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Examining Facilitators of Trust in a Pediatric Collaborative Care Model: A Qualitative Study

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Abstract

Examining Facilitators of Trust in a Pediatric Collaborative Care Model: A Qualitative Study

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Community-based participatory research is an equitable approach to research involving the community in all aspects of the research process to help promote the application of research findings directly to populations. The current study employed a community-based participatory research approach to help identify barriers and facilitators of trust in providers in a collaborative care model of integrated behavioral health at a Federally Qualified Health Center serving mostly Latine children and families called the psychiatry conference. 14 parents and six children were interviewed qualitatively about their experiences with the psychiatry conference and a thematic analysis approach was employed to identify themes related to facilitators of trust in providers. Results found that facilitators of trust included: the primary care provider serving as a bridge to help trusting relationships form between the psychiatrist and families, reciprocal respect between providers and families, and the psychiatrist taking an educational approach. Barriers to trust included: the quality and availability of interpreter services as well as lack of a tailored approach for patients depending on diagnosis. Other factors such as parent-child synchrony and optimism contributed to final reactions to the psychiatry conference as well as retention processes. This study helps to elucidate how to implement a CBPR study in an integrated care setting as well as

ways to improve the acceptability of primary care behavioral health services for Latine children and families.

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Chapter 1: Introduction

Community Based Participatory Research

Community Based Participatory Research (CBPR) is a collaborative approach to research that aims to equitably involve the community in all aspects of the research process. CBPR's ultimate goal is to better understand problems in the community and improve health and social equity by tailoring interventions to meet community needs (Israel et al., 2003). CBPR is described as a systematic effort to involve communities in participation in research as opposed to involving communities purely as an outreach strategy (Wallerstein & Duran, 2006). Thus, CBPR is community-based and community-directed, as opposed to community-placed (Wallerstein et al., 2017). CBPR aims to change the power relationships between researchers and populations researched (Wallerststein et al., 2017).

There are 10 principles outlined as part of the CBPR approach, including: CBPR acknowledges community as a unit of identity, CBPR builds on strengths and resources within the community, CBPR facilitates a collaborative, equitable partnership in all phases of research, CBPR includes an empowering and power-sharing process that attends to social inequalities, CBPR fosters co-learning and capacity building among all partners, CBPR integrates and achieves a balance between knowledge generation and intervention for the mutual benefit of all partners, CBPR focuses on the local relevance of public health problems and on ecological perspectives that attend to the multiple determinants of health, CBPR involves systems development using a cyclical and iterative process, CBPR disseminates results to all parents and involves them in the wider dissemination of results, CBPR involves a long-term process and commitment to sustainability, and CBPR addresses issues of race, ethnicity, racism, social class, and embraces cultural humility (Israel et al., 2003, Israel et al., 2017). The CBPR framework is especially beneficial in hearing the voices of marginalized populations, which is relevant for the integrated care movement.

CBPR in Health Services Research

The CBPR framework has been noted consistently for its contributions to increasing health equity. As Wallerstein et al. (2017, xxxiii) describe, “CBPR is the research operationalization of health equity.” CBPR has been used successfully in health services research, including in studies evaluating integrated care models, and CBPR teams have included health care providers and payers as well as patients, families, and other caregivers (Alegría et al., 2017). For example, Alegría et al. (2017) used the CBPR approach to examine patient and provider interventions aimed at improving shared decision making, the working alliance, and communication between patients with behavioral health issues and their providers in outpatient behavioral health clinics. They involved patients, providers, and other stakeholders through the entire course of the study through monthly community advisory board meetings and focus groups to help determine ways to disseminate study findings. Alicea-Planas et al. (2016) used a CBPR approach in their study examining staff perceptions of barriers to providing patient education in primary care visits by getting input from the staff directly involved in patient care throughout the study. Further, Garbers et al. (2020) established a community advisory board (CAB) consisting of academic and community members for their CPBR study assessing pregnancy screening processes for Black and Latina women in primary care. The CAB members developed interview questions, completed qualitative interviews, and coded the interviews as a group (Alicea-Planas et al., 2016). Finally, DeCamp et al. (2012) worked collaboratively with a clinic that wanted to learn how to best serve the needs of limited English proficiency Latine families, and they utilized a CBPR approach in carrying out their research. Thus, CBPR is useful in health services research to help researchers and clinics learn how to better serve patients and their families.

CBPR and Behavioral Health

CBPR is an especially important and relevant approach when considering behavioral health. Health behavior change is dependent on whether treatments are in line with a family's cultural and other values. Getting patient feedback about the systems in which they receive behavioral health services has the potential to contribute to improvements in the delivery of services, which ultimately will lead to better health outcomes for children and families. In the context of behavioral health, getting patient feedback about service delivery has the potential to improve adherence to treatment recommendations and reduce stigma related to mental healthcare, especially when psychiatric medications are indicated.

The Current Study and CBPR Approach

Integrated behavioral health (IBH), or the coordination of physical and mental healthcare services, is a promising approach to improving access to mental healthcare. In the traditional primary care setting, individuals face various barriers to accessing mental healthcare. Latine children and adolescents face an especially large number of barriers in accessing mental health services (Zuvekas & Taliaferro, 2003). This is due to a variety of reasons, including disproportionate poverty and insurance rates as well as other factors such as acculturative stress, discrimination, and language barriers (U.S. Census Bureau, 2017; Hodgkinson et al., 2017; Braveman et al., 2011; Bridges et al., 2014; Cabassa, et al., 2007; Céspedes & Huey, 2008; DuBard & Gizlice, 2008). Often, clinics and providers do not have the time and capacity to address mental health concerns, even though they are often linked with and exacerbate physical health problems (Cole et al., 2014; Loeb et al., 2012). Identifying and addressing mental health problems as early as possible for children may lower the risk for later adverse outcomes, which highlights the importance of increasing access to mental healthcare and refining healthcare practices through IBH (Kessler et al., 2007a; McGue & Iacono, 2005; Richardson et al., 2009).

There are various models of IBH that have been evaluated, and one model in particular, collaborative care, includes psychiatry consultation and has been particularly effective at addressing mental health in primary care (Unützer et al., 2013). More research on how Latine youth are served by IBH is needed, and much research focuses on patients with a single mental health condition, rather than those with co-morbid or complex problems (Talmi et al., 2016; Vogel et al., 2017). Research is also lacking on how trust is facilitated as part of integrated models, which has important implications as trust is linked to various outcomes such as satisfaction with physicians, adherence to medications and treatment plans, and improvements in symptoms (Blackstock et al., 2012; Mancuso, 2010).

The current study seeks to address these gaps in the literature and evaluates facilitators of trust in a collaborative care IBH model (called the psychiatry conference) for primarily Latine children and adolescents living in low-income contexts who are patients at a community clinic in Austin, Texas. Utilizing the CBPR approach for this study ensures that youth from marginalized communities with complex developmental issues, learning problems, and/or mood problems and their families are given a voice. The CBPR approach also helps to ensure staff from the clinic, who initiated the research partnership, are actively involved in all stages of the research.

The study takes a qualitative lens to ensure a rich, in-depth understanding of complex processes that would be unable to be captured using quantitative analyses alone. Caregivers and children were interviewed to explore the experiences of caregivers and children in the psychiatry conference. Research questions were developed with the clinic and team members from the clinic have been involved in all steps of the research process, consistent with the CBPR approach. A thematic analysis approach was used to analyze the data. Qualitative interviews helped illuminate how to improve caregiver and child participation in, and responsiveness to, the conference, which hopefully will contribute to improved care and outcomes.

Chapter 2: Literature Review

Integrated Behavioral Health

Integrated Behavioral Health Definition and Benefits

IBH is a promising avenue through which to address the mental health needs of children in primary care settings. Primary care settings are the first place many individuals will turn to for mental health care (Gunn & Blount, 2009; Hodgkinson et al., 2017; Polaha et al., 2011). However, primary care providers under identify individuals who are in need of services, and even when families discuss behavioral/emotional concerns with their pediatricians, this does not necessarily lead families to receive mental health services due to various systematic barriers (Briggs-Gowan et al., 2000; Costello et al., 1988; Gunn & Blount, 2009). Thus, IBH, or the coordination of medical and behavioral health services, can be instrumental in increasing mental health care, especially for families who are underserved by the health care system (Blount, 1998; Hodgkinson et al., 2017, NIMH, 2017). IBH can improve screening efforts to allow patients to be more easily identified as having mental health problems and can also improve access to treatment. As another benefit, IBH can also reduce mental health care costs (Melek et al., 2014; Yu et al., 2017). Finally, primary care providers have reported a lack of knowledge and experience managing mental health concerns in their patients, and IBH can reduce this burden on primary care providers (Cole et al., 2014; Hodgkinson et al., 2017; Horwitz et al., 2007; Loeb et al., 2012).

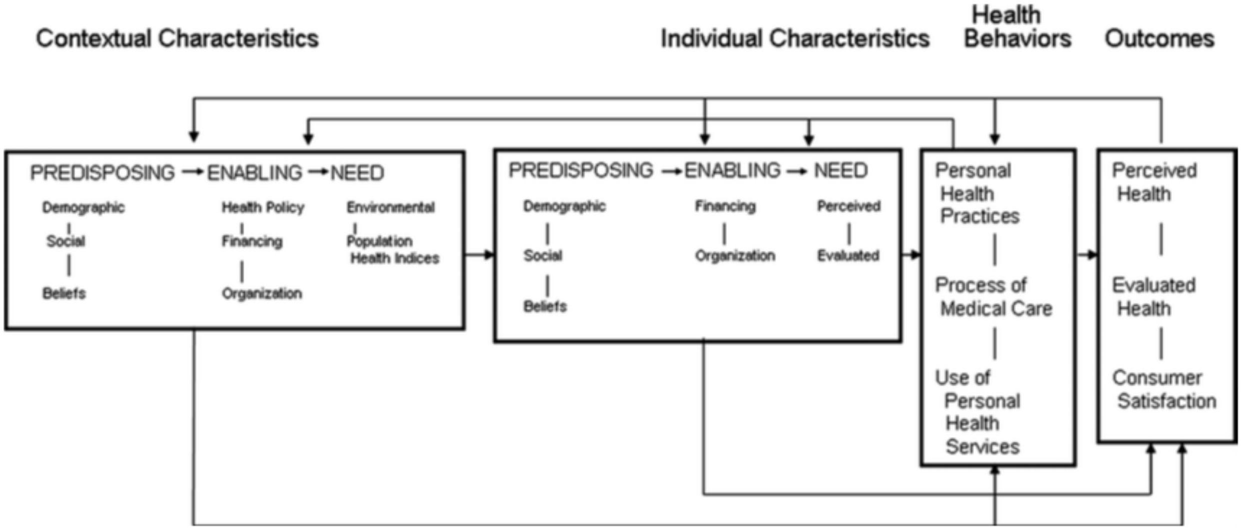
Theoretical Model

A theoretical model underlying healthcare utilization that informs IBH is Andersen's Behavioral Model of Health Care Services Use (Andersen, 1995, 2008; See Figure 1). This model describes how contextual and individual factors affect healthcare utilization, health behaviors (personal health practices, use of health services, and process of medical care which includes behaviors of providers interacting with patients such as test ordering, prescriptions, and quality of provider-patient communication), and health outcomes (perceived health, evaluated health, and satisfaction with healthcare). Andersen outlines factors that predispose, enable, or suggest the need for use of health services at the individual and contextual levels (Andersen 1995, 2008; Babitsch, Gohl, & von Lengerke, 2012). At the contextual level, predisposing factors can include the demographic compositions of communities, cultural norms, collective values, and political perspectives of the community. Enabling factors can include the supply of medical personnel and facilities as well as health policies in place. Finally, need factors at the contextual level can include population indices such as mortality and morbidity rates that suggest the need for individual use of health services as well as health-related conditions of the environment such as occupational, traffic, and crime-related injuries. At the individual level, predisposing factors can include demographics (gender, age, race/ethnicity), beliefs/attitudes about one's health and health services, and variables such as education, occupation, and culture. Enabling factors at the individual level can include insurance, income, having a regular source of care, and transportation. Need factors at the individual level can include one's perceived need for health care as well as evaluated need (professional judgment about health status and the need for medical care). Andersen's model also includes feedback loops, indicating that outcomes can impact subsequent predisposing factors, need factors, and health behaviors (Andersen, 1995, 2008).

Andersen's model provides a helpful foundation for understanding the various factors that impact healthcare utilization and health outcomes, and how health behaviors and health outcomes depend not only on downstream factors such as the structures of the healthcare system but also on more upstream factors such as economic resources (Babitsch et al., 2012; Braveman et al., 2011). This supports the use of IBH as a healthcare model that improves the structure of the healthcare system and helps reduce individual and contextual factors that may serve as barriers to mental health care utilization, especially for individuals who may face a significant number of these barriers. For example, IBH may increase the supply of behavioral health providers to primary care (enabling factor), including psychologists, psychiatrists, and case managers. As another example, IBH may reduce barriers related to transportation and insurance/income (enabling factors) through the coordination of care. IBH practices may also contribute to more acceptability of and satisfaction with healthcare by patients, which is also included in Andersen's model.

Figure 1

Andersen's Behavioral Model of Health Care Services Use



Anderson, 2008

Another recent healthcare model related to IBH that has risen in popularity is the Triple Aim model (Berwick et al., 2008). The "Triple Aim" includes three goals: improving the individual experience of *care*, improving the *health* of populations, and reducing per capita *costs* of care. These goals are interdependent, and equity is at the forefront. The researchers suggest that IBH and other approaches that challenge traditional primary care align well with the three objectives of the model. Others have argued for a Quadruple Aim model, and the aim of the fourth objective is to improve the experience of providing care, including the work life of health care providers and helping employees find joy and meaning in their work (Bodenheimer & Sinsky, 2014; Sikka et al., 2015). A primary reason for adding a fourth aim is to reduce provider burnout, which researchers argue could detrimentally impact the goals of the Triple Aim model (Bodenheimer et al., 2014; Sikka, et al., 2015). This fourth aim also aligns well with IBH, which has the potential to help reduce the burden on primary care providers in treating patients with mental health/behavioral issues for which they may feel they have inadequate expertise and these patients may benefit from a more integrated approach to their care (Loeb et al., 2012).

Models of IBH

There are various delivery strategies that prescribe ways to deliver IBH services. Most work in IBH centers on two primary models of integration: primary care behavioral health and collaborative care (Collaborative Family Healthcare Association). It is not uncommon, however, for clinics and other healthcare sites to run various models in their clinics. The following two sections will describe these two models in greater detail.

Primary Care Behavioral Health. Primary care behavioral health (PCBH) involves incorporating a behavioral health consultant/clinician (BHC) into a primary care team. The BHC provides brief, short-term care for patients of all ages with all possible presentations and concerns, such as mental health concerns or substance use, chronic disease, preventative care needs, parenting concerns, and medically unexplained symptoms (Reiter et al., 2018). BHCs are often called into exam rooms by primary care providers for a warm hand-off, and for follow-up visits patients may see both providers or only one of the pair (Collaborative Family Healthcare Association). Various studies demonstrate the effectiveness of the PCBH model in improving assess to care as well as clinical improvements (Ray-Sannerud et al., 2012; McFeature, 2012).

Collaborative Care. Collaborative care is a well-known integrated approach to care and is the model employed by the clinic in the current study (Unützer et al., 2013). In the collaborative care model, a collaborative team, including a primary care provider (such as a physician or nurse practitioner), case management staff (social worker, nurse, etc.), and a psychiatric consultant collectively provide care. Psychiatric consultation can occur directly onsite through a meeting with the patient, and can also occur indirectly through teleconferencing (Kaliebe, 2016; Raney, 2015). In the collaborative care model, progress is tracked routinely with clinical rating scales and treatment plans are adjusted if necessary for patients who present with diagnostic challenges or who are not showing clinical improvements. Through the collaborative care model, mutual learning frequently occurs through providers directly working with each other to manage patient care. Raney (2015) described how the psychiatrist's role on a collaborative care team is not only to help with treatment and diagnosis, but also to provide education and help build the capacity of team members. According to the AIMS Center, collaborative care has 5 core principles, including patient-centered team care, population-based care, measurement-based treatment to target, evidence-based care, and accountable care (AIMS Center).

Various studies have demonstrated the effectiveness of the collaborative care model. Much research on collaborative care has focused on adults with depression (the model was originally developed for patients with depression), with meta-analytic studies finding collaborative care to be superior compared to usual care in reducing symptoms of depression at 6 month timepoints and later time points as well (Atlantis et al., 2014; Gilbody et al., 2006). The IMPACT study for adult depression is the largest collaborative care trial (n=1,801), and in the study, participants at primary care clinics were randomly assigned to either care as usual or an intervention where a depression care manager (either a psychologist or psychiatric nurse) and a consulting psychiatrist worked with the patient and their primary care provider for up to 12 months (Hegel et al., 2002; Unützer et al., 2013). The care manager helped with antidepressant adherence and provided problem-solving therapy. Participants in the intervention condition were more than two times as likely to experience a substantial reduction in depression symptoms compared to the usual care group (Hegel et al., 2002; Unützer et al., 2013). Peikes et al. (2012) found that the IMPACT trial had favorable effects in achieving the objectives of the triple aim model. Thus, collaborative care is an IBH model that has the potential to better manage patient care through utilizing a team-based approach to care and achieves objectives of the triple aim model. The next section will discuss some principles of collaborative care.

Patient-Centered Care and Culturally Competent Care. Patient-centered care is foundational to collaborative care, and is the first principle of collaborative care according to the AIMS Center for Collaborative Care Research. Patient-centered care has been described as an interaction style, a quality of relationships, and as a comprehensive approach to care (Epstein et al., 2011; Saha et al., 2008). Through patient-centered care, the "physician tries to enter the patient's world, to see the illness through the patient's eyes" (McWhinney et al., 1989 as cited in Saha et al., 2008, p. 2). Patient-centered care involves using shared care plans that include patient goals, which will hopefully improve the quality of care and patient-provider relationship. This, in turn, increases patient engagement and ultimately improves patient outcomes (Saha et al., 2008; AIMS Center). Patient-centered care has been associated with reductions in health care utilization, increased satisfaction with care, and better self-management (Levinson et al., 2010; Bertakis & Azari, 2011; Rathert et al., 2013). Rathert et al. (2013) conducted a systematic review of the literature related to outcomes of patient-centered care and consistently found a positive relationship across studies between patient-centered care and satisfaction and well-being. Notably, they also found a lack of studies exploring family perspectives on patient-centered care (Rathert et al., 2013). The current study addresses this gap through interviewing both parents and their children. Finally, a review of barriers and facilitators to effective collaborative care described various clinical barriers including not engaging the patient in treatment discussions (especially surrounding medications) to ensure adherence, and noted patient-centered communication as a way to reduce these barriers (Sanchez, 2017). Interventions for the psychiatry conference often include medication recommendations, thus a patient-centered approach may be especially important.

Many principles of patient-centered care overlap with principles of culturally-competent care. Culturally-competent care can be defined as the ability to communicate appropriately and effectively (achieving valued goals and outcomes in intercultural interactions) with individuals from culturally diverse backgrounds (Alizadeh & Chavan, 2016). An essential feature of cultural competency is that it is an ongoing process and can always be improved and enhanced overtime. For this reason, some researchers prefer terms such as cultural humility, cultural sensitivity, and cultural responsiveness, as the term cultural competency suggests that it is possible to achieve a certain competency in interactions with diverse patients and does not reflect an ongoing process. Saha et al. (2008) reviewed the literature and identified commonalities in models of cultural competency, including: provider knowledge (meaning and importance of culture), attitudes (respect for various cultural norms), and skills (e.g., eliciting information from patients). Saha et al. (2008) go on to further describe similarities between cultural competency and patient-centered care at the interpersonal level and health systems level. At the individual level, similarities include: viewing the patient as a unique person, respecting patient beliefs, values, and preferences, building rapport and trust, finding common ground, being aware of biases, involving the family when desired, and tailoring education to patient level of understanding. At the health systems level, some of these similarities include: aligning services to meet patient needs and preferences, conveniently locating clinics for the community, and tailoring documents to patient language and literary levels. Considering principles of patient-centered care and cultural competency is essential when evaluating collaborative care models.

Levels of IBH Integration

In addition to different models of IBH, IBH approaches can also be distinguished based on the degree of integration, with levels and categories representing differences in the amount of colocation, clinical delivery, patient experience, and other factors. In early conceptualizations, the IBH framework consisted of 5 levels of collaboration (minimal collaboration, basic collaboration at a distance, basic collaboration on-site, close collaboration in a partly integrated system, and close collaboration in a fully integrated system) (Blount, 1998; Bridges et al., 2014; Doherty et al., 1996). It was also thought that with higher levels of integration came an increased capacity for dealing with complex patients (Doherty et al., 1996; Heath et al., 2013). IBH models have also been distinguished based on three dimensions**:** coordinated care, co-located care, and integrated care (Blount, 2003). Coordinated care takes place when services are coordinated/information is exchanged between medical and behavioral health teams who are located in different settings. Co-located care occurs when behavioral health and medical health services are located in the same suite of offices and/or share staff, but there may be multiple treatment plans. Finally, integrated care occurs when there is only one treatment plan that includes medical and behavioral health components with providers in the same setting (Blount, 2003).

Most recently, Heath et al. (2013) developed a new framework that consists of 6 levels and the three dimensions (coordinated, co-located, and integrated) described by Blount (2003), where there are two levels per dimension to distinguish between varying degrees of collaboration and integration (see Figure 2).

Figure 2

Framework of IBH Integration

Coordinated		Co-Located		Integrated	
Level 1 Minimal Collaboration	Level 2 Basic Collaboration at a Distance	Level 3 Basic Collaboration Onsite	Level 4 Close Collaboration Onsite with Some System Integration	Level 5 Close Collaboration Approaching an Integrated Practice	Level 6 Full Collaboration in a Transformed/Merged Integrated Practice

Heath, Wise Romero, & Reynolds, 2013

This new framework can help organizations better understand their level of integration and identify steps they can take towards increasing integration (Heath et al., 2013). The authors considered how the extent of interaction between physicians and behavioral health providers distinguishes between levels, as this interaction is an important component of successful integration (Heath et al., 2013). For both the coordinated care levels, *Minimal Collaboration* (Level 1) and *Basic Collaboration at a Distance* (Level 2), medical and behavioral health providers work in different settings, but there is greater communication between the two at Level 2. For the two co-located care levels, *Basic Collaboration Onsite* (Level 3) and *Close Collaboration Onsite with Some System Integration* (Level 4), medical and behavioral health providers work in the same setting. At Level 3, providers might not work in the same space within the facility and have separate systems, communicate by phone or email, and meet occasionally. At Level 4, both groups of providers work in the same space within the facility, share some systems, and communicate more in person than at Level 3. For the two integrated care levels, *Close Collaboration Approaching an Integrated Practice* (Level 5) and *Full Collaboration in a Transformed/Merged Integrated Practice* (Level 6), both medical and behavioral providers work in the same space within the same facility. At Level 5, providers communicate frequently in person and have regular meetings, but at Level 6 the facility is functioning as a true integrated system with consistent communication and collaboration, and roles and cultures blend seamlessly (Heath et al., 2013).

An important consideration across all IBH approaches is ensuring that providers are educated and trained on how to effectively utilize IBH and function as an integrated team. Njoroge et al. (2017) identified training competencies for integrated care for all providers, spanning psychiatry, psychology, and social work disciplines. These include: interprofessional communication, professionalism, integrated care systems practice, practice-based learning and education, preventative screening and assessment, and cultural competence (Njoroge et al., 2017). As a real world example of why it is important to have training competencies, Tai-Seale et al. (2010) evaluated a collaborative care model at a clinic and found that primary care providers had missed multiple opportunities to address mental health issues, including not mentioning the onsite mental health provider during visits and prescribing medication without a comprehensive mental health assessment. They recommended providing ongoing education and training to primary care providers about how to facilitate handoffs as well as education about patient-provider interactions (Tai-Seale et al., 2010). Thus, having competencies can help to ensure that providers in integrated care settings have the necessary skills to treat children and their families, and can also help to maintain the highest level of integration possible.

Populations Served by IBH

IBH for Children and Adolescents

It is imperative for children and adolescents to be identified for mental health services and receive appropriate and comprehensive care. However, Merikangas et al. (2011) found that in a nationally representative sample of adolescents who completed a diagnostic interview and reported their service use, only one third of adolescents who were identified as having mental health disorders from the diagnostic interview actually received services. Children with early-onset behavioral health needs that are not treated are at risk for various adverse outcomes including dropping out of school, teen pregnancy, and chronic medical problems (Richardson et al., 2017). This highlights the need for IBH as a way to help close this gap and ensure that children and adolescents have access to and are receiving mental health services.

Research on IBH for children and adolescents provides support for the effectiveness of IBH for this population (Fiscella, 2015; Richardson et al, 2017; Talmi et al., 2016). Asarnow et al. (2015) conducted a meta-analysis where they included 35 randomized clinical trials comparing integrated care models to usual care on behavioral health outcomes for children and adolescents, and found that integrated care models were significantly more effective in improving mental health outcomes (i.e., the outcomes measured in specific studies). They also found that collaborative care models (which examined CBT for depression or behavior problems and evidence-based medication treatments) were especially efficacious, in that there was a 73% probability that a randomly selected youth would have better mental health outcomes after receiving collaborative care than a randomly selected youth who received usual care (Asarnow et al., 2015). Richardson et al. (2009) adapted the adult IMPACT collaborative care model for depression for adolescents between 12 and 18 years old at 3 clinics. They found that at 6 months follow-up, 70% of adolescents had a 50% or more reduction in depressive symptoms. Shahidullah et al. (2018) reviewed the literature and identified 6 integrated care models that all showed positive outcomes for children with ADHD, including one model that utilized indirect psychiatric consultation through phone calls, which they identified as a promising avenue through which to provide care in settings where behavioral health services are limited. Thus, IBH and collaborative care models in particular are an effective way to increase access to mental health care for children and adolescents.

IBH for Latine Populations

IBH may be especially important for populations that are traditionally underserved by the behavioral health system, including Latine youth. Cabassa et al. (2006) reviewed the literature on how Latine adults access mental health services, and found that Latine adults consistently relied on primary care for mental health and underutilized mental health services compared to White adults. Brown and Wissow (2010) found that primary care providers were less likely to positively screen Latine and Black children for behavioral and emotional health problems compared to White children. Further, Merikangas et al. (2011) found using a nationally representative dataset that Latine and non-Latine Black adolescents were less likely to receive treatment for mood and anxiety disorders compared to White adolescents. Latine children and children who were uninsured had the highest rates of unmet mental health needs in a study using three nationally representative datasets (Kataoka et al., 2002). Supporting this finding, first generation Latine youth were less likely to receive services than non-immigrant White youth in another study using nationally representative data (Georgiades et al., 2018).

It is important to consider the social determinants of racial and ethnic disparities in health. One such social determinant that plays a fundamental role in health disparities is economic resources (Braveman et al., 2011). Poverty affects children and families at various levels, including the individual level (e.g., increasing child stress and parent stress, and reducing nutritional intake), relational level (e.g., reducing quality of family or peer relationships and increasing relational conflict), and institutional level (e.g., lowering health care access, increasing access to low quality schools, and increasing neighborhood danger) (Hodgkinson et al., 2017; Yoshikawa et al., 2012). Certain minority groups are disproportionality affected by poverty; the U.S. Census Bureau reported that in 2017, 18.3% of the Latine population were living at the poverty level compared to 8.7% of the White, non-Latine population (U.S. Census Bureau, 2017). Latine children are also more likely to be uninsured compared to White, Native American, African American, and Asian or Pacific Islander children (Flores & Tomany-Korman, 2008). However, even at the same income levels, there are a higher percentage of Latine and Black children with poorer overall health compared to White children (Braveman et al., 2011; Hodgkinson et al., 2017). This speaks to other factors that may contribute negatively to mental health and mental health access as well as overall health for Latine individuals including acculturative stress, immigration stress, exposure to violence, discrimination, stigma around mental health, and language and access barriers (Braveman et al., 2011; Bridges et al., 2014; Cabassa et al., 2007; Céspedes & Huey, 2008; DuBard & Gizlice, 2008; Gudiño et al., 2011, Zuvekas & Taliaferro, 2003). IBH may especially valuable for Latine families living in low-income contexts, in order to increase access to mental healthcare services.

Studies have found a positive effect of IBH in reducing psychological distress and treatment dropout for Latine individuals (Bridges et al., 2014; Gomez et al., 2014; Rapp et al., 2017). A randomized controlled study found that in a primary care setting, when group cognitive behavioral therapy was accompanied by case management (an IBH practice) for adults with depression, Spanish-speaking patients of lower income had reduced drop-out rates and improvements in symptoms compared to those who received group cognitive behavioral therapy alone (Miranda et al., 2003). Case management reflects a form of IBH, as social workers embedded in primary care clinics who had CBT training coordinated care between providers and provided additional support for patients in addition to the group intervention. Bridges et al. (2014) found that Latine adults (over half were uninsured) who received behavioral health services in primary care clinics (a co-located IBH model) had clinically significant improvements in symptoms overtime and were satisfied with the care they received. Myers et al. (2010) examined a collaborative care model for Latine children diagnosed with ADHD at two clinics (one urban and one rural) where children were diagnosed based on the DSM and using rating scales. A consulting psychiatrist reviewed cases with a care manager and decided on medication recommendations. The care manager communicated medication recommendations to pediatricians who followed up with patients monthly. Parents were educated about ADHD management by various providers including care management staff. They found significant reductions in ADHD symptoms for patients at both clinics. Finally, Talmi et al. (2016) documented types of behavioral health consultation offered to patients at a large behavioral health clinic that serves a majority Latine population (56% of patients are Latine and 40% of families are Spanish speaking). They found that Latine patients had more mental health consultation visits while non-Latine White patients had more Healthy Steps (0-3 years old) visits, pregnancy-related developmental consultations, developmental consultations, and psychopharmacology consultations. This highlights the broad range of behavioral health services that can be offered in the primary care setting while also demonstrating how gaps in care still exist in primary care settings especially for non-English speaking families. Other research has found improvements in depressive symptoms for Latine patients with diabetes after implementing behavioral health services in primary care including psychiatric medication and brief therapy (Ell et al., 2010). Thus, IBH appears to be valuable in providing mental health care for Latine patients, although this continues to be an under researched area, and there is room to grow in increasing access to mental health care for Spanish-speaking Latine families.

In addition to improving mental health outcomes, IBH has also been evaluated as both a feasible and acceptable model for providers, patients, and their families (Power et al., 2014; Funderunk et al., 2012), although some research suggests that feasibility and acceptability may depend on patient characteristics and preferences. For example, Rodríguez et al. (2018) conducted qualitative interviews with providers who were part of a collaborative care program at a Federally Qualified Health Center (serving mostly Latine families), where all providers (primary care providers, psychiatrists, social workers, etc.) involved in the child's care met at the same time with the family, and found mixed evidence of the program's feasibility and acceptability. For example, providers remarked that they thought patients at times appeared defensive or intimidated with the team approach and meeting with multiple providers at once (Rodríguez et al., 2018). In addition, providers noted that the psychiatry consultation placed some burden on providers who had to relay information from the meeting to patients (even though patients were present at the meeting). However, all providers remarked that the biggest effect of the psychiatry consultation was that it led to interdisciplinary integration, where providers with different backgrounds and trainings were able to contribute their expertise to better treat patients (Rodríguez et al., 2018). Thus, while IBH is generally viewed as a feasible and acceptable way to provide mental health care, it is important to assess patient acceptability to ensure that IBH is meeting patients' needs, which is addressed in this study.

Language and Mental Health

Children and caregivers who are not fluent in English face many barriers when communicating with providers in medical settings, and IBH models may help to reduce these barriers (Flores, 2000; Kirkman-Liff & Mondragón, 1991). When families with limited English proficiency are not provided with interpreters during medical visits, their care is compromised (Becker Herbst et al., 2015; Flores, 2005). For example, Kirkman-Liff et al. (1991) interviewed Latine children and parents in Spanish or English, depending on preference, about their health status, satisfaction with care, and other areas. They found that children and parents who preferred Spanish had lower health status (current health status, disability status) and more difficulties accessing care (whether it had been easy or difficult to get the medical care they needed, whether participants had been refused care, and financial problems), supporting the notion that children in need of services may fail to be identified and receive adequate care if language is not considered. DuBard and Gizlice (2008) found using data from a national telephone survey that Spanish speaking Latines were more likely to be uninsured, had worse perceived health, and were less likely to receive preventative health services compared to English speaking Latines. Further, Becker Herbst et al. (2016) found that Spanish speaking families were less likely to be identified for behavioral health consultations at a pediatric primary care clinic, and providers spent less time during consultations with Spanish-speaking families compared to English-speaking families, perhaps due to communication difficulties or provider discomfort. They also found that only 55% of visits for families who spoke Spanish or another language had documented use of an interpreter, further suggesting that communication difficulties may have impacted access to care (Becker Herbst et al., 2016). Misunderstandings are frequent when interpreters are untrained or when non-interpreters such as family members interpret at visits, which impacts quality of care and identification of mental health problems (Flores, 2005). Through a team based approach to care, gaps in understanding may be better identified and addressed. Thus, IBH may be especially important for Spanish speaking families who may have experienced more barriers in accessing mental health care. This is especially relevant for the current study, which includes a primarily Latine sample with some Spanish-speaking parents.

Gaps in the IBH Literature

Various gaps in the IBH literature have been identified. Vogel et al. (2017) and Talmi et al. (2016) discussed future directions in research on behavioral health and primary care and noted several gaps in the knowledge base, including understanding better how minoritized populations are best served by IBH. They also discussed how IBH research typically focuses on single disease states (especially depression) or a combination of two very related disease states (such as the well-studied link between depression and diabetes), even though there is a wide range of physical health problems and comorbid mental health problems (Carey et al., 2010; Richardson et al., 2017; Talmi et al., 2016; Vogel et al., 2017). Further, research is lacking on integrated care models for children and adolescents with ADHD, even though prevalence rates are high for ADHD in children (Shahidullah et al., 2018). Richardson et al. (2017) found that few studies have examined behavioral health integration for adolescents and young adults, and most of those studies have focused on patients with depression.

Another gap that has been identified is considering patient and family perspectives on IBH, including patient engagement and experience and the role of the patient in IBH teams (Kwan & Nease, 2013). More research is also needed on considering developmental level when evaluating integrated care models, including level of child involvement as children get older and parental participation in and acceptance of IBH models (Richardson et al., 2017; Brown et al., 2018). Providers at the clinic in the current study were interviewed previously by the research team to understand their attitudes and experiences towards the collaborative care model (Rodríguez et al., 2018). Results pointed at various benefits associated with the model, including increased access to care for patients with complex diagnoses, and increased learning and satisfaction. Providers also discussed challenges, including increased burden on primary care providers and perceptions of potential patient discomfort (Rodríguez et al., 2018). Although providers overall were satisfied with the collaborative care model, it is imperative to understand families' attitudes and experiences as well, since the provider perspective is only one side of the story. Finally, research is lacking on how patients experience trust in healthcare providers in general, as well as in the context of primary care (Hong & Oh, 2020; Brown et al., 2018), which will be expanded upon in the next section.

Trust

Trust in medical providers is a central component of patient-centered care, is essential to the patient-provider relationship, and is relevant for clinical outcomes. Hall et al. (2001) completed a review of the literature and shared common components of definitions of trust in the medical context. These include "the *optimistic* acceptance of a *vulnerable* situation in which the truster believes the trustee will *care* for the truster's interests" (Hall et al., 2001, p. 615). They go on to describe how trust is inseparable from vulnerability created by illness and how an optimistic acceptance is what differentiates trust from distrust, where patients may be wary or pessimistic (Hall et al., 2001). They also describe how trust takes on an emotional component, especially in the medical context, when one believes that the motivations of the provider are "benevolent and caring," as individuals place an "extraordinary" amount of trust in physicians which could also serve as a coping mechanism (Hall et al., 2001, p. 616-617). Hall et al. (2001) also outline five dimensions of trust in the provider, including fidelity (keeping patient's best interests in mind), competence (avoiding mistakes and ensuring best results), honesty (telling the truth), confidentiality (protection of private/sensitive information), and global trust (holistic aspect of trust). Murray and McCrone (2015) defined promoting trust in the patient-provider relationship as a "provider demonstration of interpersonal and technical competence, moral comportment and vigilance to support positive patient outcomes," which has considerable overlap with Hall's dimensions of trust (p. 4). Finally, Ozawa and Sripad (2013) reviewed the literature and identified 45 measures of trust among various relationships in the healthcare system. They found that honesty, communication, confidence and competence were captured frequently in measures of trust, and factors such as fidelity, system trust, confidentiality, and fairness were less captured. This study considers all of these definitions and components when identifying facilitators of trust.

Trust and Health Outcomes & Theoretical Basis. Studies have shown that trust in providers is linked to improved health outcomes. For example, in one study trust was one of two variables strongly linked to adherence rates and satisfaction with clinicians in a large sample of patients (Safran et al., 1998). Other studies have found that patients with more trust in their providers have better control over their diabetes (Mancuso, 2010; Lee & Linn, 2009), are more adherent to antiretroviral medications (Blackstock et al., 2012), and have greater use of preventative services (O'Malley et al., 2004; Caso et al., 2019). Netemeyer et al (2020) found that individuals with more trust in their doctors had more consultations with their doctors and reported increases in subjective well-being, and that these findings were partially mediated by doctor visit anxiety. Becker and Roblin (2008) found that supportive interactions between practitioners and staff in primary care teams facilitate trusting interactions between practitioners and patients, which in turn contributes to patients who play an active role in their health (patient activation). The association between trust and patient activation helps explain improved adherence and patient outcomes. Latines who are bilingual compared to Spanish-speaking only have reported higher mean patient activation scores in the literature, and higher activation scores were associated with high self-reported quality of care, better doctor-patient communication, and trust (Alegría et al., 2009). Other studies have found self-efficacy and perceived control as possible mediators of the relationship between trust and improved adherence (Gabay, 2015; Lee & Lin 2011). Thus, it is important to consider trust in the patient-provider relationship in order to improve treatment engagement and health outcomes.

Several theoretical models also inform an understanding of the relationship between trust and health. A theory that may help to elucidate how trust is related to improved health outcomes is the Theory of Planned Behavior (Vissman et al., 2011). This theory describes how carrying out health behaviors is predicted by one's intentions to perform a particular action and intention is predicted by: (a) *attitude* (evaluation of consequences or outcomes of performing behavior), (b) *subjective norms* (social pressures), and (c) *perceived behavioral control*. Studies have described how trust in providers may contribute to subjective norms (e.g. having trust in providers contributes to decision-making processes regarding health behaviors) (Quinn et al., 2011).

Two additional theoretical models that may be related to the role of trust in health care providers are the Relational Theory of Power (Hocker and Wilmot, 1995) and the Chronic Care Model (Bodeheimer et al., 2002). The Relational Theory of Power describes the importance of considering power dynamics in the context of interpersonal relationships (Hocker and Wilmot, 1995). This is especially relevant when considering hierarchical relationships such as patient and provider relationships. The theory defines three types of power: designated (based on the position one holds), distributive (one party holding power over another but power can be gained through relationship building, by focusing on qualities such as empathy and concern), and integrative (the idea that all parties have some type of power). The theory focuses on communication as a way to gain or lose power. Researchers studying vaccine decisions identified trust as a major theme that affected power dynamics between patients and providers. Researchers have suggested that distributive power could be improved through providers showing more empathy (Limaye et al., 2020).

The Chronic Care Model (CCM) may also inform research on the patient-provider relationship, including the element of trust within that relationship. The CCM has been widely cited as a model to improve the quality of chronic illness management in primary care. The model describes how self-management support, clinical information systems, delivery system redesign, decision support, health care organization, and community resources can contribute to patients taking more of an active role in their health (Bodeheimer et al., 2002). Some researchers have theorized that the CCM leads to better communication and stronger relationships between patients and providers, enhancing interpersonal trust and contributing to improved patient outcomes (Bulgaru-Iliescu et al., 2013).

In sum, theoretical models such as the ones previously described help to explain how trust contributes to health decisions, medical adherence, and thus overall health. More research is needed to develop theories to better understand how trust manifests in the context of behavioral health in primary care for marginalized populations. Enhancing trust and buy-in to treatment regimens is even more critical for populations who may have greater mistrust in healthcare. The following section describes trust among marginalized populations in greater detail.

Trust Among Marginalized Populations. Trust in providers among marginalized populations is lower than for white patients and this is affected by various factors, such as the history of unfair treatment in medical and research contexts for Black and Latine individuals. For example, the Tuskegee Syphilis Study and the disproportionate sterilization of Latine men and women for decades in the 1900s highlight historical structural racism in healthcare, which contributes to lasting mistrust (Brandt et al., 1978; Novak et al., 2018). In present times, discrepancies in screening, treatment, and mortality rates for Black and Latine individuals persist compared to White individuals, and perceived discrimination also impacts both trust in healthcare and health outcomes (Benkert et al., 2006; Brown & Wissow, 2010; Merikangas, 2011; Pascoe & Richman, 2009). For instance, Benkert et al. (2006) found that perceived racism had a significant indirect effect on satisfaction with medical care, which was mediated by cultural mistrust and trust in providers for a sample of low-income Black patients at two primary care clinics. In addition, Blair et al. (2013) measured implicit and explicit racial bias in clinicians and compared these ratings to Black and Latine patient measures of clinicians' interpersonal treatment, communication, trust, and contextual knowledge. They found that clinicians with greater implicit bias were rated lower in all patient measures of clinicians compared to clinicians with less implicit bias, supporting a negative association between provider implicit bias and trust.

These historical and contemporary factors may all contribute to the findings that Black and Latine patients have less trust in providers compared to White patients (Boulware et al., 2003). For example, Doescher (2000) used nationally representative samples and measured satisfaction and trust with physicians using two scales. They found that racial and ethnic minorities reported less satisfaction and trust with physicians compared to White individuals (Doescher, 2000). They also found that minoritized individuals living in low income contexts had especially low satisfaction and trust, and that individuals who lacked physician continuity also had low satisfaction and trust.

Trust for Latine Populations. Research is lacking on the experience of trust in healthcare and health care providers for Latine populations (Jaiswal, 2019), however there are some notable studies and factors that have been identified that may impact trust. Cook et al. (2014) used language status as a proxy for acculturation, and found that Latine parents with higher levels of acculturation were more likely to discuss mental health with their child's primary care providers compared to parents with lower levels of acculturation. They suggested that higher levels of acculturation may contribute to more trust in providers (Cook et al., 2014). Further, another study found that lower levels of linguistic acculturation in Latine adults was associated with greater perceived discrimination in and lower quality health care treatment, less confidence filling out forms, and challenges with understanding written information (Becerra et al., 2015). They also found that participants who identified as immigrants believed that inability to pay and race/ethnicity contributed to poor quality medical care (Becerra et al., 2015). Finally, Latine parents whose children were in the emergency room (and especially Spanish-speaking Latine parents) were found to have the lowest amounts of trust in physicians and in the health care system compared to non-Latine parents (Fields et al., 2016). Considering current immigration policies including blocking the Deferred Action for Childhood Arrivals (DACA) policy and threats of deportation, it is understandable that less acculturated Latines (who may have recently immigrated) may experience less trust in providers and healthcare.

Certain Latine cultural values may contribute to trust (confianza), including respeto, familísmo, and personalismo. Calzada et al. (2010) found that respeto (respect) was one of the three most salient cultural values for Mexican and Dominican mothers. Respeto, or "knowing the level of courtesy and decorum required in a given situation in relation to other people of a particular age, sex, and social status" (Harwood et al., 1995, p. 98) may be especially relevant for the current study, as parents and their children interact with various providers including psychiatrists, who may be seen as authority figures and of high status (Floríndez et al., 2020). Although respeto may indicate trust in providers, when individuals hold respeto in high value, they may be more hesitant to ask providers questions, which could contribute to misunderstandings and less satisfaction with care (Flores, 2000). In a patient-centered care model, providers should elicit information and questions from patients, ensuring that care is comprehensive, there is no hesitancy, and trust and satisfaction are maintained. In this way, respeto can also be reciprocal, as the reciprocal nature of respeto is important and is essential to patient-centered care (Flores et al., 2000). Familísmo, or the commitment to family, has been associated with less risky health behaviors and improved mental health outcomes (Keeler et al., 2014; Oakley et al., 2019). For example, Keeler et al. (2014) found that lower familísmo values were partially responsible for reduced help seeking for Mexican-American individuals with depression. Oakley et al. (2019) found initial evidence indicating that young adult Latine individuals with stronger familísmo values had lower levels of medical mistrust. This indicates support for considering familísmo ideals, especially when working with children and their parents. Personalismo (personal relationships) is stressed in Latine culture as opposed to institutional and professional relationships (Antshel, 2002). Flores et al. (2000) suggested that personalismo can be achieved in medical settings through reducing physical distance during interactions and showing a personal connection through conversing about the parent's and patient's life at visits. Personalismo may be especially relevant when considering the importance of trust in Latine patient-provider relationships. Thus, considering cultural values may help to provide understanding of how to facilitate trust in providers for Latine families.

Psychiatry Care and Trust. Research is lacking on how patients experience trust in the context of primary care. Brown et al. (2018) reviewed gaps in the literature for behavioral health programs in primary care, and found that trust in primary care as a mediator of intervention effectiveness was not sufficiently studied. There are also specific gaps in the literature related to how youth and young adults experience and respond to trust (Murray & McCrone, 2015).

Examining trust in youth and their parents in the context of behavioral health and psychiatry consultation may be especially important, as there is a national shortage of child/adolescent psychiatrists which translates into long wait times and often the inability to access psychiatry support (Hunt et al., 2020; Sullivan et al., 2020). This coupled with primary care providers expressing discomfort with prescribing psychiatric medications contributes to a significant lack of access to psychiatry care (Cole et al., 2014; Hodgkinson et al., 2017; Horwitz et al., 2007; Loeb et al., 2012). In integrated behavioral health models, mutual learning that occurs as part of interdisciplinary integration can increase provider comfort with prescribing psychiatric medication (Hodgkinson et al., 2017; Loeb et al., 2012). However, even with increased access to psychiatry support in primary care, concerns about putting children on psychiatric medications persist. For Latine families, concerns about medication may be even more salient as cultural mistrust and language barriers may further exacerbate concerns about psychiatric medication use. Given that psychiatric medication is often a frontline treatment for certain psychiatric conditions, improving treatment acceptance has important implications

(Wolraich et al., 2019). Berger-Jenkins et al. (2012) found that parents from underserved/minoritized communities of children with untreated ADHD reported concerns with medications, and therefore attended fewer mental health appointments and did not utilize treatments. The authors suggest that open discussions with parents and providing education about medications should be an essential component of care (Berger-Jenkins et al., 2012). Arcia et al. (2004) completed a multimethod study assessing Latina mothers' perspectives on stimulant medications, and found a strong preference for non-medication treatment options due to fears of addiction and concerns about whether the medication would impact physical and mental functioning in the long-term. In their results, they mentioned that physicians had an influence on the mothers' opinions, and that good management by physicians eased the acceptance process (Arcia et al., 2004). Black and Latine adult patients were less likely to be accepting of antidepressants compared to White patients in another study (Cooper et al., 2003).

Stigma about addiction, reliance on medications, and feeling like medications are for "crazy" people or that others will think they are "crazy" for taking medications can contribute to mistrust in behavioral health providers within the Latine community (Interian et al., 2007; Vargas et al., 2015). Cultural values may also intersect with trust within the IBH context in bidirectional ways. For example, Latine values such as trabajodores (hardworking), aprovechadores (taking advantage of opportunities in the United States), and familísmo (family oriented) may impact stigma related to mental health treatment and seeking care, however these values also may support seeking care as well. For example, familísmo has been found be related to service-seeking behaviors but can also serve as a barrier if families have stigma against specialty mental health services and are more inclined to use family or religious supports (Ishikawa, Cardemil, & Falmagne, 2010; Chang, Chen, & Alegría, 2014; Villatoro, Morales, &

Mays, 2014). Further, low income contexts may disrupt parenting and contribute to behavioral problems in children even if familísmo is strong (Gonzales et al., 2011).

The IBH context, and collaborative care in particular, provides a unique perspective through which to examine trust. Since families have a pre-existing relationship with their primary care providers, there may be an initial level of trust. However, this needs to be maintained in order for families to be engaged in treatment recommendations by the psychiatrists and the rest of the behavioral health team in order to follow through with treatment. Within the collaborative care model, where primary care providers are often present at psychiatric consultation meetings, trust may be especially likely to be cultivated. Cultural match (race/ethnicity, language, and other factors) between behavioral health providers and patients can also serve as a facilitator of trust and can contribute to the therapeutic alliance within the behavioral health context (Falgas-Bague et al., 2019). However, this is not always possible, and there are other ways to facilitate trust that will be explored in the current study such as through team models, cultural sensitivity, and patient-centered care (Fiscella et al., 2004; Hong & Oh, 2020). Janevic et al. (2017) found that parents' perceptions of trust in providers significantly improved following a pediatric asthma care coordination intervention where asthma care coordinators facilitated family-clinical communication and provided asthma education. In the current study, the clinic utilizes psychiatry consultation, medications are frequently discussed, and therapy is often recommended. Thus, facilitators of trust are likely an important component of families' overall experience with the psychiatry conference and should be examined, as they may impact acceptability of medications and psychiatry follow-up for Latine families.

Summary of Previous Research

There are various models of IBH, which operate at different levels of collaboration and integration (Heath et al., 2013). IBH has the potential to increase access to mental health care and reduce burden placed on primary care providers. IBH may be especially important for Latine youth living in low-income contexts, who are undertreated and may face various contextual and individual barriers when accessing mental health care. Collaborative care is an integrated approach to care that utilizes psychiatry consultation and may be especially beneficial for youth with complex mental health concerns to increase access to psychiatric care in the primary care setting. Trust in behavioral health providers and their treatment recommendations has important implications, as trust is related to improved adherence as well as overall satisfaction with care (Blackstock et al., 2012; Mancuso, 2010). Understanding how trust is facilitated in the IBH setting is critical to improving the patient experience and ultimately mental health outcomes. Research is lacking on how patients and families experience trust in providers as part of IBH. Thus, a qualitative approach is appropriate to explore this issue and generate hypotheses, which will be expanded upon in the next sections.

Research Questions

The current study aims to fill gaps in the research and consider facilitators of trust in providers for primarily Latine children and adolescents and their caregivers who participate in a collaborative care model at a Federally Qualified Health Center (FQHC) in a large Southwestern city. The study population includes children with neurodevelopmental differences and co-morbid internalizing and externalizing mental health problems and their caregivers. Understanding facilitators of trust has important implications, as trust is related to improved adherence, higher satisfaction, and ultimately, better health outcomes (Safran et al., 1998; Mancuso, 2010; Lee &

Lin, 2009). The current study occurs as part of a larger Community Based Participatory Research partnership.

Conducting in-depth qualitative interviews with children and caregivers will provide a better understanding of aspects of the model that facilitate and undermine trust. Understanding facilitators of trust has the potential to increase caregiver and child participation in the model as well as in treatment recommendations to facilitate openness and honesty with providers, which ultimately may lead to improved care and outcomes for patients. Further, the study sample includes underserved/minoritized communities and it is imperative to understand how trust is facilitated for this population, taking cultural considerations into account.

Research Question 1: What helps to facilitate caregiver trust in the psychiatrist and other providers at the psychiatry conference?

Research Question 2: What helps to facilitate child trust in the psychiatrist and other providers at the psychiatry conference?

Research Question 3: How do participants' experiences as individuals from underserved/minoritized communities affect their experience of trust within the psychiatry conference?

Research Question 4: What are recommendations for the clinic to better help children and caregivers establish trust in the psychiatrist and other providers?

Chapter 3: Methodology

Community Based Participatory Research

The CBPR partnership developed after the director of the adolescent program at the clinic wanted assistance with evaluating their innovative use of psychiatry as part of the larger IBH program. The clinic already had a pre-existing relationship with the university as the clinic served as a training site for psychology externs pursuing clinical experiences in primary care settings. The director communicated their research idea to the faculty member who placed trainees at the clinic, who then discussed the project with a faculty member whose research interests aligned with the overarching goals of the study director. The director met another faculty member separately (from a different department) when they were interviewed for a study, and the director initiated a meeting between the two faculty members to share ideas about the research partnership. They agreed to find ways to collaborate and agreed on qualitative methodology as the best approach based on the research interests of understanding family experiences in primary care, and two qualitative studies were developed based on the needs of the clinic, one of which is the current study.

CBPR has shaped this study in a variety of ways, consistent with CBPR principles (Israel et al., 2003). For example, the research partnership was established by a provider at the clinic who sought help evaluating the clinic's IBH model, consistent with the principle of focusing on community-relevant problems. The research questions were initially generated by the clinic and the study is based on the clinic's needs. Thus, community stakeholders have the primary voice in the research questions and can voice any concerns that arise. When additional research questions are introduced, input is sought by the entire research team, especially members of the team from the clinic, to ensure that the project continues to align with the clinic's goals. The team has worked with staff at the clinic to identify effective and inclusive recruitment practices (including a flyer and a $20 gift card for participation), consistent with CBPR being a cyclical and iterative process as well as a long-term process with a commitment to sustainability. The team also broke the project into smaller, more manageable chunks so that results could be disseminated in shorter amounts of time and plans were developed to disseminate results from the study to the clinic, consistent with the dissemination of findings to the community principle. Through the team having open communication, a lack of hierarchy, and less formal meeting structures to make the process more collaborative and jovial, the team is adhering to the principle of co-learning and capacity-building among team members. Finally, as previously mentioned, all members of the research team, from UT and the clinic, are involved in coding and theme development. This also helps to maintain the participatory nature of the study.

Setting

Clinic

The research team partnered with a FQHC in a large southwestern city in the United States that primarily serves low-income, Latine patients and utilizes psychiatry consultation as part of its collaborative care model to help serve the mental health needs of its patients.

The clinic offers a greater variety of health and wellness services in Austin compared to other not-for-profit clinics. The clinic offers prenatal care through eldercare, and around 17,000 patients are seen annually. The clinic employs over 200 personnel, including many primary care providers and social workers. Services also include an adolescent health center, IBH services (which are described in more detail below), nutrition and breastfeeding counseling as well as prenatal care, and a teen prenatal and parenting program. In 2017, the majority of patients were below the poverty line (74%) and identified as Latine (82.7%). In this same year, 22.6% of the clinic's patient population consisted of children and adolescents from 5 to 19 years old.

IBH program. The IBH Program at the clinic utilizes a collaborative care model which includes primary care providers (physicians and nurse practitioners), social workers, psychology interns, and consulting psychiatrists working collaboratively to address patient concerns. The larger IBH Program at the clinic includes services for adults, adolescents, and pediatric patients. One of the programs includes children and adolescents who are referred for behavioral, learning, or developmental concerns, and a developmental assessment is completed. Patients and their families typically first meet with a primary care provider who learns more about their concerns and has caregivers complete rating scales. Social workers can be called into the meeting with the primary care provider to consult with the provider and/or meet briefly with the caregiver. Caregiver rating scales are scored by staff and are given to the provider. School records (Special Education and 504 Plan records) are also collected. The provider then may either see the patient again or can ask psychology interns/externs or the social worker to meet with the parent for the psychosocial/educational component of the developmental assessment. The provider then finishes the developmental assessment, and if diagnostic or other help is still needed, they can refer to the psychiatry conference (see below for more information). This program appears to operate around a Level 4 (*Close Collaboration Onsite with Some System Integration)*. Although the medical and behavioral health providers work in the same setting, systems are not totally shared/integrated, since the primary care provider communicates with social workers and psychology interns/externs on an as-needed basis. This program aims to utilize evidence-based practices and is supported by a community advisory council that meets with professionals to review standards and resources regarding youth with special needs.

Psychiatry Conference. A unique component of the clinic's IBH model is the psychiatry conference, a collaborative care model. Around 10% of patients are referred to the psychiatry conference from the larger child and adolescent program previously described, and the psychiatry conference represents a higher level of care compared to that program because it integrates psychiatry consultation and has a focus on addressing complex mental health concerns. The psychiatry conference was developed to help providers with patients who have complex developmental issues, learning problems, or mood problems, a lack of success with prior treatments (e.g., medication and/or therapy), when diagnostic clarification is needed, or other concerns are present. Primary care providers at the clinic refer patients to the conference, and before the conference the psychiatrist reviews information collected by other providers working with the family, including behavior rating scales and other medical record and assessment information. At the psychiatry conference, the psychiatrist interviews patients and caregivers, and providers involved with the patient's care (including primary care providers, social workers, and others) are also present and contribute to the meeting. Providers fluent in Spanish interpret for Spanish speaking families. The psychiatrist then confirms/determines diagnoses and develops treatment plans with input from other providers as well as the family. Although the psychiatrists are not housed within the clinic, they are also available by phone if additional questions arise. The psychiatry conference appears to operate around a Level 5 (*Close Collaboration Approaching an Integrated Practice*), since all of the providers are present at the psychiatry conference and are involved in the child's care, which represents a high level of integration. However, since the psychiatrist may not be physically present when issues arise, and may be hard to reach by phone at all times, the psychiatry conference does not operate as a true integrated system.

Sample

Fourteen caregivers and six children/adolescents were interviewed for the current study. Over two thirds of families identified as Latine. Purposive sampling was utilized in the study with total population sampling method (Etikan et al., 2016). Purposive sampling was utilized because participants needed to meet certain inclusion criteria. Through total population sampling, defined as including the entire population that meets criteria in research being conducted, we offered every family who met criteria the opportunity to participate (Etikan et al., 2016).

For the child and adolescent interviews, inclusion criteria included: attended at least one psychiatry conference and between the ages of 9 and 17 at the time of the interview. This age range was selected because the adapted interview for children is developmentally appropriate for most children in this age range. It was also difficult to elicit information from younger children about abstract concepts, which was also taken into consideration when selecting the appropriate age range. For the caregiver interviews, inclusion criteria included: attendance at the psychiatry conference, having a child who also attended at least one psychiatry conference, and English or Spanish-speaking. To improve the feasibility of recruiting a sufficient sample of both caregivers and children, only one member of a family was interviewed (e.g. caregiver or child). This approach allowed parents to participate even if their child could not complete the interview due to a developmental disability, and allowed children to participate even if their parent was not interested in participating (and vice versa). In contrast, if the recruitment approach attempted to enroll only caregivers and children from the same families, it would be more challenging to enroll a sufficient number of families, and if only part of the sample included parent-child dyads from the same family, results may be biased. For example, there may be an overrepresentation of experiences if both members of a dyad completed interviews while other families only had one member of the dyad participate. The research team recruited enough families until data saturation was met (Guest, Bunce, and Johnson, 2006). Guest et al.'s (2020) formula for calculating thematic saturation and determining an adequate sample size was utilized. This formula takes into account when new codes were created as well as changes to code definitions or eligibility criteria. The formula divides the number of new themes or changes in codes in a run by the number of base themes (number of themes identified or codes changed within the first four to six interviews) to calculate percent saturation (# new themes per run/# base themes=% saturation). The saturation threshold was set at 5%, run length was set at 2, and base size was set at 6. Saturation was achieved with high confidence at 5%.

Parents overall participated in the psychiatry conference to a higher degree than children/adolescents, as children participated from a range of minimally to an average amount. Families attended a range from one to nine psychiatry conferences. The average parent interview length was 18 minutes and 25 seconds, while the average child interview length was 11 minutes and 23 seconds. Please see the demographics table below for more detailed information on the sample.

Table 1

Demographics

	Parent interviews (n=13)[a]	Child interviews (n=6)
Child Race	69% (n=9) White, 23% (n=3) Other (Hispanic), 7.7% (n=1) Black	50% (n=3) White, 50% (n=3) Other (Hispanic)
Child Ethnicity	69% (n=9) Hispanic/Latino (67% Mexican, 11% Honduran, 11% Salvadorian, 11% Puerto Rican)	100% Hispanic (67% Mexican, 17% Venezuelan, 17% Honduran)

Parent Race	69% (n=9) White, 23% (n=3) Other (Hispanic), 7.7% (n=1) Black	50% (n=3) White, 50% (n=3) Other (Hispanic)
Parent Ethnicity	77% (n=10) Hispanic/Latino (70% Mexican, 10% Salvadorian, 10% Honduran, 10% Puerto Rican)	100% Hispanic (67% Mexican, 17% Venezuelan, 17% Honduran)
Average Child Age	11.1	13
Average Parent Age	37.8	41.5
Child Gender	77% (n=10) male, 23% (n=3) female	50%(n=3%) male, 50% (n=3) female
Parent Gender	12 mothers, 1 father	5 mothers, 1 father
Child Diagnosis[b]	Around 84% ADHD, 21% ASD, other diagnoses include anxiety disorders, depressive disorders, PTSD, and others. 47% of children had one mental health diagnosis, and 42% of children had more than one mental health diagnosis[b]	
Average Parent Education Level	12th grade	12th grade
Parent Language Preference	53% Spanish, 38% English, 7% no preference	83% (n=5) Spanish, 17% (n=1) English
Child Language Preference	Not reported	100% (n=6) English

[a] 14 interviews completed, demographic information missing for one parent.

[b] Child diagnosis was combined across groups and is less specified so as to not identify participants.

Recruitment

In order to recruit families for the qualitative study, a staff member at the clinic approached all caregivers immediately after the psychiatry conference to see if they were interested in participating in the study. Staff members who were familiar with the study read off of a script to explain the details of the study, and answered any questions that arose. The staff member explained that if the family was interested in participating in the study, a member of the research team from the University of Texas at Austin (UT) contacted the family to explain more study details and schedule the interview. If the family agreed to be contacted by UT, the staff member had the family complete a permission to contact form where they wrote down basic contact information (parent and child name, phone number). A member of the research team at UT then called the family and explained the study in greater detail, assessed interest, and scheduled an interview with the caregiver or child, depending on caregiver/child preference as well as whether children were in the appropriate age range. Caregiver interviews took place in person or over the phone and parents only needed to provide verbal consent, because a consent document would be the only record linking identifiable caregiver data with the research. This aided recruitment efforts for parents, who often found it more feasible to schedule an interview over the phone rather than in person. Child interviews took place in person or virtually during the COVID-19 pandemic. Caregivers signed a permission form for their child to participate in the study, and children completed an assent form.

Procedure

The study involves data collection at one time point. Caregivers provided verbal consent for the caregiver interviews, and signed a permission form for their child to participate if their child was being interviewed. If a child/adolescent was interviewed, they signed an assent form. During consent, families were informed that interviews are audio recorded so that they can be transcribed for analyses, and if caregivers or children/adolescents did not agree to the audio recording, they were not able to participate in the study (no families declined for this reason). Once consent procedures were completed, caregivers completed a demographic form, where they provided demographic information for their child and themselves. A member of the research team conducted the interview either over the phone, at the clinic, or at another convenient location for the family. Since the start of the COVID-19 pandemic, all interviews were completed over the phone. Research assistants were trained in qualitative interviewing techniques and completed a mock interview with the principal investigator prior to conducting any study interviews. The interview questions were almost the same questions that the providers at the clinic answered in the previous study where providers at the clinic were interviewed, and questions were also slightly modified for children to ensure that they were developmentally appropriate (please see Appendix for parent and child interview questions). Interviews were transcribed in their original language within a week following the interview. The transcriptions were kept in a Microsoft excel file.

Measures

Demographic Information

Caregivers were asked to complete a demographic form that was created by the research team and has been used successfully in previous research studies. The demographic form assesses a range of demographic variables, including child and caregiver age, gender, educational status, and other variables. This measure was administered once and completed by caregivers. The demographic form was used as opposed to looking at patient EMRs because identifiable information was not collected in order to help with recruitment efforts (the research team only needed to provide verbal consent to caregivers).

Interview Questions

The qualitative interview questions (See Appendix) were developed collaboratively with various members of the research team, including input from the staff at the clinic. The questions were designed to elicit responses related to the range of participants' experiences with IBH and with implementing the psychiatry conference. The questions were originally developed during the phase of the study where providers were interviewed. The team modified the interview questions for children and adolescents. The entire team listened to the first two interviews completed with children/adolescents and a member of the research team from the university with qualitative expertise modified questions to ensure their appropriateness for younger children (e.g. shortening questions and replacing words that children/adolescents might not understand). The rest of the team reviewed the questions and agreed on their appropriateness. Reading level of the modified questions was at a third grade level, which aligned well with the age range for child interviews (9-17 years old). Of note, interview questions were not originally designed to focus on a specific topic (e.g., trust) but to broadly understand the experience of families as an inductive process. The theme of trust came up as a possible question once some of the data started to be coded and was reinforced by the existing literature on the importance of trust.

Analyses

A qualitative approach was carried out for a variety of reasons. By interviewing patients and families, the team achieved a rich, in-depth understanding of complex processes, that would be unable to be captured using quantitative analyses alone. In working with children with neurodevelopmental differences and other disorders, a qualitative approach allowed the research team to flexibly adapt the interview questions and process depending on the participant. A qualitative approach also gave a voice to primarily Latine children with neurodevelopmental differences and other disorders and their families, a group that is often neglected in research.

Qualitative Approach of Inquiry: Thematic Analysis

Based on the primary research questions, the study employed a thematic analysis approach. Thematic analysis is a flexible and systematic method for analyzing qualitative data and involves identifying patterns of meaning (themes) in a dataset (Braun & Clarke, 2012; Guest et al., 2013). Three phases of thematic analysis include codebook development, coding, and identifying patterns (Gulbas, 2021). This approach was most appropriate for the current study, which aims to identify themes related to facilitators of trust. This approach was chosen over grounded theory since the study's purpose was not to develop a theory and some preliminary codes were developed before coding, which is not typically part of grounded theory. Further, this approach was chosen over others that aim to analyze text itself closely (narrative analysis) and study lived experiences (phenomenological analysis). Thematic analysis can be conducted in various ways, and two common approaches are an inductive and deductive approach. In an inductive (bottom-up) approach, codes are derived from the data itself, while in a deductive (top-down) approach, concepts or theories are used as a framework to analyze the data (Braun & Clarke, 2012). The current study took a primarily inductive approach, as the research team was open to any codes that emerged. However, some preliminary codes were developed after the research team completed a literature review related to culturally competent care and patient-centered care. Some of these codes include: "cultural sensitivity," "tailored approach to patient needs," and "shared decision-making."

Members of the research team separately read the data multiple times before coming together as a group to code the interviews and identify themes. After completing six interviews, a member of the research team read through the interviews and identified the three richest and lengthiest interviews to code. The research team started with these three interviews to develop the codebook, and then coded the following three interviews, adding new codes as they arose. The research team added dates to the various versions of the codebook to keep track of when new codes were developed. At the point in which there were minimal additions or modifications to the codebook, recruitment ended and the research team worked on identifying themes based on the developed codes (Guest et al., 2006). A thematic matrix was developed to more easily identify recurrent themes in the data. The matrix columns include codes from the codebook related to facilitators of trust. The research team was also open to new second cycle codes based on the trust literature that emerged (e.g., competence). Rows were organized as individual participants.

A figure was also developed to connect themes together that are related to the trust building process. The figure organizes themes chronologically from a family's initial reaction to the psychiatry conference to final reactions/retention processes, and provides more context surrounding patients' experiences with the psychiatry conference.

Rigor. Strategies to ensure validity and reliability and achieve rigor include negative/deviant case analysis, team-based approach to coding, use of audit trails, member checking, and use of quotes (Hamilton, 2020). Negative case analysis helps to eliminate bias in reporting of results that only favorably support arguments, and was utilized in the study, specifically related to individuals who had negative experiences with the psychiatry conference. A team-based approach was utilized for coding and theme development to ensure that there is less bias and to encourage multiple perspectives, from the UT research team and members of the team from the clinic (Ryan & Bernard, 2000). This is also consistent with the CBPR approach. Virtual coding meetings took place weekly at a convenient time for all members of the team, and meetings were recorded so that members could watch the meetings if they were not present. Audit trails were used to document the data analysis process, including development of codes, decisions made, and rationale for those decisions. This helped to ensure that the research team, and others, understood the process underlying the coding and analysis and how decisions were made. Member checking involves having study participants or others involved with the participant's community review the findings to determine if findings accurately reflect patient and parent experiences. Member checking was carried out through presenting results to members of the research team from the clinic. Finally, when presenting results, quotes were shared to illustrate themes. This ensures that participants were speaking to their own experiences, and helps to avoid bias from researchers inaccurately interpreting results. Of note, in the Results section, quotes in Spanish were translated into English and original Spanish quotes can be found in the Appendix.

Positionality Statement. The primary author identifies as a White female graduate student who is interested in ways to improve families' experiences in integrated primary care. Professionally, she has experience delivering mental health services in primary care. Personal interest in this topic stems from the pursuit of health equity and improving access to mental healthcare. The three other graduate students who have been involved in the study identify as Latine. The principal investigator identifies as a Latine female, and the other primary faculty member involved in the study identifies as a White female with expertise in qualitative research. Both professors have pursued research primarily with Latine populations in Austin and surrounding areas in the pursuit of improving physical and mental health outcomes for Latine children and adolescents. Members of the research team from the clinic and who participate in the psychiatry conference represent a range of races, ethnicities, and genders. The backgrounds of the researchers should be taken into account as potential influences when interpreting results, although the diversity represented in research team is a strength.

Ethical Considerations. One ethical concern related to the sample is that participants may have felt pressure to participate in the study or to not be fully transparent about their experiences due to fear of damaging their relationship with the clinic. These areas were covered in consent procedures, where participants were told that their participation was completely voluntary, and that no identifiable information would be collected. Confidentiality was emphasized to the fullest extent possible.

Another concern is related to participants feeling uncomfortable answering certain questions. This was addressed through letting participants know that they could skip any questions they did not feel comfortable answering.

Chapter 4: Results

Two facilitators and three barriers of trust were identified from thematic analysis. These facilitators and barriers are placed in the center of Figure 3. The figure is a concept map (Kane & Trochim, 2006) that presents themes chronologically related to families' experience of the psychiatry conference, from their initial reactions to final reactions and retention processes, and highlights the trust-building process that occurs during the psychiatry conference. Accepting the team model facilitated an atmosphere and setting under which a trusting relationship could be developed. However, a common first experience was the feeling of intimidation when engaging with all providers collectively for the first time, and this intimidation at times persisted. Factors that contributed to families' **initial reactions** to the meeting include **stigma**, **previous experiences accessing mental healthcare,** and **information given in advance about the psychiatry conference**. In the process of building trust with psychiatrists and with the overall psychiatry conference model, various facilitators of trust emerged including: **reciprocal respect**, **the psychiatrist's approach**, and **primary care provider as a bridge**. Barriers of trust included **quality and availability of interpreter services** as well as **lack of a tailored approach**, especially for children with diagnoses of anxiety. These barriers and facilitators contributed to **final reaction and retention processes,** including whether families attended another psychiatry conference when indicated. **Parent and child synchrony** and **optimism** both contributed to the process of building trust as well as to final reactions to the model and retention. Finally, **child diagnosis** shaped families' experience with the psychiatry conference from start to finish, including with the trust-building process.

The results section below will start by reviewing the facilitators and barriers of trust and answering the first two research questions: what helps to facilitate trust in the psychiatrist and other providers at the psychiatry conference. Other elements of the figure will then be discussed in more detail. This will help to provide the context in which barriers and facilitators of trust may unfold, including how initial reactions to the model may impact initial trust and how the trust building process contributes to final reactions. The figure includes elements of the context of a family's reactions to this team-based psychiatry approach, and orders themes chronologically. Below the figure is a table which presents the number of participants who endorsed themes. Some researchers discourage against reporting qualitative results quantitatively (Sandelowski et al., 2001), however this approach helped inform understanding of the data and emerging patterns.

Figure 3

Concept Map of Trust-Building Process and Contextual Factors

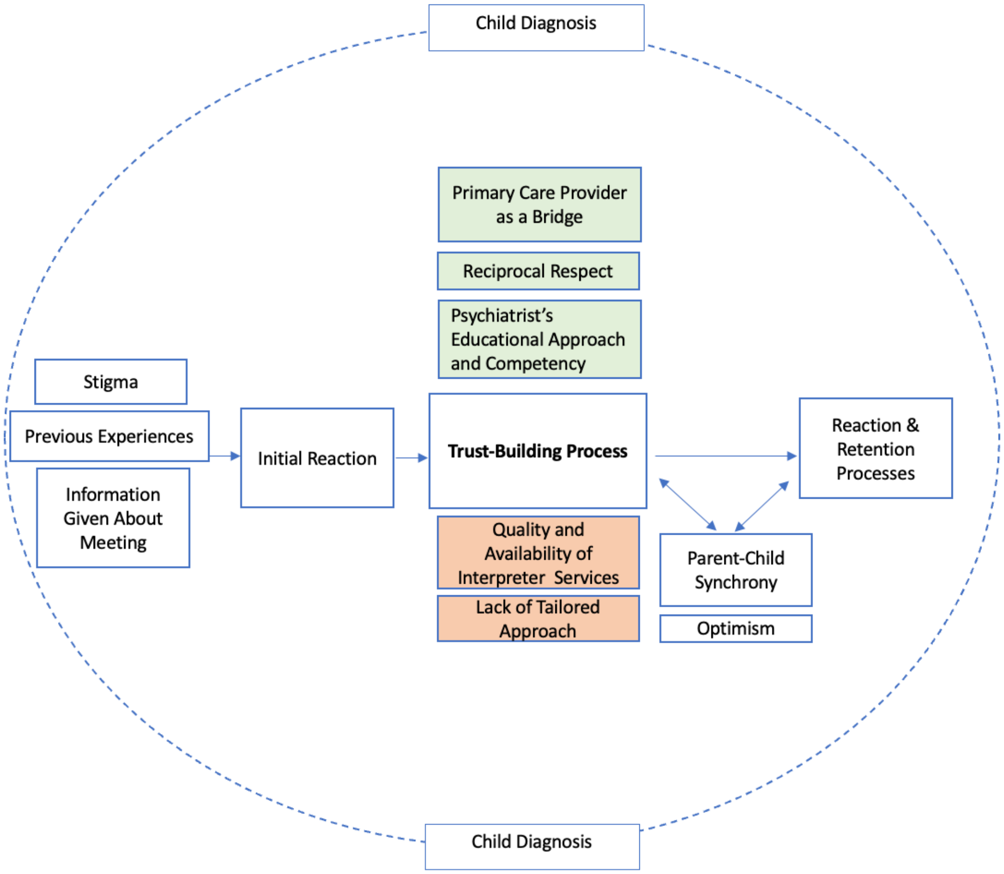


Table 2

Qualitative Themes With Counts

Theme	Number of Parents who Endorsed Theme
Initial Reaction	7 intimidated/ unexpected; 7 positive
Reciprocal Respect	
• Atmosphere	7 (6 positive; 1 negative)
• Parent Participation	14 (12 high; 2 low)
• Child Participation	Parent report of child: 7 low; 4 average/high; 3 not reported Self-report: 2 average amount, 4 low
Psychiatrist's Educational Approach and Competency	
• Educational Approach	7
• Competence	7
Primary Care Provider as a Bridge	6
Quality and Availability of Interpreter Services	4 (All Spanish-speaking parents)
Tailored Approach	9 parents agree; 4 discussed lack of tailoring (3-based on child temperament; 1-not wanting to start medications)
Optimism (parents)	5 (all Spanish-speaking parents)
Final Reaction	12 positive; 2 negative (meds and anxiety concerns)
Child Diagnosis	7 anxious/shy

Note. Counts include parent interviews only, unless otherwise indicated.
Green shading: facilitators of trust
Red shading: barriers to trust
Red font: themes related to culture/Latine populations

Facilitators of Trust

When families participate in the psychiatry conference, a trust-building process occurs where families acclimate to the model and to meeting with a psychiatrist, and initial fears start to dissipate. In developing trust, three major themes capture facilitators of trust for parents and children: having a primary care provider present at the meeting as a bridge to facilitate trust with the team model and the psychiatrist, taking an educational approach which includes perceiving the psychiatrist as competent and professional through their ability to explain things in a way parents can understand, and finally, the welcoming atmosphere and participatory nature of the conference contributing to reciprocal respect between providers and families.

Primary Care Provider as a Bridge

Most families discussed having longstanding relationships with the clinic spanning years. Some parents remarked that they have been attending the clinic since their children were born. As such, primary care providers had often been working with the same families for some period of time prior to attending the first psychiatry conference. As families developed trust with this team-based model of care and with the psychiatrist, primary care providers, who also attend the psychiatry conference, served as a bridge for facilitating trusting relationships. When parents felt like their primary care provider cared for them and had them in the “forefront of their minds,” it helped to facilitate trust in new providers and new treatment regimens. Having the support of their primary care provider helped one mother agree to try out a psychiatric medication for her child even though she was reluctant to try medications, which ultimately “did end up changing his life and being a big impact on him and I’m glad I did it.” Thus, having the primary care provider present at the meeting helped parents feel confident in trying psychiatric medications and instilling trust in a new provider. The longitudinal relationship between families and the clinic helped parents feel supported and confident in starting new treatment regimens and services, with the support of their primary care provider: “His doctor [primary care provider] is really nice. She does, you know, she knows all his things. She’s very attentive to my concerns (…) she took my concerns into account and made sure that was the best option for him.” Having existing trust with the primary care provider helped to transfer this trust to the psychiatrist and the overall team model. This finding is consistent with the warm handoff literature, where an introduction to a new provider is related to improved comfort and trust (Mitchell et al., 2022;

Young et al., 2020). Thus, in a team model format, having familiar faces and longitudinal relationships with providers helps to facilitate trust in psychiatrists and the team model.

Psychiatrist's Educational Approach and Competency

Families appreciated access to psychiatrists and especially appreciated the psychiatrist's approach to their childrens' care. Families noted the competence of the psychiatrists as well as ways the psychiatrist educated families about conditions and medications/treatments, noting that the psychiatrist appeared professional through ensuring understanding and not using complex terminology. Both perceiving the psychiatrist as competent and the educational approach used by the psychiatrist contributed to confidence in treatment recommendations, which in turn helped to facilitate trust in the psychiatrist and in psychiatric medications.

Competence. Consistent with the literature on trust in medical providers emphasizing competency (Murray & McCrone, 2015), parents generally perceived the psychiatrist as competent and as "professional" and the team approach as a comprehensive way to care for their child. This manifested in parents sharing their confidence that the psychiatrist would help their children: "It is a beautiful experience because you begin to have confidence that when you see the psychiatrist it is not because you are crazy but that they are going to help you in something that you cannot." This sense of confidence is consistent with the trust literature describing confidence as a factor associated with trust in medical providers. Perceiving the psychiatrist as competent helped to instill trust and hope in the psychiatrist and in the team based model of care. In addition to families remarking on the psychiatrist's competence, the team model itself emerged as an avenue in which comprehensive and competent care is fostered: "Well, I think that the relationship between them, I imagine that for some reason the doctor referred me to them because she knows the work that they do, and, well, it's like a team. If the doctor does not refer me to them, they will never find out that my daughter is unwell." Thus, sense of provider competency and noting the effectiveness of the team-based model helped to facilitate trust.

Educational Approach. The way the psychiatrist educated families about diagnoses/treatments helped calm families and instilled hope and trust in the team model and in treatment recommendations. Parents shared having a solid understanding of treatment and next steps as a result of the psychiatrist's educational style, including the way he ensured parent understanding:

> "Not just like, you know, listening and throwing out a prescription, but, you know, listening and then, you know, educating, you know, based on the behavioral things and based on, you know, the medication and the expectations and what the medication is doing, just you know, really explaining things in a teaching way. Obviously we're not going to, you know, understand the level of having gone through med school, so I think they're explaining things, you know, instead of just throwing out terms or diagnoses. They're really explaining things in a way that we can understand."

This educational approach is consistent with the literature on the relationship between communication and trust, as the psychiatrist took steps to ensure he was communicating effectively (Ozawa & Sripad, 2013). As a result of this educational style, parents understood next steps in their child's care, and were more reassured and "bought into" treatment. This resulted in parents feeling calm and generally clear about next steps in their child's care that would be followed. The psychiatrist was perceived as professional in his ability to educate the family and help parents understand treatment, rather than using complicated jargon that only other providers could understand.

Finally, the psychiatrist's educational style helped validate parents regarding their concerns with their children. Parents shared having a greater understanding of not only treatment recommendations but also diagnoses and illness courses: "the psychiatrist told me that...well, because he was still small and could still have changes...that he could not give him a...like, something complex. Well, because the children were growing and could change a lot." When parents had a comprehensive understanding of treatments and recommendations, they felt better equipped to follow through with treatment plans as a result of having a better understanding of treatments. Thus, the educational approach had multiple benefits, from helping parents improve their understanding to also validating parent concerns. The psychiatrist's validation helped facilitate trust through alleviating parent fears of feeling judged for their parenting or other factors: "instead of being judged they listen to you and help you."

Although most parents appreciated the educational approach, concerns arose for one family with the consultative approach for accessing psychiatry support. In particular, she shared concerns related to whether the psychiatrist had a good sense of her child's condition after one meeting, explaining that "they only the see the child only time. My concern is, are you [psychiatrist] able to see, especially when the child cannot express themselves?" Thus, limited meetings with the psychiatrist may impact trust for some families in that they may be concerned about whether the psychiatrist has a comprehensive understanding of their child and their behavior, and thus whether they are able to provide accurate assessment and treatment.

Reciprocal Respect

A third facilitator of trust for children and families in the psychiatry conference was the feeling of reciprocal respect. Families expressed having respect for the psychiatrist and the other providers, while also feeling as though their voices were heard and that giving their opinions was encouraged. The atmosphere of the psychiatry conference, from the physical set-up to the interactions between providers and with families, contributed to feelings of mutual respect. Families generally felt comfortable asking questions and giving their input, however parent participation was higher than child participation.

Atmosphere. The atmosphere of the psychiatry conference facilitated mutual respect between providers and families. The seating arrangements at the psychiatry conference helped to facilitate a trusting atmosphere. Families shared negative experiences with previous setups such as when providers sit behind a desk, and appreciated the round table setup of the psychiatry conference: "I like how he's [psychiatrist] sitting directly beside her [child] and talking to her." The round table format contributed to a feeling of egalitarianism where everyone's opinions are valued:

> "Being around the table, it's sort of more egalitarian. It's sort of, you know, with the previous psychiatrist that [red] had, he was like at a desk, and [red] was on a short sofa, you know it was intimidating and I don't know."

In the virtual psychiatry conference format, parents also appreciated and commented on being able to see all the providers at once on their screens. Thus, the round table format of the psychiatry conference contributed to a set-up where families felt valued and respected.

In addition to the physical setup of the room, parents also commented on and appreciated other aspects of the atmosphere of the psychiatry conference. Being referred to "person-to-person" helped parents feel respected and appreciated. Having multiple providers present also helped families feel safe and supported: "this is a more safe feeling, and feeling more supported, like having more people in the room just feels like a really supportive atmosphere." This parent also described other aspects of the psychiatry conference such as "some joviality, there's some joking, which, you know, helps put everyone at ease, or put us at ease." Other parents commented on the friendly atmosphere of the psychiatry conference, with one commenting that "It's more like a casual talking environment but with problem solving at the same time." Another parent shared a similar sentiment when they explained:

> "They seemed pretty comfortable with the format they had going and it moved really smoothly and everything and they gave us time to ask questions and if we missed something they would go back and do it they weren't rushing into anything or anything like that."

Participants also commented on the amount of individuals present at the meeting, and one parent appreciated how "when there's other people there, and usually they're like interns or you know, other people that kind of introduce us, you know, 'is it okay for them to be there.'" Other participants seemed unsure about who all was present at the meeting and their roles. Thus, families had mixed experiences related to the way that the team was introduced, which may impact intimidation and initial trust development.

Participation. The welcoming atmosphere of the psychiatry conference resulted in high levels of involvement and participation from families in the psychiatry conference. Parents overall commented on their high levels of participation in the psychiatry conference, while children generally participated at the meeting less than parents.

Parents reported high levels of participation at the psychiatry conference and felt supported by the other providers at the meeting. Once parents acclimated to the team model, in part through the welcoming atmosphere, they "had the confidence to talk." Parents gave their input about their children's behavior and described a combination of both answering and asking questions, resulting in better understanding of their child's condition(s). High levels of parent participation resulted in better utilization of the team model to determine treatment plans. Parents felt supported when discussing their children’s behaviors at home: “I get to give my input into her behavior and what I'm seeing is aggressive behavior with her.” For one parent whose partner was not able to attend, the family took the initiative to have the other parent write notes that could be presented by the other parent at the meeting. Thus, the family took steps to ensure that they could advocate for their child during the meeting. The parent shared that “through that sharing,” the team “gave me solutions, the different ways that we could treat it [problem with their child].”

One parent who struggled to acclimate to the model shared her experience of participating in the psychiatry conference: “I guess the way it was set up, I had to listen to what everybody else had to say and then I could make a comment.” This resulted in a lack of shared-decision making, where the mother perceived that providers had already made a decision regarding her child’s care and that she could not provide input: “I would definitely try to have it less intimidating, less like there is this group of professionals and that this is their decision and that they're just talking at you.”

Children participated at equal or lower levels than their parents in the psychiatry conference. This was partially due to children’s’ comfort levels interacting with individuals they did not know very well. Children without shy or anxious temperaments were generally more likely to interact with providers, whereas children with anxiety or described as shy by their parents were less participatory: “It's hard for him to open up to a person especially when there's a lot of people involved, so there was not really that much involvement on his side.” Other children participated less even without anxiety or shy temperaments: “so you know how there's a president, a vice president, and a commander? I was the commander. Like I couldn’t really do anything." With less participation in the psychiatry conference also came a negative perception of the psychiatrist for this child: "school's hell and like the psychiatrist is kind of like hell too 'cause they ask so much questions [like] 'did you tell your mom.'"

Barriers of Trust

Two themes capture barriers to trust for parents and children which shaped families' participation in the psychiatry conference: quality of and access to interpreter services, and lack of a tailored approach for children with anxiety disorders.

Quality of and Access to Interpreter Services

Spanish interpreter services at the clinic are provided by providers who speak Spanish fluently. At the clinic, these individuals are often staff members, as the current psychiatrist and main primary care providers do not speak Spanish. Although it is helpful to have access to bilingual staff, these staff members often interpret for other providers who do not speak Spanish as untrained interpreters. As a result, Spanish-speaking parents reported gaps in understanding between them and the providers at the clinic:

> "The meetings are in English and yes it helps me because I do not understand what they speak about but they give me a short summary and they tell me what is happening and they explain to me and help both me and my child."

Although this parent noted that the staff are helpful in providing translations, she mentioned that she is provided with short summaries as opposed to staff interpreting everything said at the meeting which would ensure culturally sensitive care. Interpreting using short summaries was shared by other parents as well, and a child also described interpreting for his mother at the meeting. Due to providers/staff at times only conveying short summaries in Spanish to families, parents shared gaps in understanding what was discussed at the meeting: "I feel like I'm about

20% there at the moment because I don't know how to speak English." When parents' understanding of their child's care is compromised due to language barriers, parents may not have all their questions and concerns addressed, including concerns related to follow-up planning, impacting communication and trust with providers:

> "They should have talked to me or sent me a letter and told me, "Listen ma'am, everything is okay, don't worry, we are going to continue holding another meeting," or "we are not going to proceed anymore because your girl is fine." I think maybe I would like to know what they deduced from this and what it derives from."

The uncertainty related to follow-up shows the need for improved care and coordination for Spanish-speaking parents who participate in the psychiatry conference. Discussion from parents highlights goals related to the need to hire more Spanish-speaking providers or trained interpreters: "Well, I would like them to learn a little more of the language, just as I also need to learn more of their language."

Other families were satisfied with interpreter services and described a process where misunderstandings were clarified to ensure understanding: "it helped me when they tried to clarify something that I did not understand." Thus, facilitating an atmosphere where parent understanding is ensured and where parents feel comfortable asking follow-up questions helps to overcome language barriers (Jones, 2018). This is consistent with literature on cultural competency highlighting patient preferences for providers who speak their language, which is also related to increased likelihood of attending medical visits and seeking preventative care as well as improved communication and better quality care (Gonzales, Vega, & Tarraf, 2010; Ma, Sanchez, & Ma, 2019). Improved quality of care, reduced frustration, and improved communication may help to improve trust, as communication is related to trust (Jones, 2018).

However, feeling supported may help overcome concerns with trust due to language barriers, so the psychiatrist's approach as described earlier may help to alleviate some concerns related to the impact of interpreter services on trust. This idea was also reinforced in a study by Limaye et al. (2020) highlighting how empathy can help overcome power dynamics in medical provider/patient relationships.

Tailored Approach to Parent/Patient Needs

Families reported strengths and weakness regarding the psychiatry conference format/process as a tailored approach to the needs of families. Families appreciated how the psychiatrist and other providers tailored treatment recommendations based on the family/specific child's concerns. Families also appreciated that the psychiatrist took the developmental level of the child into account during interactions with children. In these ways, the psychiatry conference is tailored to patient and parent needs. The psychiatry conference operates as a standard process where any providers who are available to attend are present at the psychiatry conference, even if children express discomfort with interacting with multiple providers at once due to a shy temperament or anxiety. In this way, the psychiatry conference process lacks a tailored approach based on family preferences for the amount of providers present and the way that providers are introduced to families. When children with anxiety first interact with multiple providers at the conference, it can be difficult to open up:

> "I felt like there was probably a gap, with my son, with a connection with the [psychiatrist] and my son because like I said my son had the anxiety kind of issue going, so it felt like a lack of connection. My son wasn't able to open up because those people are surrounding him."

Echoing this point, a child explained that “if there's a lot of people, people don't want to open up as much.” When children have trouble opening up during the psychiatry conference and feel uncomfortable participating, establishing a trusting relationship is hindered from the very beginning. For some children, the inability to develop trust due to discomfort with the team model persisted over time, which will be touched on in later sections.

Recommendations for more tailored psychiatry conferences even with all the benefits that come from a team-based model of care arose: “I guess more of, I guess, clarifying with the patient how many people will be involved and is that's okay or will the patient feel comfortable with that, that way they know what to expect and prepare the patient.” Since parents and children often were surprised by the format of the psychiatry conference, which will be described in the Initial Reaction to Team Model Section, this recommendation makes sense in light of these findings. Eliciting parent and child understanding of the purpose and format of the psychiatry conference may help to provide suggestions for more tailored approaches to help ensure patient comfort and set the stage for building trust in the psychiatrist and in the team model.

Although the psychiatry conference team-based format lacks a tailored approach, the psychiatrist himself tailors his approach in working with children of varying developmental stages and diagnoses. One child appreciated how the psychiatrist spoke to them directly, explaining “you know how doctors they don't speak to kids very often but sometimes they actually do, that's the kind of doctor I like.” Talking to children directly about their diagnoses, treatments, and strategies was appreciated by both parents and children. Finally, one parent appreciated the psychiatrist’s interaction style with her child based their developmental level, noting that “I love how he basically breaks down the questions she can only answer yes or no to, simple questions.”

Factors Contributing to Initial Reaction

When families first enter the psychiatry conference, their initial reactions to the model help provide context for the barriers and facilitators of trust that come into play following these initial reactions. Stigma associated with seeking access to mental healthcare, perceptions of healthcare and previous experiences accessing healthcare, and information given about the psychiatry conference in advance all helped to shape a family's initial reactions to their first psychiatry conference and family's initial perceptions of trust in providers and in the team model.

Stigma

Stigma related to mental healthcare manifested as participants sharing concerns about seeking help in general with mental health concerns, as well as specific concerns related to psychiatric medications. Sentiments were shared related to feeling embarrassed to ask for help. Cultural values related to self-sufficiency and relying on other sources of support such as family members may contribute to stigma around asking for help. Parents expressed fears of them or their child appearing "crazy" (locos) as well as concerns about the implications of meeting with a child psychiatrist for medication. This manifested in parents "automatically assuming the worst" about their children's diagnosis or potential treatment recommendations and fearing that their children had "serious problems":

> "It is scary when they tell you 'psychiatrist' and that you are going to take medication, then the first thing that comes to mind is that you are crazy or that you have a very strong, very serious problem. That is what scares you."

Relatedly, parents also expressed concerns related to how they would be perceived as parents. This may be related to parents' Latine identity and concerns that the medical "establishment" might discriminate and think less of them as a parent. Concerns about parenting practices, including assumptions of poor parenting emerged:

> "I was nervous. Just because mostly I want to say, I don't want to generalize, usually in Latino families we're scared to involve or ask for help because we automatically assume that they're going to think that we're the worst parents because we need this or we need help with this so I was kind of nervous that they were going to assume that I was the worst parent."

Together, stigma about seeking help, medications, and concerns related to judgments about parenting contributed to families' initial reactions of nervousness and intimidation when first participating in the psychiatry conference.

Previous Experiences Accessing Mental Healthcare

Some families discussed previous experiences with accessing mental healthcare for their children, themselves, or family members which shaped their perceptions of mental healthcare delivery and treatment. Other families had more limited experience navigating the mental healthcare system outside of the clinic (due to lack of need, inaccessibility, and other factors). Lack of access to free or low cost mental health care and psychiatric support in particular, led families to seek care at the clinic: "as far as mental heath care in general outside of [the clinic], it's pretty abysmal;" "financially, you can't attend expensive places where you know that these types of meetings or appointments are very expensive that you could never pay for them."

One parent painted a detailed picture of her son's negative experience with a previous psychiatrist. She described the set-up of the appointment and the space, including how her child was intimidated by the psychiatrist sitting at a desk. She also described her dislike of not being present for the majority of the meeting and how she "had no idea what had been covered or things that I was concerned about were covered.” She noted how the psychiatry conference format has improved communication between the whole family and the psychiatrist. Further, she discussed her son’s experience of mistrust with his previous providers due to miscommunication:

> “You know, [child] got really upset with one of the psychiatrists that he saw and then he got upset with a therapist because they were miscommunicating between them, you know, so he came to mistrust them both because the things that he had talked about were being miscommunicated across, so I just think it's really good to have everybody there.”

Finally, the novelty of the psychiatry conference approach and round table format contributed to families appreciating this approach compared to previous experiences with mental health services. Thus, previous experiences accessing mental health services shaped families’ initial reactions to the meeting, in that families with previous negative experiences or inability to access services in the past came into the meeting with more hopefulness. This ultimately contributed to initial trust in this new model of care.

Information Given About the Meeting

Finally, a third factor shaping families’ initial reactions to the meeting is information given about the meeting in advance. Families were unaware of the amount of people who would be present at the meeting as well as their roles and shared that they were not told this information going into the meeting:

> “We were thinking more of a private kind of setting, but, it was just like a lot of doctors and other, like, not sure, you know, like, students. I'm not sure what they were but, you know, other helpers, like assistants. So it's like, okay, it was more like, you know, more people than we expected.”

Unexpectedness about the format of the psychiatry conference contributed to nervousness and intimidation when first entering the psychiatry conference, which necessitates building trust to help families acclimate to the model.

Notably, children were very unsure of the purpose of the psychiatry conference, perhaps due to lack of information shared by providers or caregivers. Confusion about the structure of the meeting and what would be discussed contributed to initial feelings of nervousness. Concerns such as “I thought they were going to take me somewhere” or “I thought it was going to be an intervention where they say you need to stop doing this” highlight children’s’ initial intimidation as a result of not having information about the meeting in advance.

Initial Reaction to the Psychiatry Conference

Information given about the meeting in advance, stigma about mental healthcare and seeking help, and previous experiences accessing mental healthcare support all shaped families’ initial reactions to the psychiatry conference model. Based on these factors, some parents and most children’s initial reactions included elements of intimidation and nervousness, while others immediately acclimated to the team-based model.

Child Initial Reactions

Child reactions varied from initial ease to nervousness, and child diagnosis partially contributed to these reactions. Children without anxiety appeared to quickly acclimate to the team model, explaining that they quickly accepted the model and the amount of people present at the meeting. One mother remarked about her son’s immediate reaction to the meeting, explaining:

> “He seemed really good about meeting new people so he was excited and he's not very shy so he was fine with it. (…) Like I said, [child] is very outspoken when he first meets people so I had to calm him down a few times.”

Quickly acclimating to this team based model of care set the foundation for trust to be further developed during the psychiatry conference meeting. Children who were less comfortable around larger groups due to anxiety or other factors experienced discomfort with the team model. This led to various reactions such as feeling overwhelmed, nervous, and feeling a lack of connection:

> “I felt like there was probably a gap, with my son, with a connection with the therapist and my son because like I said my son had the anxiety kind of issue going, so it felt like a lack of connection. My son wasn't able to open up because those people are surrounding him.”

With all the benefits that come from an integrated team-based approach to care also come disadvantages for children who are more comfortable interacting with providers one-on-one.

Lack of information given about the roles of the various individuals at the meeting contributed to discomfort with the model for one adolescent:

> “There were two girls and one boy, and it felt weird with two men, I don't know. And they were all staring. Whenever I was talking to the psychiatrist, there was another girl typing everything I was saying. It was weird, I didn't know what she was doing. I didn't like it.”

Unclear information about the people present and their roles contributed to an initial dislike of the team model. Thus, child reactions spanned from initially accepting the model to apprehension and nervousness with receiving mental health services in a group setting.

Parent Initial Reactions

Parents also had mixed initial reactions to the psychiatry conference, spanning from initial acceptance to initial intimidation and feeling overwhelmed. Feelings of intimidation and nervousness by the amount of people present at the meeting as well as the purpose of the meeting led some families to have negative initial reactions to the model:

> "It scared me because I saw several people sitting there, as if to say... I didn't know what to think. I thought it might be like they were going to ask me things that I wasn't going to be able to answer to them like they were going to study me, something I was doing wrong. I don't know why that's how I felt."

Parents who did not have previous experience accessing psychiatry support especially had negative reactions when first joining the psychiatry conference. When providers gave reassurance and discussed the purpose of the meeting, parents felt more comfortable with the approach: "they explained everything how it was going to happen (…) they just kind of reassured us that this is just to evaluate him and how he is in his developmental stage and his mentality." This reassurance helped to ease families into accepting this team-based model of care. Other parents quickly acclimated to the model and started noticing the benefits of the team-based approach immediately. When parents had previous negative experiences with accessing psychiatry support and with the quality of psychiatry services, they appreciated having a group of providers present at the meeting who were already waiting to talk to them and help their child. Further, having a group of providers contributed to hopefulness. With this hopefulness, families quickly accepted the team model and the potential support that could be provided to their child, which contributed to positive initial reactions. In this way, parents with previous negative experiences with accessing psychiatry support came into the meeting more trusting of the approach and of the care that their child might receive.

Parent-Child Synchrony

After the trust-building process occurred, parent-child synchrony contributed to families' ultimate reactions to the psychiatry conference and whether families attended additional psychiatry conferences when indicated. When parents and their children both had positive experiences at the psychiatry conference, there was no indication that families would be hesitant to attend another psychiatry conference. When parents and their children had differing experiences, however, interactions between the parent and the child shaped retention processes. For some parent-child dyads, despite the child having a negative experience with the psychiatry conference, their parent developed enough trust in the providers and process to understand the benefits and followed through with recommendations to attend subsequent conferences. However, for one parent-child dyad, the child (who had a diagnosis of anxiety) made the decision to not attend another psychiatry conference, which the parent ultimately went along with: "it was good for me, that we were in a place that can help with problems, but she did not want to return to it."

In cases like this, parent child-synchrony impacts retention due to lack of trust-building for the child. These interactions may be also shaped by developmental level, as the patient described earlier was an adolescent who may have more autonomy in health decision making compared to younger children. Assessing parent and child reactions after the first psychiatry conference may help to improve overall retention in the model and may help to elucidate ways to improve trust in providers and in the model.

Optimism

As a result of the psychiatry conference and the trust-building process, parents expressed optimism which contributed to final reactions to the team-based model. Optimism manifested as parents expressing hopefulness as a result of the psychiatry conference that their child's symptoms would improve. Spanish-speaking parents in particular reported feeling optimistic after the psychiatry conference concluded: "My thoughts are that thanks to them my son will improve in school and in his learning." A parent whose daughter decided to stop attending the psychiatry conference still felt optimistic that the doctors would have helped her daughter:

> "I wouldn't know what to say because I really didn't experience it because my daughter unfortunately left before they could help her, right, but if she had this change, for me, it would have been much better and more with the help of someone."

Parents reported relief as well as confidence that their children could potentially get help with concerns that in many cases have been long-standing. The theme of optimism is in line with definitions of medical trust highlighting optimism that comes with trusting the care of medical providers (Hall et al., 2001).

Final Reactions/Retention Processes

After the trust-building process, families overall reported positive impressions of the psychiatry conference and the help that would be afforded to their children. Parents appreciated and noted the efficient service delivery of the psychiatry conference compared to other models of care: "Oh, way better delivery of services. Yes, it's a huge improvement over any other primary care situation. I wish I could find a model like that for myself." Parents also particularly came to understand that the team model itself, with different providers contributing their expertise, is what ultimately contributed to improvements in their children's mood and behavior:

> “Well, I think that the relationship between them, I imagine that for some reason the doctor referred me to them because she knows the work that they do, and, well, it's like a team. If the doctor does not refer me to them, they will never find out that my daughter is unwell. However, when they had already looked at her, then they can already tell the doctor what is going on with my daughter, and what is appropriate, and she [the doctor] tells me and then it would be a matter of just going to the appointment and that she tells me what happens next.”

After parents acclimated to the team model and started to trust the providers and the process, they also were able to identify specific benefits to a team-based approach to care. These benefits included “clearer communication and better integration in the treatment plan all together between the medical and the psychiatry, better coordination and coordinating with the family.” Ultimately, clearer communication contributed to improved trust in the psychiatrist, other providers, and in the psychiatry conference model: “[I felt] that I was safe and secured by different people that I could trust.” This is consistent with the literature highlighting the importance of communication as it relates to trust. Improved mental health outcomes arose as a result of the psychiatry conference:

> “Before, he had no interest in his life. It was a very deep sadness. With these conferences, now he smiles and thinks about his dream. He is happy and is interested in going to work for NASA. For me it's good because I'm studying again and it's already making him want to. Now he is interested in being someone and before he didn’t, he would say “for what, if I'm going to die? If not, I would". Now he says "yes I can and I'm going to want it". His nightmares subsided. If he has a problem, he finds a solution.”

Families who did not acclimate to the team model had negative reactions at the end of the meeting related to feeling forced into making a decision and deciding not to attend another psychiatry conference. Thus, when trust is not facilitated during the psychiatry conference, negative consequences such as not attending future psychiatry conferences may occur.

Child Diagnosis

Child diagnosis served as a factor contributing to initial reactions to the meeting, the trust building process, as well as final reactions to the psychiatry conference model. Children with anxiety or considered “shy” by their parents felt more nervous and intimidated when joining the psychiatry conference for the first time (as discussed in the Child Initial Reactions section) compared to children without anxiety. During the meeting, children with anxiety were overall less participatory: “My son is very quiet, he just watches and listens to what he says. If they ask him anything, he answers, but he's pretty quiet.” Lack of participation impacted the trust-building process, as children were less likely to form a connection with the psychiatrist and other providers present at the meeting when they were less participatory. The virtual format also affected participation for one participant: “He is very nervous and he doesn't like the camera at all. Once they kind of asked questions, he was listening still. When I didn't know the answer to a question he shyly jumped in.”

Ultimately, less participation in the psychiatry conference and less trust-building contributed to neutral or negative final reactions to the conference for children with anxiety or shy temperaments. On the other hand, children without anxiety were more open to the team model from the start and were more participatory during the meeting, contributing to more positive final reactions and an improved sense of trust. Thus, child diagnosis shaped children’s’ reactions before, during, and after the psychiatry conference.

Chapter 5: Discussion

CBPR allows for clinic stakeholders and community members to have a voice in research and direct research initiatives. The current study utilized the CBPR approach to assess family perspectives on a collaborative care program at a FQHC in Austin, Texas. Collaborative care is an IBH model that traditionally has a high level of integration (Unützer et al., 2013) and is a promising approach to reducing disparities in access to mental health care (Atlantis et al., 2014; Gilbody et al., 2006). The current study explored the process of developing trust between families and providers, and how trust is facilitated as a result of the collaborative care model.

The concept of trust is important to examine, as trust is related to improved satisfaction with healthcare providers as well as adherence (Blackstock et al., 2012), which in turn contributes to improved health outcomes (Lee & Linn, 2009; Mancuso, 2010). However, marginalized populations including Latine patients often have less trust in healthcare due to discrimination faced in medical settings (Doescher, 2000; Fields et al., 2016). In addition, cultural values may contribute to ambivalence or apprehension regarding psychopharmacological and other behavioral health interventions for individuals that already face significant barriers in accessing mental health services in the first place. Thus, it is imperative to consider how to enhance patient and family trust in providers in the primary care context. In the current study, the qualitative approach allowed for a more in-depth exploration of processes underlying the patient-provider relationship in a collaborative care model within primary care. Trust arose from the qualitative inductive process as a salient factor impacting satisfaction within the collaborative care model. The following sections will address the four research questions from the current study.

Research Questions One and Two

Research questions one and two asked about facilitators of caregiver and child trust in the psychiatrist and other providers at the psychiatry conference. Various facilitators of trust emerged, including reciprocal respect, the psychiatrist's approach, and the primary care provider serving as a bridge to helping trusting relationships develop between families and the psychiatrist. Some of these themes are in line with the existing literature on factors related to trust. For example, as part of the psychiatrist's approach, a subtheme captured the competency of providers as an important element in helping facilitate trust, in that families noted the psychiatrist as professional and very knowledgeable. This is consistent with previous literature demonstrating competence as an important component of trust (Hall et al., 2001; Ozawa & Stripad, 2013). Further, communication has been captured in measures of provider trust (Ozawa & Stripad, 2013) and emerged in the current study through parents and children describing the psychiatrist's approach as an educator who tailors his approach to the needs of parents and children, including considering the developmental age of the child during communication as well as not using jargon and ensuring parent and child understanding. Supporting these findings, Pearson and Raeke (2000) reviewed a patient trust subscale and found that it correlated most highly with patient assessment of physician's communication, level of interpersonal treatment, and knowledge of the patient. The theme related to primary care providers serving as a bridge aligns well with research on the effectiveness of warm-handoffs in not only instilling trust in a new provider but also contributing to patient engagement and continuity of care (Mitchell et al., 2022; Young et al., 2020). Additionally, the theme of reciprocal respect is supported by the patient-centered care literature. Through the psychiatrist and other providers at the psychology conference encouraging and valuing parent and patient perspectives, families felt comfortable sharing their concerns and asking questions. This contributed to increased trust in providers as well as overall satisfaction with the approach of the psychiatry conference. Supporting this finding, Fiscella et al. (2004) found that physicians who took time to understand their patients' perspectives on their illness (using a patient-centered care approach) were considered more trustworthy by standardized patients and actual patients. Ultimately, the three facilitators of trust identified contributed to retention in the psychiatry conference model and improved outcomes for children, supporting literature demonstrating that trust is related to improved adherence and patient well-being (Blackstock et al., 2012; Lee & Linn, 2009; Mancuso, 2010).

Barriers of trust that emerged include the quality and availability of interpreter services as well as a lack of a tailored approach for children with anxiety. The barrier related to interpreter services is directly related to research question three, which asked about how participants' experiences as individuals from underserved/minoritized communities affected their experience of trust within the psychiatry conference, and is discussed in more detail in the section below. The second barrier to trust identified in the current study is related to lack of a tailored approach based on child characteristics. The psychiatry conference adhering to a strict model where all providers available are present at each meeting detracts from the patient centered care approach of collaborative care where families do not have the option to express concerns with the format of the psychiatry conference or request a slow introduction to the rest of the providers present at the meeting. Adjustments to the way that the team is introduced to children/families, especially for children with anxiety, may be warranted to improve overall trust and reduce intimidation, which is counter to forming trust.

Research Question Three

Consistent with the third research question related to how participants' experiences as individuals from underserved/minoritized communities affects their experience of trust within the psychiatry conference, various themes emerged including language, optimism, and respect. Consistent with the previous discussion, families who preferred Spanish at times had trouble understanding what was happening during the psychiatry conference compared to parents who preferred English. Thus, these families were placed at a disadvantage in that their language ability detracted from their understanding of treatment plans and next steps to be followed. When working with Spanish-speaking patients, it is imperative to have trained interpreters or access to tele-interpreter services, as not using trained interpreters contributes to gaps in understanding, less satisfaction, and increased stress for families, ultimately impacting adherence and health outcomes. This is imperative in providing culturally competent care for the population served by the psychiatry conference. After parent interviews were completed, staff at the clinic shared with the research team that they now have access to video interpreter services through an iPad which they have remarked that providers are using more frequently in interactions with families who prefer Spanish. Parent perspectives on video interpreter services would be a beneficial next step in further evaluating this barrier.

Considering the population that the clinic serves (a mostly Latine population), it is important to consider the cultural match between providers and families. In the case of the psychiatry conference, the psychiatrist who attends the meetings does not identify as Latine. Other providers present at the meeting represent various races/ethnicities, and it is not guaranteed that a provider of the same race/ethnicity as the patient will be present. Patient-physician racial and ethnic concordance has been associated with improved health outcomes (fewer emergency department visits and lower total healthcare expenditures) (Jetty et al., 2022). Similarly, patient-physician language concordance is associated with greater primary care utilization and lower specialist, inpatient, and emergency department utilization (Chandrashekar et al., 2022; Lor & Martinez, 2020). Patient-centered care approaches including the collaborative care model may potentially help to alleviate some of the challenges that arise when providers and patients are from different racial, ethnic or linguistic backgrounds, with the focus on giving patients a voice in their healthcare and treating the provider-patient relationship less hierarchically and more as a partnership. The psychiatry conference, with its round-table format and patient-centered approach, helps to reduce power differentials that may be especially at play with families from minoritized communities who may have had negative experiences in the past when accessing healthcare and may come into the psychiatry conference feeling intimidated and nervous about racial/ethnic discrimination, deportation, and other factors (Anderson et al., 2020; Napoles-Springer, 2004). Having more individuals present in the room may also help to alleviate concerns related to patient-physician language discordance, as there may be more opportunities to pinpoint gaps in understanding. Although most parents appeared to have a good understanding of next steps following the psychiatry conference, a few parents after the psychiatry conference wanted more clarification about their child's treatment and whether they would be attending a future psychiatry conference. Thus, while patient-centered and team-based approaches may help to alleviate intimidation and misunderstandings that occur with racial and language discordance, it is important to establish clear care plans (especially for Spanish-speaking families) and utilize effective interpreting practices.

Interestingly, parents who preferred to be interviewed in Spanish were more likely to report feeling optimistic as a result of the psychiatry conference. In fact, no parents who preferred English endorsed this theme. Various factors may contribute to this finding, including the potential that although there were slight gaps in understanding at times due to lack of formal interpreter services, having a team model, especially with a patient-centered care approach, contributed to an improved experience of care for these families compared to previous negative experiences navigating the health care system. The team-based model combined with the patient-centered care approach may have contributed to an increased ability to pick up on misunderstandings and clarify concerns for families, increasing buy-in and optimism. Given the fact that Spanish-speaking families are less likely to be identified for behavioral health consultations and are less likely to receive preventative health services (Becker Herbst et al., 2016; DuBard & Gizlice, 2008), the fact that these families have gotten through this barrier and are at the point of receiving psychiatry care may contribute to an increased sense of optimism following the psychiatry conference. Additionally, parents who preferred Spanish may have felt especially intimidated and perhaps discouraged prior to the psychiatry conference meeting, which may have contributed to an increased sense of optimism at the end of the psychiatry conference. Intimidation can arise with patient-provider language discordance due to fears of language-based discrimination as well as fear of deportation and other stressors (Napoles-Springer et al., 2004). Interestingly, Garcini et al. (2022) found that optimism, which fell under a broader category of cognitive reframing, was a strategy used by undocumented Latine immigrants to help cope with adversity. Participants that Garcini et al. interviewed described optimism as hopefulness despite challenges faced. Considering the myriad of challenges that undocumented Latine parents face, including chronic stress, threats, discrimination, and racism, optimism and cognitive reframing strategies may be especially important for persistence. This supports the notion that optimism may have been especially salient for Spanish speaking parents in the current study.

Optimism may also be related to cultural values such as respeto. When parents and their children interact with psychiatrists, who have specific expertise in addressing mental health concerns, the respect that families hold for these individuals may contribute to optimism that they will work in the best interest of their child. The findings from the current study build on research related to respeto as a salient cultural value for Latine families and highlight the importance of the reciprocal nature of respeto and how this can be achieved through patient-centered care approaches, as mutual respect was a central theme in the current study (Flores et al., 2000; Calzada et al., 2010).

Finally, it is important to continue considering the role of perceived discrimination on trust. With a majority Latine sample in a healthcare setting comes the potential for cultural mistrust, especially when interacting with providers of different races/ethnicities and who speak different languages (Benkert et al., 2006). Lower linguistic acculturation (adjusting to/learning and obtaining comfort with a new language) has been found to be related to greater perceived discrimination in medical settings as well as lower quality treatment (Becerra et al., 2015). Other studies support the notion that Latine patients have less trust in healthcare providers and in broader systems of care (Fields et al., 2016). Consistent with these findings, in the current study a common experience for families first joining the psychiatry conference was the feeling of intimidation. Through a trust building process, this intimidation lowered as families developed confidence and hope in providers as well as in the psychiatry conference model. Since trust emerged as a salient factor impacting the overall experience of the psychiatry conference, the clinic in the current study should consider explicitly asking families about their experience of trust, especially in the context of cultural mismatches between families and providers. This will also enhance the culturally responsive and patient-centered nature of the psychiatry conference.

Research Question Four

Consistent with research question four, which asked about recommendations for the clinic to better help children and parents establish trust in the psychiatrist and other providers, various recommendations related to introducing teams have been identified in the collaborative care literature (Whitebird et al., 2015; AIMS Center). One such recommendation is completing a true warm handoff prior to the collaborative care meeting between the primary care provider, the case manager, and the patient and family. Whitebired et al. (2015) evaluated how to effectively implement collaborative care and found that warm handoffs were one factor that especially contributed to patient activation. Similarly, Moise et al. (2018) found that warm handoffs contributed to more patient engagement in collaborative care models in primary care. Finally, Tai-Seale et al. (2010) evaluated collaborative care implementation and found that “cold” or “lukewarm” handoffs were often taking place (e.g., passively alluding to the presence of behavioral health providers rather than transfer of care directly in front of the patient and providing psychoeducation) and they highlighted the need to train providers on how to conduct true warm handoffs. When the primary care provider introduces the psychiatry conference to families, there is no formal process for introducing the case manager and other supporting staff to families, and families receive a phone call to schedule the psychiatry conference. Since at the psychiatry conference the child’s primary care provider is often present when available but does not necessarily have to be available, a true warm handoff may help to alleviate anxiety prior to the first psychiatry conference. The findings highlight the need to evaluate the effective implementation of collaborative care models and the importance of taking steps such as using warm handoffs to increase trust and engagement in collaborative care.

Secondly, other methods to provide families with information about the psychiatry conference, such as handouts with provider names, pictures, and descriptions of their roles, may help families better understand the purpose of the psychiatry conference and who all will be present at the meeting. This came up as a concern in the current study where families were unsure of the purpose of the meeting and how many providers would be in attendance. The University of Washington's Advancing Integrated Mental Health Solutions (AIMS) Center (who helped develop the collaborative care model and conducted the largest collaborative care trial – the IMPACT trial; Unützer et al., 2002) developed a handout for collaborative care models which includes a description of the patient/family role (which emphasizes patient centered care by reminding families that they are the most important members on the team and encourages them to voice questions or concerns). Consistently providing warm handoffs and providing other methods to help educate families about the psychiatry conference such as using handouts with visuals may help to alleviate anxiety. Other approaches to alleviate anxiety and intimidation may be warranted as well, such as starting the psychiatry conference with perhaps only the psychiatrist and primary care provider present to help families slowly acclimate before other individuals (social workers, residents, etc.) join the conference. Working with the clinic to discuss the feasibility of such an approach is an important next step.

Clinical Implications

As behavioral health integration becomes a national priority as described in a recent statement by the U.S. Department of Health and Human Services and President Biden's Strategy to Address our National Mental Health Crisis, it is important to not only advocate for more systemic integration but also identify best practices towards implementing IBH to ensure its success. The collaborative care model has a strong evidence base for various populations including racial/ethnic minority populations (Hu et al., 2020). The current study addresses the gaps in the literature on integrated care research related to how minoritized populations are best served by IBH and patient and family perspectives on IBH (Vogel et al., 2017; Talmi et al., 2016; Richardson et al., 2017, Shahidullah et al., 2018; Kwan & Nease, 2013).

The current study demonstrates that in this line of work, it is important to take into account various characteristics of populations when implementing IBH models. For Latine families, considering needs based on language is imperative. It is not enough to have bilingual or language concordant staff; this study demonstrates the importance of training staff in effective interpretation practices to ensure care is equitable for Spanish-speaking families, as there are ethical and professional challenges that can arise when using staff as untrained interpreters, and this can also impact trust (Delgado-Romero et al., 2018). Further, the current study demonstrates the importance of considering how patient diagnosis may impact trust and comfort with interactions between patients and staff. The collaborative care approach has been demonstrated to be effective for treating anxiety disorders in adults (Muntingh et al., 2016). The current study found that for children with anxiety, a modified team-based approach may be more beneficial to reduce intimidation and increase trust. Relatedly, ensuring that all families have a comprehensive understanding of the model of care in advance by using visuals and providing a space to answer questions that arise may help to improve-buy in and retain families in integrated behavioral health models.

As patient centered care is an important and foundational facet of collaborative care, this study helps to define what patient-centered care looks like in the context of collaborative care for children and adolescents (American Psychiatric Association, 2018; AIMS Center). Some of the factors identified in the current study include: educating families without using complex medical jargon, ensuring patient understanding through asking questions and eliciting feedback, and utilizing a round table approach/method when feasible to instill an atmosphere of mutual respect.

As most of the participants in this study participated before the COVID-19 pandemic, difficulties with scheduling were noted by families. The clinic has started utilizing telemedicine more frequently which has the potential to improve coordination and scheduling. Per Goodrich et al. (2013), telemedicine has been instrumental in helping with the success of collaborative care, especially for rural communities. Continuing to utilize telemedicine is an important implication from this work.

Other avenues to explore in integrated behavioral health research include peer navigation models of care. Navigation models of care involve having either professionals or individuals with lived experience in navigating mental health systems (and who sometimes share cultural background with patients) work with patients to improve engagement in mental health services. There has been limited research on integrating family navigators into pediatric primary care settings to address mental health concerns (Godoy et al., 2019). In efforts to improve trust in psychiatrists and other providers in primary care, utilizing navigators would offer unique opportunities for families to increase their engagement and trust in mental health care.

At a systemic level, advocating for more financial resources to increase the behavioral workforce as well as supporting training in integrated healthcare settings is imperative to increase the availability of behavioral health services in primary care. Since this is already discussed in recent statements by the current presidential administration to address the mental health crisis, this hopefully will continue being a priority. Initiatives such the Behavioral Health

Workforce Education and Training Program through the Health Research Services Administration provide funding to academic institutions to help train individuals from various disciplines in integrated behavioral health practices. A combination of adequate training and financial resources to support careers in integrated settings is critical for increasing the behavioral health workforce in primary care settings and thus increasing access to mental health care for marginalized communities.

Qualitative results could inform the broader field of psychiatry related to stigma and mental health. Despite the high need for more psychiatrists and mental health providers in the workforce, families often feel intimidated accessing these services. Latinx families may be especially intimidated due to historical and present discrimination related to accessing and receiving healthcare services. In the current study, intimidation due to stigma and other factors was a common experience for families, and the current study outlines various ways to overcome initial fears and intimidation. The current study found evidence for a variety of ways to facilitate trust in psychiatrists, including instilling mutual respect to using language that families can understand regardless of language or educational background.

Limitations

The current study has a number of limitations that should be taken into account. The findings cannot speak to whether there are specific aspects of the psychiatry conference (such as clarifying diagnoses and starting/managing medications) that are most impacting mental health outcomes, since the team only collected data at one time point and is not able to search for individual families in the clinic's medical record due to confidentiality. Related, information is lacking on retention outcomes for the psychiatry conference and this would be interesting to explore in future research utilizing medical record data. Another limitation is related to the amount of children who were interviewed. Although saturation was met and parent interviews were richer than child interviews, more child interviews would have added to the richness of the current study to obtain a similar number of perspectives from parents and children. Recruitment strategies may need to be modified, since children were less interested in participating in interviews than parents. The age range for child interviews was also limited due to developmental level, which also impacted the amount of child interviews obtained. A fourth limitation is related to the demographics of the sample. The sample included is primarily Latine (Mexican-American) however other ethnicities and groups are represented. The design does not allow for comparisons across groups including various Latine subgroups. A fifth limitation is related to the wording of the qualitative interview questions. While the questions were open-ended, they did not specifically ask about trust. However, the theme of trust arose through an inductive process, which was intended through the study design. A final limitation is related to the sample of caregivers who were interviewed; only one father participated in the study. However, this is consistent with the clinic population and suggests that this clinic and others could work towards better engaging fathers in treatment.

Strengths

The current study has various strengths that should be considered. Previous IBH research has focused on single disease states and the current study seeks to understand the experience of children and adolescents with varying complex/comorbid mental health concerns (Talmi et al., 2016; Vogel et al., 2017). Spanish-speaking families may experience communication difficulties with providers (Flores, 2000) and the psychiatry conference allows for an open channel of communication between providers and families. The group setting may help providers pinpoint gaps in understanding, increasing access to and quality of care for this population.

There are various strengths related to the study population. The study sample includes individuals predominately from minoritized communities who often experience disparities in mental health access due a variety of factors including poverty, discrimination, acculturation, and language barriers (Braveman et al., 2011; Bridges et al., 2014; Céspedes et al., 2008; U.S. Census Bureau, 2017; Zuvekas et al., 2003). Findings may help provide insight into the experience of the psychiatry conference for this population, which could inform changes to the structure and format of the psychiatry conference. This could have direct benefits for low-SES Latine children and families and others from minoritized communities participating in the psychiatry conference.

Finally, the CBPR approach represents an important strength of this study. Through the approach, the research team was able to focus research efforts on the needs of the clinic. As a result, the clinic will likely be motivated to quickly implement feedback from the current study, as the research helps address concerns that providers had related to improving the patient experience of the psychiatry conference and reducing intimidation. Consistent with CBPR, the team plans to help the clinic with implementing recommendations from the current study through meeting with administrative and clinical staff who participate in the psychiatry conference. Thus, as a result of the CBPR approach and focusing on the needs of the clinic, research findings are easily translatable into practice which is large strength of this study. Another strength related to the CBPR approach is the input of staff from the clinic throughout the research study, from the development of research questions to coding interviews and identifying themes. This insider perspective provided a richer understanding of patient and caregiver experiences that would not have been elucidated from the interviews alone. For example, members of the research team from the clinic had insight into organizational processes and the structure and flow of the psychiatry conference, which helped to contextualize processes described in interviews.

Implications and Future Research

Implications of this research include improving the experience of accessing mental health support for marginalized communities, specifically in the context of integrated primary care. The current study contributes to the literature on the importance of trust in provider-patient relationships in primary care, which is an under-researched area. Improving patient-provider trust has important implications for improved retention and adherence, and ultimately improved mental health outcomes for patients. Finally, the CBPR partnership allowed for a close relationship with the clinic and the ability to translate research findings into practice more easily, which is also a future direction for this research. For example, modifications to interpreter services, information given about the psychiatry conference to families in advance, utilizing warm handoffs, and modifying the way that families are introduced to the team are concrete steps to work on as a result of study findings. Implementing these changes could help maximize the benefits of the psychiatry conference. Broadly, evaluating models/approaches to introducing large primary care teams to families would be a beneficial area for future research to help alleviate intimidation in healthcare settings. Conducting additional interviews with families after modifications to the psychiatry conference have been implemented would be an important next step. Future research could also utilize medical record data to collect retention data to identify long term impacts of patient-provider trust. In line with this, examining whether as a result of participating in the psychiatry conference families are on top of other aspects of their child's medical care such as attendance at well visits would be beneficial to determine whether the benefits of the patient-centered collaborative care approach impact families' engagement in the clinic outside of the psychiatry conference. Future research should also consider other positive outcomes that may occur as a result of the psychiatry conference, such as increasing services/accommodations in schools. Finally, for the current study, the clinic was the unity of community for the CBPR partnership, however future research could consider an additional study in which the unity of community is the patient population served by the clinic.

Conclusion

In sum, the current study utilized a CBPR approach to identify factors that contributed to facilitators of trust in providers for Latine children and caregivers who participate in the psychiatry conference. Results pointed at various facilitators including primary care provider serving as a bridge to help develop trusting relationships between patients and the psychiatrist, reciprocal respect between providers and families, and the psychiatrist taking an educational approach. Barriers to trust included the quality and availability of interpreter services as well as lack of a tailored approach for patients depending on their diagnosis. This study helps to elucidate how to implement a CBPR study in integrated care as well as practical implications related to improving the acceptability of primary care behavioral health services for Latine children and families.

Appendix

Interview Questions (Parent)

Question	**Underlying Info Needed**
1. Describe your role at People's Community Clinic (PCC). ***If provider or staff*** *P: How long have you worked in your role?* *P: How would you describe the mission of PCC?* *P: Do you speak Spanish? Do you use it in your work?* ***If patient*** *P: How long have you been a patient at PCC?* *P: What is your perception of the care you receive at PCC?* ***If family of patient*** *P: How long has your family member been a patient at PCC?* *P: What is your perception of the care your family member receives at PCC?*	Introduction; get general information about the individual and their familiarity with PCC; get patient and family perceptions of their care at PCC
2. What is your experience with the behavioral health care system, and in what context?	Get information on the individual's experience with mental health care
3. Have you attended a Psychiatry Conference at PCC? **OR** Have you seen the psychiatrist (or meeting with a psychiatrist?)? **OR** Has your family member seen the psychiatrist? ***If yes*** *P: How many have you attended?* ***<u>If no (SKIP 3, 4, & 8) and ask:</u>*** ▪ What is your perception of the Psychiatry Conference?	General sense of individual's attendance at a psychiatry conference

4. What was it like for you to participate in the Psychiatry Conference? OR What was it like for you to see the psychiatrist? OR What was it like for your family member to see the psychiatrist? ***P: What was your immediate reaction to the conference/meeting (e.g., when first walked in)?*** ***P: Describe the format of the conference/meeting with the psychiatrist. What do you think about it?*** ***P: What was your level of involvement during the conference/meeting? Or if attended multiple, what is your general level of involvement?*** ***P: What were your thoughts at the end of the conference/meeting?***	Get information on individual's experience with the conference, first impressions, and level of involvement
5. How do people at the conference/meeting interact with one another? ***P: Describe your own interactions with other individuals present at the conference/meeting.*** ***P: How was information communicated?*** ***P: Was a translator present? If yes: Describe the interactions among the individuals.***	Get information about the collaborative aspect of the psychiatry conference
6. Are there any **benefits or disadvantages** of the Psychiatry Conference? Tell me about them. OR Are there any benefits or disadvantages to seeing the psychiatrist? Tell me about them. *P: What is a benefit for:* ▪ *Patients and families* ▪ *Primary care providers* ▪ *Psychiatrists* ▪ *Behavioral Health Staff* ▪ *PCC* *P: What is a disadvantage for:* ▪ *Patients and families* ▪ *Primary care providers* ▪ *Psychiatrists* ▪ *Behavioral Health Staff* ▪ *PCC*	Get information on the benefits and disadvantages of the psychiatry conference model
7. What do you think about using the psychiatry conference to provide mental/behavioral	Get information on the effectiveness of the psychiatry conference as a delivery

health services? OR What do you think about using the meeting to provide mental/behavioral health services? *P: Is there an effect on:* *- clinic's delivery of services?* *- your knowledge and competence?* *- patients and families?*	model for psychiatric services; get information on the effect it has on knowledge and level of competence (e.g., patients knowledge of mental health diagnosis, physician comfort in prescribing medication)
8. What was the impact of attending the psychiatry conference/meeting with psychiatrist? ***P: Impact on delivery of services?*** ***P: What was the impact for:*** ▪ ***Patients and families*** ▪ ***Primary care providers*** ▪ ***Psychiatrists*** ▪ ***Behavioral Health Staff***	Get information on the impact of attending the conference
9. What suggestions do you have for the people running the psychiatry conference/meeting with the psychiatrist?	Get information on suggestions or recommendations for the psychiatry conference

Interview Questions (Child)

Question	Underlying Info Needed
How long have you been a patient at PCC?	Introduction; get general information about the individual and their familiarity with PCC; get patient and family perceptions of their care at PCC
Sometimes we visit doctors to keep our bodies healthy. So we go for check-ups, or to see the doctor if we are sick. But we can also see a doctor if we need help for other kinds of problems, not just for our bodies. So help with our feelings, or our behaviors. Have you ever done this? Tell me about that.	Get information on the individual's experience with mental health care
There are special kinds of doctors call psychiatrists. Have you heard of this kind of doctor? (If no, define – a special kind of doctor to help us with our thoughts, feelings, and behaviors). Have you ever seen a psychiatrist?	General sense of individual's attendance at a psychiatry conference

(For psych conference), one time I think you came to this room, and there was a psychiatrist there. Do you remember? So we call that the Psychiatry Conference. Have you heard that phrase before? What was that psychiatry conference like?	
So I want you to close your eyes, and think about the time you came to that room, for the psychiatry conference. When you first came into the room, what did you think? Then what happened? What kinds of things did you say? What did you think after?	Get information on individual's experience with the conference, first impressions, and level of involvement
There were a bunch of people there at the conference, right? What kinds of things did they say? Were they speaking in English or Spanish? Did someone help with the Spanish? What did you think of that person?	Get information about the collaborative aspect of the psychiatry conference
What was good about coming to the conference that day? What was good about seeing the psychiatrist? What was bad about the conference? The psychiatrist?	Get information on the benefits and disadvantages of the psychiatry conference model
How did it help you?	Get information on the effectiveness of the psychiatry conference as a delivery model for psychiatric services; get information on the effect it has on knowledge and level of competence (e.g., patients knowledge of mental health diagnosis, physician comfort in prescribing medication)

If you could change one thing about that day, what would it be?	Get information on suggestions or recommendations for the psychiatry conference

Saturation Calculation

Version	**Codebook Changes**	**Threshold**
1	14	
2	8	
3	8	
4	1	
5	2	
6	5	
BASE	38	
7	1	
8	0	
9	2	8%
10	1	8%
11	0	8%
12	1	5%
13	1	5%
14	0	5%
15	0	3%
16	0	0%
17	1	3%
18	0	3%
19	0	3%
20	2	5%
21	1	8%
22	1	11%
23	1	8%
24	0	5%
25	0	3%
26	0	0%
27	0	0%
Saturation Level		**5%**

Original Spanish Quotes and English Translations

- Es una experiencia bonita porque empiezas a tener confianza en que cuando ves al psiquiatra no es porque estas loco sino que te van a ayudar en algo que tu no puedes

- It is a beautiful experience because you begin to have confidence that when you see the psychiatrist it is not because you are crazy but that they are going to help you in something that you cannot

- Bueno, yo pienso que su relacion entre ellos, me supongo que por algo la doctora me refirio con ellos por que ella sabe su trabajo que hacen, y pues es como un equipo. Si el doctor no me refiere con ellos, ellos nunca se van a enterar de que mi hija esta mal. Sin embargo cuando ellos ya la miraron, ellos ya le pueden decir a la doctora que es lo que pasa con mi hija, que procede, y ella me comunica a mi y entonces ya seria cuestion ya nada mas de ir a la cita y de que ella me diga que es lo que sige.
- Well, I think that the relationship between them, I imagine that for some reason the doctor referred me to them because she knows the work that they do, and, well, it's like a team. If the doctor does not refer me to them, they will never find out that my daughter is unwell. However, when they had already looked at her, then they can already tell the doctor what is going on with my daughter, and what is appropriate, and she [the doctor] tells me and then it would be a matter of just going to the appointment and that she tells me what happens next.

- Pues ehm...no te podría decir...como...en que...pues fue (...) una habitación...pues el pediatra me dijo que...perdón, el psiquiatra me dijo que...pues que él aun estaba pequeño y que aun podría tener cambios...que no le podría dar una...como algo, algo complejo. Entonces, porque los ninos iban creciendo y podrían cambiar muchísimo.
- Well, um...I couldn't tell you...well, it was (...) a room... well, the pediatritian told me that...sorry, the psychiatrist told me that...well, because he was still small and could still have changes...that he could not give him a...like, something complex. Well, because the children were growing and could change a lot.

- La primera impresión es que uno dice ""no estoy loco"". No quería ir porque nos iban a decir que estamos locos. Pero ya que estas ahí y vas conociendo el tema y en vez de que te vayan a juzgar te escuchan y te ayudan
- The first impression is that one says ""I am not crazy"". I didn't want to go because they were going to tell us that we're crazy. But once you are already there and you are getting to know the subject and instead of being judged they listen to you and help you.

- Bueno, si me sentia nerviosa porque no sabia lo que me iba a exponer entonces no sabia lo que me iban a preguntar, no sabia lo que iban a decir de mi niña, no sabia si tenia que actuar asi muy rigidamente. No sabia lo que me esperaba pero sin embargo cuando ya llegue ahi, si tenia la confianza de hablar y pues de lo que me preguntaban todo lo entendi.
- Well, yes, I felt nervous because I didn't know what she was going to expose me to, then I didn't know what they were going to ask me, I didn't know what they were going to say about my little girl, I didn't know if I had to act like that very rigidly. I didn't know what was waiting for me, but nevertheless when I got there, I had the confidence to talk and, well, what I was asked about, I understood everything.

- Bueno, se compartian ideas, me daban las soluciones, las diferentes maneras que podiamos tratarlo. Obviamente me traducia... una persona me hacia la traduccion tambien.
- Well, we shared ideas [answering how they interacted], they gave me solutions, the different ways that we could treat it. Obviously, they translated for me...someone did the translations for me, too.

- Las juntas son en ingles y si me ayuda porque no entiendo lo que ellos hablan pero ellos me hacen un pequeño resumen y me dicen que es lo que esta pasando y me explican y me dan ayuda tanto a mi como a mi niño
- The meetings are in English and yes it helps me because I do not understand what they speak about, but they give me a short summary and they tell me what is happening and they explain to me and help both me and my child.

- Siento que soy como para 20% ahí en el momento porque yo no se hablar ingles
- I feel like I'm about 20% there at the moment because I don't know how to speak English.

- Pues yo pienso que eso si deberian decirle a uno, bueno si yo ya fui a mi junta, ya hale con esas personas, ya miraron como es mi nina, ellos ya hablaron y ya deducieron, platicaron lo que pasaba o mas o menos deducieron lo que ella tendria... pienso en mi ver que deberian de haberme hablado o de perdis una carta y decirme, oiga senora, todo esta bien, no se preocupe, vamos a seguir haciendo otra junta, o ya no vamos a proceder por que su nina esta bien. Pienso que a lo mejor me gustaria saber que ellos deducieron de esto y que deriva despues.
- Well, I think that they should tell someone, well if I already went to my meeting, I already talked to those people, they already looked at how my girl is, they already talked and deduced, they talked about was happening or more or less deduced what she has...I think of myself seeing that they should have talked to me or sent me a letter and told me, ""listen ma'am, everything is ok, don't worry, we are goig to continue holding another meeting,"" or ""we are not going to proceed anymore because your girl is fine."" I think maybe I would like to know what they deduced from this and what it derives from.

- Pues, me gustaria como que aprendieran un poquito mas el idioma, al igual que yo tambien necesito aprender mas el idioma de ellos.
- Well, I would like them to learn a little more of the language, just as I also need to learn more of their language

- Sí, me ayudaba cuando ellos trataron que aclarar algo que no entendía y sí me pareció bien
- Yes, it helped me when they tried to clarify something that I did not understand and yes, it seemed fine to me

- Es que si da miedo cuando te dicen psiquiatra y que vas a tomar medicamentos pues lo primero que se te viene a la cabeza es que estas loco o que tienes un problema muy fuerte, muy serio. Eso es lo que asusta a uno. Pero ya cuando estas viendo que te los estas

tomando (los medicamentos) y ves que estas mejorando. Ya no hay tanto dolor ni preocupaciones. Y con ayuda de la consejera se va todo poquito a poquito
- It is scary when they tell you ""psychiatrist"" and that you are going to take medications, then the first thing that comes to mind is that you are crazy or that you have a very strong, very serious problem. That is what scares you. But when you are seeing that you are taking them (medication) and you see you are improving. There is not as much pain or worries. And with the help of the counselor, everything goes little by little.

- No, no. Yo pienso que no es desventaja, al contrario es lo bueno contar con mas recursos en la clinica para poder ayudar a la gente. Pienso que a veces en muchos lugares no hay ese tipo de ayuda, y hay veces que uno anda ayudando, y a veces que no. A veces economicamente uno no puede assistir a luigares caros donde uno sabe que ese tipo de juntas o de sitas son muy caras que uno nunca las podria pagar.
- No, no. I don't think that it is a disadvantage, on the contrary, it's good to have more resources in the clinic to be able to help people. I think that sometimes, in many places, there is not that kind of help, and there are times that one is helping, and sometimes not. Sometimes, financially, you can't attend expensive places where you know that these types of meetings or appointments are very expensive that you could never pay for them.

- Me dio miedo por que vi varias personas sentadas ahi, como diciendo… yo no supe que pensar. Pense que a lo mejor era como que me iban a preguntar cosas que yo no iba a poder responderles como si me fueran a estudiar a a mi, algo que yo estaba haciendo mal. No se por que asi me sentia.
- It scared me because I saw several people sitting there, as if to say... I didn't know what to think. I thought it might be like they were going to ask me things that I wasn't going to be able to answer like they were going to study me, something I was doing wrong. I don't know why that's how I felt.

- Pues, antes de ir la, la de ella, para mi fue bien, que estabamos en un lugar que pueden ayudar con los problemas, pero a ella ya no quiso regresar.
- Well, before I went to hers, it was good for me, that we were in a place that can help with problems, but she did not want to return to it

- Mis pensamientos son de que gracias a ellos mi hijo va a mejorar en su escuela y su aprendizaje.
- My thoughts are that thanks to them my son will improve in school and in his learning.

- No sabría que decir porque realmente no experimenté porque mi hija desafortunadamente se salió antes de que le puedan a ayudar, verdad, pero si ella tuviera este cambio, para mí, había sido mucho mejor y más con ayudo con alguien
- I wouldn't know what to say because I really didn't experience it because my daughter unfortunately left before they could help her, right, but if she had this change, for me, it would have been much better and more with the help of someone

- Mi hijo es muy callado, el nada mas observa y escucha lo que aun dice. Si le preguntan algo lo contesta, pero el es bastante callado.
- My son is very quiet, he just watches and listens to what he says. If they ask him anything, he answers, but he's pretty quiet.

- Mas a el que a mi. Antes no tenia interés en su vida. Era una tristeza muy profunda. Con estas conferencias ahorita sonríe y piensa en su sueño. El esta contento y tiene interés de que va a trabajar para la NASA. Para mi es bueno porque estudio otra vez y ya le esta echando ganas. Ahora tiene interés de ser alguien y antes no decía "para que si me voy a morir, si no podía". Ahora dice "si puedo y le voy a echar ganas". Disminuyeron sus pesadillas. Si tiene un problema ya encuentra una solución.
- More for him than for me. Before, he had no interest in his life. It was a very deep sadness. With these conferences, now he smiles and thinks about his dream. He is happy and is interested in going to work for NASA. For me it's good because I'm studying again and it's already making him want to. Now he is interested in being someone and before he didn't, he would say “for what, if I'm going to die? If not, I would". Now he says "yes I can and I'm going to want it". His nightmares subsided. If he has a problem, he finds a solution.

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