respondents, further limiting our understanding of how this impacts response patterns to questions. Considering these limitations, future research on cultural context and behavioral health processes in IPC and PCBH should engage all behavioral health providers in the IPC and PCBH model. A direct assessment of cultural context and factors is warranted; Structural, institutional, and practice factors and direct effects on patient engagement in referral is essential to quantify equitable care in behavioral health for diverse populations.

Implications for Future Research

Integrated primary care intends to enhance collaboration between healthcare teams to improve overall patient health outcomes. When exploring culture in our research, the main focus was the BHC perspective of culture's impact on behavioral health processes. Future research would incorporate the perspective of patients and MAs to explore similarities and differences in how culture is defined and the impact on behavioral health processes within the IBH model. Identifying and observing behaviors that constitute cultural humility rather than cultural competence during patient and provider encounters could provide valuable information on curriculum fidelity in medicine that educates providers on multiculturalism. Relative best practices for incorporating cultural context in understanding patients' behavioral presentation and how symptoms are expressed could improve outcomes in diagnosis and promote culturally tailored treatment. Additionally, surveys on patient perspectives the efficacy of IPC in addressing behavioral health needs and collaborative decision-making in treatment can address systemic factors, namely, the authoritarian approach in medicine, that drives inequity in behavioral health. By practicing cultural humility and use an egalitarian approach in IPC, symptoms and risk factors can be understood in context, improving interventions and total health outcomes for BIPOC patients.

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Notes on Contributor

Shane´ J. Gill, PhD, LPC is an adjunct in the Department of Health Sciences & Clinical Practices at Thomas Jefferson University and the CEO/Founder of the Center for Racial & Health Equity LLC. Dr. Gill has over a decade of clinical experience and is currently a student in the Quantitative Methods program at the University of Pennsylvania. She recently completed a

certificate in Innovations for Substance Use from Johns Hopkins University. Her interest is in predictors that increase disparities in behavioral health diagnoses for marginalized populations and treatment in primary care. She aims to create technological interventions that can increase access to and improve behavioral health outcomes for marginalized populations globally.

***Carine Kambou,* BS, PA-S1** is currently a Physician Assistant/Doctor of Health Science student in the College of Health Professions at Thomas Jefferson University. She completed her undergraduate degree in Biomedical Sciences at the University of South Florida. Throughout her educational career, she has had an interest in examining health disparities plaguing Black populations. She aims to mitigate these disparities and empower marginalized patients by providing equitable, evidence-based care.

Brooke Mauriello, MPH is a Youth Coordinator at Atlantic Prevention Resources. After completing her undergraduate degree in psychology at Rowan University, she pursued a master's in public health from Temple University, with a concentration in social and behavioral science. While in the master's program, she developed an interest in health equity and substance use research. Brooke is also an experienced data manager for an Overdose Fatality Review Team, contributing significantly to the understanding and mitigation of overdose fatalities.

ORCID

Shane´ J. Gill, https://orcid.org/0000-0003-0352-3723
Carine Kambou, https://orcid.org/0009-0002-6709-7831
Brooke Mauriello, https://orcid.org/0009-0009-2787-9389

Appendix A

Table A1 Final Themes

Theme	Codes	Description
Eurocentrism-Americanism	Culture, Western Culture, and National Culture	Attitudes, beliefs, values, and behaviors that reinforce the notion of Whiteness as superior and the norm or frame of reference for which all other cultural groups are to be compared. In the context of American culture, (an extension of European culture), this frame of reference is defined as "White, male or masculine, cisgender, and heteronormative"; assessment, diagnosis, and treatment in medicine and behavioral health for all groups are influenced by this frame of reference and ultimately, a Eurocentric or White worldview.
Cultural Alignment	Provider Identity, Bias, Explicit Bias, and Identity Concordance	Providers' individual expression of their identity (e.g., race, ethnicity, nationality, sex, gender, language, spirituality, religion, creed, education status, marital status, etc.) and perspectives on their alignment with Eurocentrism or practices that may enforce White, male or masculine, cisgender, heteronormativity as superior to all other groups. The degree of alignment with Eurocentrism or the dominant cultural ideology shapes implicit and explicit biases and interactions between patients and providers.
Structural Inequity	Systemic Factors, Institutional Factors, Departmental Factors, and Practice Factors	Inherent or habitual and unintended rules, regulations, practices, and processes that contribute to inequities in access, quality, overall care, and total health outcomes for Black, Indigenous, People of Color (BIPOC). Structural Inequity is the byproduct of systems that are not culturally informed and consequently, fail to deliver or minimally deliver care that is both culturally sensitive and relevant to diverse patient populations, exacerbating inequity observed for vulnerable groups.
Patient First-Wellness Centered	Therapeutic Approach, Assessments, Formal Assessments, Informal Assessments, Socioeconomic Characteristics, General Pop Referrals, BIPOC Pop Referrals, and Diagnostic Approaches	The Patient First-Wellness Centered Approach emphasizes the individuality of the patient first and necessity of core tenants of humanism; the providers' focus is on the totality of the patient, using formal and informal means to explore factors that may influence his/her/their welfare and well-being. The welfare and well-being of the patient is the providers' priority but is defined by and in collaboration with the patient. Contrary to the Patient-Centered Approach, cultural competence is continuously developed and is an iterative process throughout the duration of the therapeutic relationship; This requires knowledge of racial/ethnic and socioeconomic and sociocultural factors that impact patients' welfare and well-being and for these aspects to be incorporated at the onset of treatment.
Cultural Framework	Culturally Sensitive Approaches, Cultural Humility, Communication, and Verbal Communication	A Cultural Framework is an orientation adopted by a system or systems that seeks to obtain knowledge from a variety of sources to continually be informed on the patient populations served. One of these sources of knowledge must include the patients; through this knowledge, practices and processes in treatment are adapted to (1) meet the needs of the patient as an individual, (2) reflects knowledge of unique cultural factors that shape presentation and expression of concerns, and (3) incorporates these cultural factors in treatment as deemed appropriate by the patient (e.g., language, recognition of behavioral health conditions and terminology, relational patterns, positionality, religious/spiritual practices, use of traditional or indigenous treatment, etc.) to ensure care is both sensitive and responsive to their needs.
Systemic Outlook	Systemic Progress, Systemic Changes, Care	Providers perspectives and prospective on factors that impact behavioral health treatment for patients, their ability to render care at each level of the system, and strategic changes to improve

	Coordination, and Bx Health Referrals	processes within the system to enhance access and quality of care for all patients.
Relationship Dynamics	Social Identity, Patients' Attitudes and Beliefs, and Individual Identity	Factors that impact the therapeutic rapport between patients and Behavioral Health Consultants (BHCs), collaboration, and decision-making in treatment.

Appendix A

Table A2 Themes and Their Associated Quotes

Theme	Interview	Abbreviated Quote	Full Quote
Eurocentrism - Americanism	Interview 4	"I define culture by commonalities that are identified by language, commonalities and shared experiences that others may not be familiar with, I also define culture by how people do life, how they show up and how they do life, and that these are agreed upon values and mores and customs... You can take two couples, put them in the same room, and they're different."	I define culture by commonalities that are identified by language, commonalities and shared experiences that others may not be familiar with, I also define culture by how people do life, how they show up and how they do life, and that these are agreed upon values and mores and customs. So you have culture, then you have subculture and sub subculture. I even break it down, honestly, Dr. Gill, to when I'm meeting with patients and their relationships, I tell them, your relationship is a culture. You can take two couples, put them in the same room, and they're different. One culture, they enjoy movies and nights out, another relationship, they enjoy dancing and walking their dog. That's a culture. So I think it's an agreed upon shared customs, values, the way people do life, worldview that are very identifiable and are different.
Eurocentrism - Americanism	Interview 1	"...Mental health I think is so nuanced... talking about cultures, maybe different countries or places in that regard may have a different relationship in terms of what mental health is or what mental health care looks like."	Right. And mental health I think is so nuanced, and also different cultures may have, I'm [inaudible 00:05:28] talking about cultures, maybe different countries or places in that regard may have a different relationship in terms of what mental health is or what mental health care looks like. And so I think being mindful of depression and anxiety and how it shows up in the United States and maybe our understanding, it may be different in a different country as well, or different place.
Eurocentrism - Americanism	Interview 2	"We have always and historically tried to align medicine with white cisgender care, and that's not right... So, I really do think that it's up to individual providers to use the tools that we currently have that we need to use, and using them in a way that is filled with cultural humility, that is filled with conversation and clarity, and not taking a number as the only data point... So, I think that those single data points that we use, it is a point, I get it. We need some form of measurement to do good work, but that shouldn't be the only form of measurement..."	So I don't think that the screening tools that we currently have incorporates that for the most part. And I'm going to going to speak more broadly. I don't think it's a Jefferson specific. I think that this is a void across healthcare in general, is that we have always and historically tried to align medicine with white cisgender care, and that's not right. And I think that we're moving away from that, but I also think, especially as a behavioral health professional, that's even more delayed. Because the words in which we use to describe things, how we describe things, past traumas, cultural traumas, historical traumas aren't brought into the conversation. So I really do think that it's up to individual providers to use the tools that we currently have that we need to use, and using them in a way that is filled with cultural humility, that is filled with conversation and clarity, and not taking a number as the only data point. But I don't think screening tools provide that, or at least I haven't come across one that has provided that yet.

Cultural Alignment	Interview 2	“But to me, sometimes my conscious bias is that I'm representing white authoritarian medicine. I think I have an unconscious... Not an unconscious. I have a very conscious bias that I also represent, and when people hear social worker specifically from the BIPOC community, that that can be very scary... I could represent something that's very reassuring to the BIPOC community, but I tend to take the lens that I represent kind of what's wrong with these systems.”	I subscribe and I believe, and even when I teach, that's actually one of my initial slides, is the labeling of both conscious and unconscious biases that we have. And I think that when I think about I'm sure I have plenty of unconscious biases that could be or seen, conscious biases, I tend to be along the lines of what I've previously said where I'm probably a little bit more even aware of what I represent. And that can be a biased approach, because that's not fair to the person that I'm meeting with. I could represent their sister. I could represent their mom, their best friend. But to me, sometimes my conscious bias is that I'm representing white authoritarian medicine. I think I have an unconscious... Not an unconscious. I have a very conscious bias that I also represent, and when people hear social worker specifically from the BIPOC community, that that can be very scary. I've had patients say to me, "Don't take my kid." Things like that. And I validate that, because that is real. We come from implicitly racist and biased systems, and I think that sometimes I think appropriate... I really don't. But again, I don't think I give every individual the benefit, because I could represent something that isn't harming. I could represent something that's very reassuring to the BIPOC community, but I tend to take the lens that I represent kind of what's wrong with these systems.
Cultural Alignment	Interview 4	“God's working on me...I remember this one really showed me my bias. So elderly woman from a Latin country just arrived in America a few years ago after her husband passed away... She didn't speak English at all. So, her son was there and he was translating or interpreting... And I said, ‘Well, can I ask what caused you to come?’... "[She said] ‘and I think maybe on that day I was feeling a little down, but I'm fine. I don't really need your help.’ And then she just was so adorable and Latin and full of laughter. And Dr. Gill, it was like shame came over me. I just said, "I cannot believe I was so", and I think I couldn't connect with her.”	I would say my bias would be what comes to mind, it is sad, but I'm working on it. God's working on me. If... And this is all because of communication, and I'm a big person on clarity. So if I'm not able to receive a lot of clarity about what they're saying because of a thick accent, then I make assumption, no, not assumptions. This was a good one. I remember this one really showed me my bias. So elderly woman from a Latin country just arrived in America a few years ago after her husband passed away in their mother country that she moved here after husband passed to live with adult children, all adults. She's a grandmother. She didn't speak English at all. So her son was there and he was translating or interpreting. So I had to do the screenings with him, and then he translated, and so she would give him the answers. But when I started to just assess, it just felt like a lot of work. I was exhausted, and I just didn't realize it at first, because that's what it was, I asked because she kept saying, "Yeah, I'm fine. I'm fine. It's a few things." She was so sweet and she would just do this. And so then my thought was, okay, all of this work, translate all of this work, and she's fine. And I said, "Why are you

			here?" And I said, "Well, can I ask what caused you to come?" And then she said, "Oh, I was just having a doctor's visit." Her son, of course, is telling me, "I was just having a doctor's visit", and she was asking me these questions, and I answered, "And I think maybe on that day I was feeling a little down, but I'm fine. I don't really need your help." And then she just was so adorable and Latin and full of laughter. And Dr. Gill, it was like shame came over me. I just said, "I cannot believe I was so", and I think I couldn't connect with her. I was connecting with her through her son. And then hearing she didn't have any issues. And it was just really her doctor doing a thorough job and saying, "Well, hey, go talk to this person who's here." And she even said, "If I need you, I'll come, but I don't need anything. I'm fine. I dance. I stay in my room. I'm good." And so it turned out to be a very short visit, but it was so lighthearted at the end, she would've never known what was on the inside of me, but it was something I had to sit with, and I'm not happy about that.
Cultural Alignment	Interview 1	"I try to check myself about this, but I think maybe there's empathy that may be potentially missing, and it's not like I go out of my way, I don't care, but it's just our lived experiences are different. So maybe I have a hard time understanding what it's like to be a Black person or what it's like to be an Indigenous person because that's just not my lived experience. But I try to find overlap or commonality, I guess, to foster that empathy."	I try to check myself about this, but I think maybe there's empathy that may be potentially missing, and it's not like I go out of my way, I don't care, but it's just our lived experiences are different. So maybe I have a hard time understanding what it's like to be a Black person or what it's like to be an Indigenous person because that's just not my lived experience. But I try to find overlap or commonality, I guess, to foster that empathy. And I feel like I'm pretty good at it, just being a therapist, I feel like I need to be. I feel like I've kind of mastered that skill in some way. And also, I don't know, there's someone that could have my identity and for whatever reason, personality wise, we just don't click. And there's someone that could be like BIPOC identity and we're like, oh, I feel like I think like this person. And so there could be overlap there. But I think it's just different lived experience and I may have a hard time a conceptualizing it or empathizing, I would say.
Cultural Alignment	Interview 2	"This actually just triggered a whole [other] memory of a patient I worked with through the pandemic, through the murder of George Floyd, Breonna Taylor. And she said to me... At the end, we had worked with her PCP, who's also white, cisgender female. And she had said, "Mollie, I had almost stopped seeing all white providers. But the way that you and the other provider	I have also had patients say, "Mollie, you seem like a great person. I want someone that looks like me." And I say, "I honor and I respect that. Let me help you out with this. Please know though that I'm always here for you." You know what I mean? "So don't feel like we need to close the door." This actually just triggered a whole nother memory of a patient I worked with through the pandemic, through the murder of George Floyd, Breonna Taylor. And she said to me... At the end, we had worked with her PCP, who's also white, cisgender female. And she had said, "Mollie, I

		just talked to me, tried to understand where I was coming from, even though you knew you could never understand it, helped me through."	had almost stopped seeing all white providers. But the way that you and the other provider just talked to me, tried to understand where I was coming from, even though you knew you could never understand it, helped me through." And I think, again, this isn't for me to... I think sometimes again, we can get on our high horse. It's not always that case, right? I want to give balance. There's plenty of times where patients want specific, again, that cultural identity. And if that's, again, seeing someone that looks like them, then that's what I'm going to do. I'm not going to say, "Oh no, stay with me. I've helped this many people before." No, it's not about that. It's about what they want in that moment in time.
Cultural Alignment	Interview 1	"Well, I'm thinking of screeners that I administer, like the PHQ-9 and the GAD-7 and the PCL-5. I don't know. I guess I'm thinking about, I have one patient and they're Portuguese speaking and I have to be mindful of how certain things are translated and received, and so I'm thinking about language differences and maybe leading to certain language barriers."	Dr. Shane' Gill: From your perspective and considering that definition then, how does culture shape current screening and assessment practices for patients that have behavioral health concerns? Speaker 2: Well, I'm thinking of screeners that I administer, like the PHQ-9 and the GAD-7 and the PCL-5. I don't know. I guess I'm thinking about, I have one patient and they're Portuguese speaking and I have to be mindful of how certain things are translated and received, and so I'm thinking about language differences and maybe leading to certain language barriers.
Structural Inequity	Interview 3	"I don't work under one roof, and there's so many different services. It's more of a splintered experience here at... and so it's not... We're kind of all splintered, and so it's not as easy to just refer someone to a social worker, to be honest with you."	I can't really tell you much because I work out of five or six offices, most of them virtual except for one, and the one I'm at in person, we don't have a social worker. So it's really through just messaging that I may say, "Maria, do you have recommendations for transportation?" I don't work under one roof, and there's so many different services. It's more of a splintered experience here at [my organization], and so it's not... Where I used to work, there was a social worker literally in the same building down the hall. There was a lawyer, there was a nutritionist, there was a diabetes educator, there is a legal team. We're kind of all splintered, and so it's not as easy to just refer someone to a social worker, to be honest with you.
Structural Inequity	Interview 2	"… I also know that those systems are very difficult to navigate, and they're historically difficult to navigate, again, for systemic, conscious and unconscious, racist and bias forming of it. Who should receive services and who should not receive services?"	So I am biased towards integrated care. I will share that. And I find that referring out can lead to, again, these ongoing stigmatization and lack of resources. So whenever I refer out, I always remind that I am still here, because I want to honor them in connecting them to the resource that they want. But I also know that those systems are very difficult to navigate, and they're historically difficult to navigate, again, for systemic, conscious and unconscious, racist and bias forming of it. Who should receive services and

			who should not receive services? So when I think about what I do is more along the lines of health equity, I try to align that.
Relationship Dynamics	Interview 4	"...Certain cultures that it's a stigma to receive mental health...if you're disenfranchised or on the margin, just that anxiety about being seen, having to unpack. I think that if certain individuals come in with that mindset, you may not get accuracy because whatever those agreed upon terms and customs and ideas can influence how a person shows up in the session and even answers."	Okay. How does culture shape that? Well, immediately what I think about is willingness to open up and share if you have certain cultures that it's a stigma to receive mental health or if you're disenfranchised or on the margin, just that anxiety about being seen, having to unpack. I think that if certain individuals come in with that mindset, you may not get accuracy because whatever those agreed upon terms and customs and ideas can influence how a person shows up in the session and even answers. And then on the flip side so, I think, yeah, either way, whether it's a willingness and openness, a yes, I've arrived and I'm grateful to be here, or the other side of the spectrum where it's more just very hard to open up and to warm up because of these ideas. Can I give you an example?
Relationship Dynamics	Interview 1	"...I think, and maybe I'm overthinking it, but I think socially speaking it's like, oh, you're a white man and there's a lot of privilege attached to that, and I think it's kind of sometimes it can be like, okay, well I'm going to trust you as this knowledgeable resource. Maybe not knowledgeable is the right word, but as this person because of the power association, and other times it's like you don't share my identity, so I can't trust you or I can't open up to you."	I think it could work in my favor in some ways and then it could be a disadvantage in other ways. I think, and maybe I'm overthinking it, but I think socially speaking it's like, oh, you're a white man and there's a lot of privilege attached to that, and I think it's kind of sometimes it can be like, okay, well I'm going to trust you as this knowledgeable resource. Maybe not knowledgeable is the right word, but as this person because of the power association, and other times it's like you don't share my identity, so I can't trust you or I can't open up to you.
Patient-first Wellness-centered Approach	Interview 4	"... I am that mediator for them. So, if they're virtual, I put them on a three-way, and I'm that bridge for them to help them get comfortable speaking to entities they don't know... I do the referral during the session, and I let the patient know the social worker will be reaching out to them within 24, 48 hours so that they know that there's a team that they're being heard, and I'm on it immediately...So just doing a lot of that bridge work and helping them build comfort and even coaching them, patients who, yeah, so definitely being a three-way,	Also, sometimes if there are resources that I'm aware of that are very unique, and I know that that's one of the major barriers or the causations, we just make time and make that the session calling places, if they're nervous or they're struggling with communication or comprehension, I am that mediator for them. So if they're virtual, I put them on a three-way, and I'm that bridge for them to help them get comfortable speaking to entities they don't know. But then also in person, we get on the computer together. So literacy, I have a couple of patients who are in their forties, never got their GED, but they're very nervous, very ashamed. So just doing a lot of that bridge work and helping them build comfort and even coaching them, patients who, yeah, so definitely being a three-way, being a bridge, connecting with resources. I'm a big believer that part of my being a therapist is a case manager. I feel like that's an integral

		being a bridge, connecting with resources."	part. If you remove the trigger or the barrier, maybe you lessen the depression. Depression didn't just come out of nowhere, so I even do job searching with them. So a lot of even job readiness, role play and get them connected. A couple of my elderly patients who were very lonely, isolated in the session, we've gone on to the adult day center, looked at some of their Facebook pages and how much fun they're having. Then I've called the places with the patient there and I've talked on their behalf and encouraged them to kind of speak up a little bit. And all of those are different types of concerns.
Patient-first Wellness-centered Approach	Interview 2	"... And when I use things, I use universal we. I use a universal we. I use a very humanistic approach. So even if we are coming from different backgrounds and cultures, and that can be seen, again, right off the bat by the color of my skin or by my gender, that I still go back to the fundamental principles of our physiology, and how we are always trying to cope and manage different situations. And I explore that through that way, using a contextual interview."	But that's also building rapport, because patients feel comfortable in that sense. I'm trying to think, what else do I do that is intentional? I think just how I ask the question, the curiosity. The interest in them as a person here and now. And when I use things, I use universal we. I use a universal we. I use a very humanistic approach. So even if we are coming from different backgrounds and cultures, and that can be seen, again, right off the bat by the color of my skin or by my gender, that I still go back to the fundamental principles of our physiology, and how we are always trying to cope and manage different situations. And I explore that through that way, using a contextual interview.
Patient-first Wellness-centered Approach	Interview 1	"... I'll give different measures, like the PHQ-9 for depression, the GAD-7 for anxiety, PCL-5 for trauma. Those are the ones I mainly give. And then we have an intake, I guess smart phrases [inaudible 00:13:53]. And so, we have what brings you here, what are your presenting issues, what are your goals? And so based off of all those questions, both quantitatively and qualitatively, like I said, I usually make an assessment."	Well, both qualitatively and quantitatively, like I said, I'll give different measures, like the PHQ-9 for depression, the GAD-7 for anxiety, PCL-5 for trauma. Those are the ones I mainly give. And then we have an intake, I guess smart phrases [inaudible 00:13:53]. And so we have what brings you here, what are your presenting issues, what are your goals? And so based off of all those questions, both quantitatively and qualitatively, like I said, I usually make an assessment.
Cultural Framework	Interview 2	"...When I think about historical traumas within healthcare of the BIPOC population, how many times has a white person said, 'I'm the expert, you are not. And I am going to not tell you X, Y, and Z'? And it still happens today. So, trying to dismantle that authoritarian approach is actually probably something	I have enough information to know that I have to address these things in a very formal way to create a level of rapport, and to address it right off the bat for many BIPOC patients that I see. And I think that that's also too where I come down to you are the expert, because again, when I think about historical traumas within healthcare of the BIPOC population, how many times has a white person said, "I'm the expert, you are not. And I am going to not tell you X, Y, and Z"? And it still happens today.

		that I'm quite intentional about, and more so with BIPOC patients."	So trying to dismantle that authoritarian approach is actually probably something that I'm quite intentional about, and more so with BIPOC patients, because I believe... And it's not for everyone, but I believe that that does need to be addressed in order for a level of safety.
Cultural Framework	Interview 1	"...I guess I'm thinking about just my identity and maybe how it's being received as a white cisgender man and working with patients... I see religion comes up a lot and faith and spirituality, and so I think one question is have you had thoughts about killing yourself or harming yourself, and how in a religious way that could be seen as maybe potentially insulting or like I would never do that because of my faith-based practice. And so, I think being mindful of that."	I don't know. I guess I'm thinking about just my identity and maybe how it's being received as a white cisgender man and working with patients who may have differing identities, or even sometimes the same identity as well, and what could come up based off of that. It's pretty broad. I guess I'm having a hard time thinking of specific examples right now, but I mean, I see religion comes up a lot and faith and spirituality, and so I think one question is have you had thoughts about killing yourself or harming yourself, and how in a religious way that could be seen as maybe potentially insulting or like I would never do that because of my faith-based practice. And so I think being mindful of that.
Cultural Framework	Interview 4	"... So, before they became available in Epic, we used to just have the screening tools as papers, and I would give them to the patient. And I noticed some of them would struggle, and I used to be a school teacher, so now I ask... So, in terms of the administration, when they're with me and I administer to them, I use language such as small, medium, large, or not at all, rather than whatever it is."	Dr. Shane' Gill: So I am curious, I know that you did mention the use of universal screening tools, and so I am particularly curious about how it is that you actually use the results of the universal screening tools and how you incorporate that into the treatment planning process. Speaker 2: So I'll answer in three parts. The first is how I administer, I'm always sensitive that not everyone is able to read and comprehend because the language is very clinical. So before they became available in Epic, we used to just have the screening tools as papers, and I would give them to the patient. And I noticed some of them would struggle, and I used to be a school teacher, so now I ask, well, now I don't have to because they can access through Epic and answer on their own. But when they're sitting with me and they haven't completed the screenings, or if they have, and I see their score, I'll just mention it. So in terms of the administration, when they're with me and I administer to them, I use language such as small, medium, large, or not at all, rather than whatever it is.
Systemic Outlook	Interview 2	"I do think that there needs to be an intentional dismantling of white, heteronormative, cisgender male culture…But you have to give power. When we think about power and control, if the people in power aren't sharing the power, then	Well, I think it comes multifaceted. I think that we need to have patients... I know we have patient advisory committees, but I really do think that patients need to sit on the board, period. Not just wealthy individuals sitting on the board. I think it comes from both places, but I do think that there needs to be an intentional dismantling of white, heteronormative, cisgender male

		it doesn't matter what happens down below.”	culture. You know what I mean? But it has to come here, because it can come from below. But you have to give power. When we think about power and control, if the people in power aren't sharing the power, then it doesn't matter what happens down below. And I think that that happens on a macro level. I think it happens on a micro level of teaching this humility, of being, saying, and doing. I come with expertise, but I am not the expert in you.
Systemic Outlook	Interview 2	“But to me, a good medicine program would be like, ‘Yeah, we can train you how to do all your facts, but let's actually train you how to be a human. Let's do that and let's really confront those things.’”	Yeah. So I mean, sure, we can discuss good programs. But to me, a good medicine program would be like, "Yeah, we can train you how to do all your facts, but let's actually train you how to be a human. Let's do that and let's really confront those things." But that's not just medicine. And I think we're, and I'm using the universal we. We as mental health professionals generally get that training to some extent, but not all healthcare professionals do. And I think that too, you need to have your smarts to be a doctor. I'm not worried that they can't look up and do the research. But it's like, how are you a person?
Systemic Outlook	Interview 4	“Definitely researching I would say how [my organization] could begin to partner with entities within Philadelphia who want to provide upliftment in these particular populations…So I would say maybe one [preventative protective factor] is to just kind of check the pulse and maybe get some surveys about patients specifically with that in those needs.”	Definitely researching I would say how [my organization] could begin to partner with entities within Philadelphia who want to provide upliftment in these particular populations. I know that there was a lot going on during the quarantine and right after the police brutality, and there was just such an incredible saturation of Zoom meetings and webinars and cultural, and I just sometimes when things are trendy, but I'm a believer in staying consistent. And so I don't want it to just be the trend until the next something happens. So sometimes the next something doesn't have to happen if you have preventative protective factors in place. So I would say maybe one is to just kind of check the pulse and maybe get some surveys about patients specifically with that in those needs. Also, I do know that [my organization] does have some kind of financial assistance program, and I do refer my patients to them, but it doesn't seem like they're making good headway with that.