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Examining Mental Healthcare Underutilization Among Latino Immigrants: Healthcare Providers' and Community Health Workers' Perspectives

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Abstract

Latinos continue to experience many logistical and systemic barriers to professional mental health services (Derr, 2016) despite being the second-largest racial-ethnic group in the United States (U.S.). With a community of 65 million people (U.S. Census Bureau, 2024), Latinos experience mental healthcare inequalities (Cook et al., 2019) due to structural, cultural, and systemic barriers. Although prior research has emphasized culturally responsive care as a pathway to reducing disparities (Nagy et al., 2025), much of the literature has focused on Western medical models, with limited attention to community-based perspective. Guided by the Knowledge, Attitude, and Practices (KAP) framework, the present study examined how community health workers (CHWs; $n = 39$) and healthcare providers ($n = 22$) conceptualize and respond to the underutilization of mental health services among Latino immigrants. Using a community-based participatory research approach, qualitative data was collected through focus group interviews and analyzed using thematic analysis (Braun & Clark, 2006). Findings revealed both shared and distinct perspectives across KAP domains. Within the knowledge domain, CHWs emphasized non-clinical and externally mediated pathways to recognizing psychological distress, including somatic symptoms, behavioral changes, and institutional involvement, whereas healthcare providers conceptualized distress through trauma-informed and clinical frameworks. Within the attitude domain, CHWs described mental health service utilization as reactive, crisis-driven, and requiring sustained relational support, while healthcare providers framed engagement as shaped by trust, cultural responsiveness, competing life demands, and sociopolitical vulnerability. Within the practice domain, CHWs reported implementing flexible, relationship-based, and community-grounded strategies that extend beyond formal roles, whereas healthcare providers emphasized adapting clinical care to improve engagement and retention

within existing systems. Across domains, findings suggest that mental health service utilization among Latino immigrants is a dynamic, multi-stage process shaped by cultural values, structural constraints, and relational processes. Importantly, the study highlights a critical misalignment between how mental healthcare systems are structured and how engagement unfolds within Latino immigrant communities. By integrating CHWs' community-based knowledge with healthcare providers' clinical expertise, interdisciplinary approaches may enhance cultural responsiveness, improve engagement and retention, and better align mental health services with the lived realities of Latino immigrant communities.

Chapter 1: Statement of Purpose

The Latino[1] community is the largest racial-ethnic group in the United States, comprising 65 million people, of whom 20.4 million identify as immigrants, with approximately 7.4 million individuals having precarious immigration legal status (e.g., undocumented immigrants; U.S. Census Bureau, 2024; Millet & Pavilon, 2022). Previous studies examining the prevalence of mental health disorders among U.S. immigrant Latinos have found mixed results, particularly when researchers aggregate Latinos into a single group that masks substantial variability in the lifetime risk of developing mental health disorders across Latino subgroups (e.g., Mexican, Honduran, etc.; Cervantes, Gattamorta, & Berger-Cardoso, 2019; Algeria et al., 2008; Alarcon et al., 2016). The variability of mental health disorders among the U.S. immigrant Latino population has caused significant implications for policy making, clinical care, and public health (Alarcon et al., 2016). In general, the U.S. Latino population faces systemic inequities in terms of socioeconomic status and access to care, and this is compounded by barriers such as language (Jimenez et al., 2019). The barriers faced by the U.S. population have turned into an urgent concern. The Institute of Medicine (2003) has stated that Latinos "face greater barriers than any other racial and ethnic group in the U.S.," specifically with accessing adequate mental health care services (Jimenez et al., 2019). With the ongoing rapid growth of U.S. immigrant Latino communities, mental health disparities faced by the community could be addressed by increasing providers' knowledge of culturally competent and culturally humility frameworks to address mental health disparities impacting Latino immigrants (Chu, Wippold, & Becker, 2022). This may include expanding knowledge related to culturally grounded experiences, barriers to care, and the role of patient-centered approaches to treatment engagement. Furthermore, providers

[1] The term "Latino" is used throughout this report to represent people, of any gender, with origin in Latin America and where the language of the place of origin is Spanish.

who prioritize culturally responsive and value patient responses within treatment have been shown to demonstrate positive attitudes to culturally tailored treatment delivery, which has been associated with improved therapeutic relationships and trust among Latinos in treatment (Smith & Trimble, 2025). Indeed, attitudes demonstrated by providers are an essential component with fostering engagement and reducing stigma-related barriers within the Latino immigrant population (Falgas-Bague et al., 2019). In relation to practice, culturally responsive providers emphasize the implementation of strategies that enhance retention and engagement in the delivery of mental health services (Hai et al., 2021). Therefore, contributing to reduction of disparities seen with reduced treatment utilization among Latinos (Castro, Berkel, & Epstein, 2023; Cardona et al., 2023; Moreno et al., 2022).

Review of the Literature

Chapter 2: Latino Prevalences

Among the U.S. Latino population, the risk of mental health-related concerns may be exacerbated due to stressful social determinants (i.e., hostility towards immigrants, acculturative stress) that could inhibit psychological well-being (Garcini et al., 2022; Johnson et al., 2023: Williams, 2018; Bekteshi & Kang, 2018). Scholarship on Latino mental health prevalence rates has been an area of research that has been growing and has brought awareness to the mental health of the U.S. Latino population (Calzada et al., 2020). However, scholars have scrutinized previous studies on mental health disorder prevalence rates among the U.S. Latino population due to researchers on the subject pathologizing and/or undermining cultural beliefs, traditions, and lived experiences (Arellano-Morales et al., 2016; Canino & Alegria, 2008). Despite the reviews of previous studies, national institutions (i.e., Office of Minority Health) have reported significant rates of mental illness within the Latino community. For instance, the 2023 National

Survey on Drug Use and Health (NDUH) conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that nearly 19.9% of U.S. adult Latinos reported having a mental illness, with five percent reporting a serious mental health illness, and seven percent reporting a co-occurring mental illness and substance use issue. Two comprehensive studies (e.g., Community Health Study & Study of Latinos) that included 15,864 self-identifying Latinos from multiple ethnic backgrounds (e.g., Mexican, Puerto Rican, Dominican, Cuban, Central American, and South American) reported significant rates of depressive symptoms among those recruited (Wassertheil-Smoller et al., 2014). Specifically, among individuals of Mexican and Puerto Rican backgrounds, Wassertheil and colleagues (2014) noted that high depressive symptoms were reported by 22.3% of self-identifying Mexican individuals and by 38% of self-identifying Puerto Ricans. By utilizing the 2022 Household Pulse Survey, the Hispanic Research Center (2022) noted that approximately 33% of U.S. Latinos reported frequent anxiety symptoms, with 22% reporting both anxiety and depressive symptoms.

Among the U.S Latino immigrant population, research has shown that the immigrant community has better mental health outcomes when compared to native-born Latino individuals (Cervantes et al., 2019). Known as the “immigrant paradox”, Vega and colleagues (2010) associated the disparity in mental health outcomes between immigrant and native-born Latinos as a result of the progressive loss of traditional culture and the associated negative impact on health seen among new generations or time spent in the U.S. For example, literature examining prevalence rates of mental illness among the U.S. Latino population found that Mexican immigrants have lower rates of depression in comparison to Mexican-American individuals (Alegría et al., 2008; Hernandez et al., 2022; Moreno et al., 2018). Nonetheless, Alderete and colleagues (2000) conducted a study investigating the prevalence rates of mental health disorders

among migrant workers from Mexico and Guatemala. They found that the lifetime prevalence of developing a mental disorder was 16.8% for women and 26.7% for men. Further, the research also found that the prevalence of alcohol dependence among men (12.9%) was significantly higher than among women (1.7%). Although the prevalence of depression among U.S. Latino immigrants are comparable to the overall U.S. and worldwide population (Kessler et al., 2005; Aguilar-Gaxiola & Gullotta, 2008), the Hispanic Health and Nutrition Examination Survey found that island-born Puerto Ricans had significantly higher rates of mood disorders (e.g., major depression) and anxiety disorders than in any other foreign-born groups (Alarcon et al., 2016). Due to political unrest seen among many South and Central American countries, individuals migrating from these countries often exhibit symptomatology associated with post-traumatic stress disorder (PTSD; Alarcon et al., 2016). Among 1630 Latino immigrants included in the National Latino and Asian American Study, 11% of immigrants reported exposure to political violence, and 76% noted additional lifetime exposure to trauma (Fortuna, Porche, & Alegria, 2008).

Chapter 3: Mental Health Help-Seeking Behaviors Among Latinos

Within the literature, mental health help-seeking behaviors among the U.S. Latino population are less consistent when compared to other racial-ethnic groups in the U.S. (Maura & Weisman de Mamani, 2017; Moreno & Cardemil, 2013; Sun et al., 2016; Villatoro, Morales, & Mays, 2014). Notably, knowledge encompassing mental health help-seeking behaviors among Latinos is a vital component when addressing the mental health needs of the community, due to help-seeking behaviors being associated with the utilization of mental health services (Sun et al., 2016; Mendoza, Masuda, & Swartout, 2015; Villatoro et al., 2014). Within the Latino community, a salient factor that impacts mental health help-seeking behaviors is the role of

stigma (Eghaneyan & Murphy, 2020; Santana et al., 2023; Schnyder et al., 2017); notably, stigma towards experiencing mental health illness (Collado et al., 2019). For instance, research has provided evidence that stigma is a significant barrier to receiving mental health treatment within the Latino community (Turan et al., 2019; Mascayano et al., 2016; Eghaneyan & Murphy, 2020). Further, other marginalized identities impacting Latinos (e.g., documentation status) can contribute to mental-health-related stigma, therefore limiting help-seeking behaviors (Farooqi et al., 2019). In addition to stigma, researchers have identified other factors that inhibit formal mental health help-seeking behaviors, including mental health literacy (Benuto et al., 2019), faith-based beliefs (Brenner et al., 2018; Moreno & Cardemil, 2013), and Latino cultural values based on gender norms (Brenner et al., 2018; Moreno et al., 2026).

Brenner and colleagues (2018) reported that rigid gender norms found within Latin American countries, where it is more acceptable for women to seek formal help and men seeking help could be seen as a weakness and a lack of control, can be a contributing factor in limited help-seeking behaviors for mental health issues in the U.S. Latino population. Furthermore, scholars have also found that higher levels of religiosity among Latinos may have a negative relationship with mental health help-seeking behaviors, which perhaps may be due to the belief that God may help them navigate issues with their mental health or fear that they may be perceived as not having enough faith in God to guide them through mental health issues (Brenner et al., 2018; Rogers et al., 2018; Galvan et al., 2022). Additionally, high levels of religiosity among Latinos may also contribute to the belief that mental health issues are a punishment from God, therefore contributing to self-stigma when seeking mental health services (Rogers et al., 2018). To highlight these findings, research conducted by Caplan and colleagues (2019) found that within Latino faith-based communities, experiencing mental illness (e.g., depression) was a

culturally defined factor and perceived to be a spiritually related issue, rather than a mental health illness. Research conducted by Bucay-Harari and colleagues (2020) also calls attention to the fact that the Latino community experiences a reduced perception of the utility of mental health treatment, which may be in part related to long-term treatment modalities used for more serious mental health illnesses (Gearing et al., 2024).

Scholars have also found that mental health help-seeking behaviors may also differ based on the Latinos' generational status. Bauldry & Szaflarski (2017) noted that first-generation Latinos tend to seek mental healthcare services less frequently, in comparison to second- and third-generation individuals. Galvez (2024) reported that first-generation Latinos seek mental healthcare less due to greater reported linguistic and institutional barriers. Further, the researchers also shared the age of migration as a factor when seeking mental health services, reporting that Latino immigrants who migrated to the U.S. at age 18 or older reported the lowest perceived stigma when seeking mental healthcare services. However, evidence provided by Chang and Biegel (2018) contradicts the findings provided above, which suggests that being a younger Latino impacts mental health help-seeking behaviors. Importantly, Chang and Biegel (2018) noted that family-level factors might impact help-seeking behaviors among U.S. Latinos; specifically, lower levels of family support were associated with mental health service dropout. Indeed, Caplan and colleagues (2019) found that Latinos who have supportive families that encourage open communication, foster the recognition of mental health, and acceptance of mental health illness are vital factors in overcoming barriers associated with seeking services for mental health. Further, the scholars reported that normalizing the belief that mental health illness could impact any individual, whether it be through receiving education, televised talk shows on the topic, and exposure to close peers and/or family members, is a positive contributing factor

that leads to Latinos proactively searching for mental health services and receiving treatment (Caplan et al., 2019).

Healthcare Utilization of Latino Immigrants

Before the implementation of the Patient Protection and Affordable Care Act (ACA) in 2010, 33% of U.S. Latinos under 65 were uninsured (UnidosUS, 2024). In 2014, the ACA's extension to Medicaid aimed to increase healthcare coverage for low-income adults who were previously ineligible and provide financial assistance to individuals seeking to purchase insurance. By 2022, this initiative had reduced the proportion of uninsured Latinos without healthcare coverage to 18% (UnidosUS, 2024). Despite the notable increase in U.S. Latinos having healthcare coverage, Chen and colleagues (2016) found that the U.S. Latino population disproportionately experiences the underutilization of healthcare in comparison to the rest of the U.S. population. Some of the factors identified as contributing to the underutilization of healthcare services among the Latino community include citizenship status, language, and socioeconomic factors, which increase challenges for Latinos to benefit from the ACA (Garcia Mosqueria, Hua, & Sommers, 2015). Despite the ACA extending coverage for a large proportion of the U.S. Latino population, undocumented Latino immigrants are ineligible for federally subsidized health insurance programs, do not have employment that provides healthcare coverages, and do not utilize safety net healthcare programs due to the fear of deportation; thus, many delay seeking healthcare services due to the significant financial impact associated with receiving services (Porteny, Ponce, & Sommers, 2020; Artiga & Diaz, 2019; Galvan, Lill, & Garcini, 2021). The interrelationship between healthcare and immigration policy is well noted within the literature (Joseph, 2016; Rhodes et al., 2015), with undocumented Latino immigrants refraining from using public healthcare programs due to the risk of being detected and/or

classified as “unauthorized” immigrants (Pedraza, Nichols, & LeBron, 2017). Pedraza and colleagues (2017) contend that with the rising anti-immigration climate in the U.S., the psychological aversion to utilizing healthcare services is not exclusive to undocumented U.S. Latino immigrants but also extends to U.S. Latino citizens who want to minimize the harassment associated with disclosing their documentation status. With undocumented U.S. Latino immigrants, a qualitative study conducted found the U.S. government’s labeling related to Latino immigrants taking up resources from U.S. citizens, further burdening Latino immigrants from utilizing healthcare services, which is compounded by the U.S. government’s reluctance to dedicate resources for immigrant healthcare, even though many undocumented Latino immigrants pay U.S. taxes (Galletly et al., 2023; Moreno et al., 2025). This sentiment is further exacerbated when aftercare is needed after a major procedure. Although applications for emergency Medicaid are available to undocumented immigrants (Fernandez & Rodriguez, 2017), due to the underlying U.S. government’s views that immigrants are a burden to the healthcare system, emergency Medicaid funding does not dedicate resources for aftercare services (Galletly et al., 2023; Fernandez & Rodriguez, 2017; Gittler et al., 2017). For instance, after primary operations (e.g., hysterectomy), undocumented Latinos have limited access to necessary recovery services needed after a major procedure (Galletly et al., 2023).

As the U.S. Latino population continues to grow, the expansion of Latino communities into new migration sites, without a longstanding presence of Latino immigrants, brings about new healthcare challenges for Latinos in these areas. Traditionally, most Latinos have resided in states (e.g., California, Texas, Florida, and Arizona) with a longstanding presence of Latino communities (Batalova, 2024). However, new areas within the U.S. (e.g., North Carolina, Arkansas, and Tennessee) have begun to see an influx of Latino communities emerging, bringing

new challenges for healthcare officials (Jacquez et al., 2015; Moreno et al., 2020; Topmiller et al., 2017). Within areas that are experiencing a new growth of Latino immigrants, healthcare utilization is an issue among the community due to these areas not having the proper resources, programs, and appropriate infrastructure to address the needs of these individuals (Jacquez et al., 2015; Galvan et al., 2021; Jacquez et al., 2015; Moreno et al., 2026). For instance, healthcare providers have noted that cultural factors, such as the language and communication styles, reduce the confidence of Latino immigrants to engage with the U.S. healthcare system (Florindez et al., 2020). Notably, a study conducted by Luque and colleagues (2018) among uninsured Latina immigrants in South Carolina found that these individuals utilized alternative methods to accessing healthcare services, including traveling to Mexico for healthcare, praying to the Virgin of Guadalupe when encountering life-related stress, and practicing alternative medicine (e.g., boiling lemon peels with cinnamon for the flu; chamomile tea for anxiety) to mitigate the out-of pocket expenses for healthcare services.

Chapter 4: Mental Health Providers Working Among Latinos

Within the U.S., there is a significant shortage and need for mental health providers who can provide Spanish-English bilingual services (Delgado-Romero et al., 2020). Within the field of psychology, Hamp and colleagues (2016) have reported that approximately 5.5% of licensed clinical psychologists can provide clinical services in Spanish. Mental health-related institutions have recognized the dire need to provide linguistic and culturally responsive services in Spanish for clients across a developmental spectrum; however, there are limited opportunities for prospective students to obtain training in Spanish within U.S. graduate school mental health programs due to geographical and economic limitations (Delgado et al., 2020; Moreno et al., 2023). Indeed, most mental health providers rely on translators, interpreters, or other methods of

communication when working with Spanish-speaking individuals (Villalobos et al., 2016). Among bilingual mental health providers, Delgado and colleagues (2020) share that many of them fall within the category of language brokers (i.e., informal act of translation/interpretation), who are mental health providers not formally trained in being able to provide clinical services in Spanish and are solely supervised in English, yet offer services in Spanish. Although this criterion of mental health providers helps build a bridge between the Latino community and the field of mental health. These mental health providers serve as language brokers and face unique challenges in navigating the Latino culture and the predominantly White and monolingual field of mental health in which they work (Lo & Nguyen, 2018). Furthermore, mental health providers who serve as language brokers may also struggle with many aspects of the technical and theoretical language essential to conduct effective psychotherapy, diagnosis, and case conceptualization (Delgado et al., 2018).

Research on Latino clients in therapy has found that individuals who use a specific language at home (i.e., Spanish) are more likely to feel more comfortable discussing sensitive topics with their mental health provider (Collado et al., 2016). In contrast, individuals who attempt to use their secondary language (e.g., English) have a significantly higher chance of being disconnected from their provider, which can negatively affect the therapeutic process (Softas-Nall et al., 2015; Torres et al., 2016). Consequently, mental health providers working with Spanish-speaking individuals might interpret the language barrier as clients being detached within the therapy session (Torres et al., 2016). Among bilingual therapists, Spanish may be used as a method to create trust and further progress the therapeutic relationship (Torres et al., 2016), but quite often the focus of bilingual mental health providers is centered around using the correct terminology and pronunciations rather than the therapeutic process (Estrada, Brown, & Molloy,

2018), leading to negative consequences for Spanish-speaking Latinos (e.g., lack of understanding of their mental health illness and care; Torres et al., 2016).

Institutional and Provider Actions to Address Mental Health Disparities Among Latinos

Despite the gains made in the U.S. healthcare system to address mental health issues impacting the country's population, the Latino community continues to experience notable mental health disparities (Pineros-Leono et al., 2022). With a growing U.S. Latino population, mental health clinics and providers will, at some point, start to interact with Latinos seeking mental health services, who are likely born outside of the U.S. and have limited proficiency in English (Bridges & Dueweke, 2020). At the microcosm level, mental health clinics and providers are considering how to tailor overall treatment protocols when working with Latino individuals (Bridges & Dueweke, 2020). For instance, Bridges and Dueweke (2020) argue that self-awareness when working with Latino individuals begins at the start of intake, where both clinicians and clinics should appreciate and respect the multiple intersecting identities Latinos have and how they may manifest within therapy; which can include the importance of honoring cultural values, explore stressors that are unique to Latinos, and have awareness of the power differential between Latino clients and the providers they work with. Furthermore, the researchers argue that treatment should be tailored to the individual Latino client and oriented therapy to reduce stigma for the individual (Bridges & Dueweke, 2020).

An ongoing issue with addressing mental health disparities in the Latino community is related to being able to identify and offer the appropriate treatment to individuals (Herman et al., 2015). For many Latinos, the first line of treatment for trauma-related mental health issues begins within primary care settings (Kaltman et al., 2019). Scholars have explored various models for integrating mental health care into primary care settings (Watson et al., 2019; Cabassa

et al., 2015). One specific model that is noted within the literature is the collaborative care model, which is a systemic-level intervention to increase screening and accurate diagnosis and expand the use of evidence-based interventions (e.g., psychotherapy and/or medication) to address mental health disparities impacting the Latino community (Watson et al., 2019; Katon et al., 1995). The collaborative model emphasizes the importance of a patient-centered team that includes a care manager, a nurse, and/or a social worker, facilitating communication between the patient and their primary care provider, as well as a consulting psychiatrist (Watson et al., 2019). Overall, the collaborative model is efficacious in reducing mental health-related symptoms (e.g., depression and anxiety), increasing adherence to care, and improving patient satisfaction among Latino individuals (Hernandez et al., 2024; Jackson-Triche et al., 2020).

For Latinos experiencing severe mental health illnesses (SMIs), such as schizophrenia, the risk of developing and/or exacerbating physical illness (e.g., diabetes, weight gain, and cardiovascular disease) is greater due to the medication required to treat SMIs (Cabassa et al., 2014). The health needs of Latinos experiencing SMIs are often worsened due to fragmented care occurring within primary care settings, as well as additional barriers related to health care discrimination, language, and the negative sentiment towards Latino immigrants (Cabassa et al., 2018; Cabassa et al., 2014). To address this issue, Cabassa and colleagues (2018) examined a culturally adapted healthcare manager intervention, Bridges to Better Health and Wellness (B2BHW), which is an intervention based on the primary care referral and evaluation program aimed at improving health outcomes for individuals in primary care settings. The 12-month B2BHW program was shown to be effective in enhancing patient activation (e.g., self-management), self-efficacy, patient-rated quality of care, receipt of preventative care

services, and quality of life for Latinos experiencing SMIs and at risk for physical illnesses (Cabassa et al., 2018).

Community Health Workers (Promotores de Salud): History, Roles, and Credentialing

Promotores de salud is a commonly used Spanish term referring to community health workers (CHW), who have duties related to being an outreach worker, navigator, health advisor, and patient advocate (Ell et al., 2023). Notably, CHWs working within the Latino community are trained, culturally attuned healthcare workers who do not provide direct healthcare services; however, they offer culturally tailored education, guide individuals navigating barriers to accessing care, and aid in communication between the Latino community and healthcare professionals (Delgado, 2019). More importantly, due to CHWSs sharing cultural similarities with the communities they serve, they are trusted and respected leaders within the community, and have been implicated in positively contributing to health advocacy, as well as promoting behavioral change related to health outcomes in hard-to-reach, socially isolated, and/or marginalized communities (e.g., undocumented Latino immigrants; Garcia, Sprager, & Jimenez, 2022; Burkett et al., 2021; Gonzalez et al., 2021; Kim et al., 2016; Lechuga et al., 2015).

The effectiveness and credibility of CHWs are grounded in a long-standing history of community-based health advocacy (Rosenthal et al., 2010). Specifically, CHWs within the Latino community have historical grassroots origins in 1950s Latin America (Cheney et al., 2026; Balcazar et al., 2016), where peer education programs trained women (*promotoras de salud*) to address diverse health issues in rural Central American communities (Early, Burke-Winkelmann, & Joshi, 2016; Perez & Martinez, 2008). Within this context, CHWs throughout the region succeeded throughout the region by using their role to help mend the unequal distribution of health resources and address health inequities impacting the communities

they served (Delgado, 2019). Beginning in the 1960s, CHWs began to emerge in the U.S. as part of the Great Society domestic programs (Delgado, 2019; Knowles et al., 2023; Perez & Martinez, 2008). Through this initiative, the federal government created and promoted CHWs as entry positions for career development (Skinner & Wright, 2023). However, formal federal support for CHW programs was established with the implementation of the Federal Migrant Health Act of 1962 and the Economic Opportunity Act of 1964 (Rosenthal et al., 2010), where federal law mandated outreach efforts to low-income communities and migrant worker camps (Nemcek & Sabatier, 2003; Perez & Martinez, 2008). CHW programs saw a reduction in prominence during the 1970s and early 1980s, but experienced a resurgence in the late 1980s and early 1990s within the migrant and seasonal farmworking communities (Perry, Zulliger, & Rogers, 2014; Perez et al., 2008). Respectively, programs established during this period, such as *Nuestra Comunidad Sana* in Hood River, Oregon, played a central role in healthcare delivery systems (Kutcher et al., 2015). Throughout history, community health workers have emerged and reemerged in responses to health care crises, particularly during periods of social and political upheaval aimed at addressing social injustice and inequity (Bhutta et al., 2010; Ignoffo et al., 2024).

As health inequities persist and strain the U.S. health care system (Papanicolas et al., 2025; Jindal et al., 2023; Richwine, 2023), the historical role of CHWs has evolved into a position that delivers culturally tailored, evidence-based interventions within Latino communities (Gustafson et al., 2025). With the increasing demand and strain on healthcare professionals to provide evidence-based, culturally tailored interventions for Latinos, CHWs are being increasingly utilized to offer intervention programs within Latino communities (Garcia et al., 2021; Portillo et al., 2020; Brown et al., 2018). For instance, in Oregon, there has been

exploration with CHWs being able to provide culturally informed crisis interventions within Latino communities due to the state recognizing that there are not enough adequately trained mental health providers to serve Latinos (Garcia et al., 2021). Mental health providers within Oregon have also recommended a multi-pronged approach in addressing emotional crises occurring within Latino communities, where CHWs are addressing crises under the supervision of professionally trained behavioral health providers (Garcia et al., 2021). Furthermore, in El Paso, Texas, CHWs have also been used to address physical health disparities (e.g., cancer and cardiovascular disease) impacting the Latino community (Portillo et al., 2020). Healthy Fit (*En Forma Saludable*) is a health promotion program that incorporates CHWs trained in motivational interviewing, a person-centered interview intervention intended to bring behavioral change by increasing intrinsic motivation (Miller & Moyer, 2006; Jelsma et al., 2015), to encourage underserved Latinos living within El Paso to participate in cancer screenings and heart health-related activities. An evaluation conducted by Brown and colleagues (2018) of the Healthy Fit program found that it extended the public health department's infrastructure and provided vulnerable Latinos with referrals to preventive services by utilizing trained CHWs. Within this evaluation, the researchers also discovered that CHWs helped alleviate personal barriers, such as embarrassment and fear of cancer screenings, and provided culturally attuned solutions (e.g., asking family members for a ride) to ensure that Latino residents could successfully attend clinic appointments. Brown and colleagues (2018) also noted that a notable strength of CHWs was their ability to tailor their approach to information delivery and recognize the facial expressions of Latinos when communicating about the program.

In response to the expanding roles and responsibilities of CHWs, national efforts have emerged to establish standardized competencies and credentialing models that formally define

and support the roles of CHWs (National Association of Community Health Workers, 2016). Distinctly, CHW-related training has often varied in the scope of practice and has been limited to disease intervention, as well as specific populations (Sultan et al., 2025; Lee et al., 2021; Olaniran et al., 2017). Furthermore, critiques of standardizing CHW training, particularly through academic-based curriculum, have raised concerns about whether such approaches could compromise the community identity central to CHW practice, as well as the potential implications to the existing workforce (George et al., 2021; Czabanowska et al., 2024). In 2014, CHWs and stakeholders created the Community Health Worker Core Consensus (C3) Project as an avenue to build national consensus on the scope of practice (roles) and competencies among CHWs (Rosenthal et al., 2021). In a two-phase process, the overall intent of the C3 Project was to support action through empirical research and advance the CHW profession (O'Meara & Castro, 2019; Rosenthal et al., 2021). Each of the two phases consisted of various components, with Phase 1 including the analysis of CHW roles, skills, and consensus building. Following Phase 1, Phase 2 involved critically analyzing the influence of a CHW's work setting on roles and skills, as well as examining CHW assessment best practices (Rosenthal et al., 2021). It is important to note that the C3 Project, in and of itself, is not a credentialing or certification body (Jones et al., 2021). Rather, as noted above, the C3 Project is a consensus-based framework of roles and competencies for CHWs that can be used by state certification boards and training programs that are seeking credentialing criteria and academic curriculum (Rosenthal et al., 2010). Building upon the C3 Project, many state-level certification boards and training programs for CHWs have adopted competency-based certifications that reflect nationally endorsed roles and skills (Schleiff et al., 2021; Kissinger et al., 2022; Jones et al., 2021). Although certification requirements vary across states and training programs, such requirements delineate multiple

domains of practice, including advocacy, community-based education, and cultural mediation, with cultural humility and responsiveness embedded as core competencies (ASTHO, 2018). Indeed, credentialing bodies highlight that culturally responsive engagement is not an informal aspect of CHW practice, but rather a foundational component of the role (Cupertino et al., 2013; Texas Department of State Health Services (DSHS), 2024).

Chapter 5: Theoretical Framework & KAP Model

Health behavior theories emphasize that professional practices in mental health are shaped by cognitive, affective, and social practices, including knowledge, beliefs, values, and perceived control (Glanz et al., 2015). For instance, the Health Belief Model posits how individuals' understanding of health issues and beliefs about risk, benefits, and barriers influence behavior, highlighting the foundational role of knowledge and beliefs in decision-making (Carpenter, 2010; Rosenstock, 1974). This perspective is extended within the underpinnings of the Theory of Reasoned Action and the Theory of Planned Behavior, where both of these theoretical perspectives postulate how attitudes and social norms shape the intention and likelihood of action (Montano & Kasprzyk, 2015; Hagger & Hamilton, 2025), therefore reinforcing the importance of attitudes in bridging the gap between individuals' understanding and behavior (Glanz, Rimer, & Viswanath, 2015). Furthermore, Social Cognitive Theory emphasizes that behavior is socially and environmentally instilled through observational learning, self-efficacy, and interactions (Bandura, 2000), while the Transtheoretical Model is conceptualized as a dynamic process influenced by readiness, knowledge, and beliefs (Prochaska &Velicer, 1997).

Taken together, these theories share a common premise that health-related behaviors emerge from the interactions between knowledge and attitudes and their influence on action. The

theories stated above paved the way for the Knowledge, Attitudes, and Practices (KAP) Model (Glanz, Rimer, & Viswanath, 2015), which provides a practical framework that has utility in examining behaviors within health-based settings (Zarei et al., 2024). Generally used within quantitative studies, the KAP Model can be used to assess health-related beliefs and behaviors within specific contexts (e.g., Latino immigrant mental health; Andrade et al., 2020). According to scholars, the KAP Model is a practical framework used to investigate novel public health-related concerns (Sarria-Guzman et al., 2021) and can also be utilized within qualitative research (Andrade et al., 2020). Lumb and colleagues (2013) noted that the KAP Model can provide valuable information for resource allocation, as well as the implementation of public health-related programs. KAP-aligned studies provide vital input needed to design programs and can be used to assess the baseline level of awareness about mental health and mental health-seeking behaviors before the implementation of interventions/programs among a population of interest (Andrade et al., 2020). Importantly, KAP studies can be used to assess misconceptions, cultural influences, and other factors that can impede the utilization of mental health services within underserved populations (Andrade et al., 2020).

In the context of Latino immigrant mental health, the KAP Model provides a framework to investigate how healthcare providers and community health workers conceptualize and respond to the underutilization of mental health services within the Latino immigrant community. By examining healthcare providers' and community health workers' knowledge, the KAP Model allows for an investigation into factors (e.g., barriers to care) that shape the mental health needs of Latino immigrants. Indeed, differences in training (e.g., Western-aligned training programs vs. community-aligned knowledge) may result in distinct interpretations of the mental health needs impacting the Latino immigrant community. The model also allows for an analysis

of attitudes, which includes beliefs involving Latino immigrants' preparedness for engaging in services, cultural values, and efficacy of treatment. Healthcare providers may conceptualize underutilization of mental health services primarily through a systemic lens, whereas CHWs may interpret barriers through the realities that the Latino immigrant community faces and how relational dynamics influence underutilization. These attitudinal differences may influence how each group approaches engagement, outreach, and retention. In relation to practice, this component examines the strategies implemented to address disparities in utilization. For healthcare providers, this may include adapting evidence-based practices, integrating collaborative care models, and/or utilizing interpreters within treatment. For CHWs, practice may involve community outreach, informal psychoeducation, navigation support, and culturally grounded intervention within the community. By analyzing knowledge, attitudes, and practice across these roles, the KAP Model enables the identification of alignment, divergence, and potential gaps of service delivery that contribute to continued underutilization of mental health services among Latino immigrants. Collectively, applying the KAP Model within this study allows for a systemic exploration of how knowledge structures, cultural attitudes, and applied practices intersect to either mitigate or sustain mental health disparities among Latino immigrants. The KAP Model provides an empirical framework to inform interventions, interdisciplinary collaboration, and policy-level changes aimed at improving access and engagement in mental health services within the Latino immigrant community.

Chapter 6: Purpose of the Study

The overall goal of the present study focuses on investigating the knowledge, attitudes, and practices of healthcare providers and CHWs regarding the underutilization of mental health services among Latino immigrants. Grounded in the KAP Model, this study seeks to identify

how differing training backgrounds, roles, and community embeddedness shape how healthcare providers and CHWs conceptualize mental health disparities, engage Latino immigrant communities, and implement strategies to address barriers to care. Thus, the study aims to address the following questions:

1. What knowledge do CHWs and healthcare providers have regarding the underutilization of mental healthcare services among Latino immigrants?
2. What attitudes do CHWs and healthcare providers hold about Latino immigrants' engagement in mental healthcare services?
3. What practices do CHWs and healthcare providers implement to address underutilization?

Chapter 7: Method

Procedures

The present study is a part of a larger, mixed-methods project (Moreno & Barbosa, 2025) that aims to understand the mental health needs of Spanish-speaking Latino immigrants within a mid-Atlantic city. The broader project was designed using a community-based participatory research (CBPR) approach, as this method emphasizes addressing persistent healthcare disparities that impact populations, including socioeconomic status, lack of health insurance, and membership in racial and ethnic communities (Viswanathan et al., 2004). Additionally, CBPR bridges the gap between researchers and community members by relaying key pieces of information and knowledge relevant to the community of focus (Viswanathan et al., 2004). Thus, aligning with CBPR principles, the research team utilized a community advisory board that included six individuals (CAB; Newman et al., 2011) and a steering committee consisting of 33 individuals (SC; Israel et al., 2005) to gain input on significant issues impacting the mental

health of immigrant Latinos. Furthermore, members of the CAB and SC provided the research team with valuable information related to potential barriers (i.e., the length of interviews), recruiting participants (community health workers and healthcare providers), and methods to address any obstacles that arose. Members of the CAB and SC included participants from: local health districts, state/regional organizations, community-based mental health clinics, health systems, state/local government institutions, foundations, and faculty from state universities. Lastly, findings from the present study were disseminated to members of the CAB to ensure transparency, solicit feedback, and support ongoing community-informed interpretation of the results.

To address our research questions, the study centered on gathering qualitative data derived from focus groups with community health workers and healthcare providers working with the Spanish-speaking Latino immigrant community. The goal of these focus group interviews was to gain insight into challenges experienced by immigrant Latinos, personal experiences working with this community, barriers to accessing mental health services, available resources for this population, and suggestions for improving mental healthcare services and related policies. Participants in these focus groups were then asked to participate in an hour-long interview, conducted either in person or via Zoom. Participants were then asked if they preferred the interview be conducted in either Spanish or English to ensure they were comfortable answering questions throughout the interview. The focus group interviews were audio-recorded with the participants' consent to ensure that the discussions were accurately captured. Furthermore, the group facilitator also noted key points from the interviews to focus on during the transcription and analysis process later. The participants were monetarily compensated $100

for their time after completing the focus group. Respectively, the Institutional Review Board (IRB: HM20028497) approved this study, ensuring ethical principles were met.

Participants

Eligible participants for this study included healthcare providers and community health workers (CHWs) working with the Latino immigrant community. In total, 22 healthcare healthcare providers participated in the focus group interviews, which included physicians (e.g., adolescent psychiatrists, pediatricians, primary care physicians), licensed clinical social workers, psychologists, clinical case managers, victim advocates, and counselors. Thirty-nine CHWs participated in this study and were recruited from local organizations focused on working with the local Latino immigrant community. The CHWs in our group predominantly consisted of individuals who identified as women, ranging in age from 30 to 60 years old, and men ranging in age from 30 to 65 years old. About half of the CHWs shared that they were bilingual and were current university students. Notably, the CHWs, who consisted of individuals from various Latin American countries, were able to effectively engage the Latino community due to their strong knowledge of Latino culture, traditions, beliefs, and values. Furthermore, some of the CHWs shared that their success in engaging with the Latino community was also related to speaking indigenous languages, in addition to Spanish. Through discussion, the CHWs in our group noted that they were trained on how to successfully provide services to the local Latino community, which included giving psychoeducation on mental health illnesses (e.g., depression & anxiety), referrals for preventative care services (e.g., mammograms), vaccination advocacy, and engaging in community outreach programs to disseminate resources.

Regarding the healthcare providers in our study, many worked in clinical settings that offered both behavioral and physical health services to immigrant Latinos. To illustrate, one of

the clinical sites offers primary and dental care services, as well as behavioral health services, to immigrant Latinos. Some of these healthcare providers noted that they were trained in providing services in Spanish and shared that they were themselves part of the Latino community. For example, a psychiatrist within a focus group reported that she was Latina and provided bilingual services to immigrant Latinos in the area, while one mental health clinician identified as White and reported being proficient in being able to offer services in Spanish. For both the provider and CHW focus groups, pseudonyms were assigned to protect confidentiality.

Materials

The focus groups consisted of semi-structured interviews guided by open-ended questions created in consultation with the SC and CAB (Appendix A: Community Health Workers; Appendix B: Healthcare Providers). As noted, the research developed two interview questions, one in Spanish and one in English. For each category of focus groups (community health workers and healthcare providers), the research team conducted four focus groups, each with 5-10 individuals. For interviews held via Zoom, the interviewer recorded and stored interviews in a secure data file, with related notes for each interview stored within a secure file locker. For in-person interviews, the research team utilized tape recorders, which were then uploaded to a secure data file, and any notes were filed in a secure file locker.

Data Analytics Plan

The research team conducted a thematic analysis to analyze the qualitative data (Braun & Clark, 2006). Following Braun and Clarke (2006), thematic analysis was composed of six steps: (1) data familiarization, (2) generation of initial codes, (3) searching for initial themes, (4) reviewing themes, (5) defining and naming themes, and (6) producing the final report. The process of data familiarization involved the research team transcribing the qualitative data,

including translating Spanish transcripts into English, reviewing the transcripts, and noting down any initial ideas that may be relevant to generating codes. This initial step was followed by the research team generating any initial codes, which involved reviewing the data, identifying significant sections within it, and labeling these sections for the next step in the analysis process. Once this was conducted, the research team reviewed and categorized the initial codes to identify any potential overarching themes related to the identified codes. Following this step, any identified themes were named, defined, and paired with pertinent segments of the data through collaborative processes among the research team. Following this step, the finalized themes were written up to produce a final report. Scholars have found thematic analysis to be a suitable approach in conducting qualitative research, due to its rigorous nature in identifying and interpreting patterns within qualitative data (Braun & Clarke, 2012; Clarke & Braun, 2017; Braun & Clarke, 2006). Thus, thematic analysis is deemed a suitable analytical approach to address the research questions of the present study.

The research team consisted of one principal investigator (a doctoral candidate) and two undergraduate research assistants (URAs). Before conducting the data analysis, the research team met and reflected on positionalities (i.e., identities, personal biases, and worldviews) that can impact their interpretation of the data. Furthermore, the principal investigator involved both URAs throughout the thematic analysis process to ensure that each member of the research team provides their insights and assists one another in generating codes/themes through a consensual process. Using thematic analysis (Clarke & Braun, 2017), the research team applied an inductive and deductive approach in which themes were derived both from patterns emerging directly from participants' responses and from theoretical frameworks (e.g., KAP Model).

To enhance the trustworthiness and reliability of the present study, the research team utilized triangulation (Donkoh & Mensah, 2023) and maintained an audit trail (Carcary, 2020). Concerning triangulation, the researchers employed *investigator triangulation,* a method used when multiple researchers are involved in a qualitative study (Thurmond, 2001). Investigator triangulation involves individual members of the research team analyzing the qualitative data independently (e.g., creating codes/themes) and comparing findings through discussion. Furthermore, investigator triangulation provided an opportunity for research team members to explore discrepancies in the findings and refine key themes, thereby reducing the potential for bias in the results. By maintaining an audit trail, the principal investigator provided transparency by maintaining a detailed record journal that included: (a) how the research team made decisions on how the data was coded and finalized, (b) how discrepancies with data analysis between the researchers were managed, and (c) how the process of generating the themes was conducted. Additionally, the journal included information on any changes made to analytic processes and any relevant details regarding data cleaning.

Researchers' Positionality

The principal investigator of this study identifies as a cisgender, heterosexual, Latino man in his early 30s. His interest in this study has developed through life experiences, including: (a) being a son of Latino immigrants, (b) working and growing up in a primarily Latino community that faces various mental health inequities, and (c) being a mental health clinician working with Spanish-speaking Latino immigrants. Furthermore, the principal investigator has been researching health disparities affecting racial and ethnic marginalized communities since the start of their graduate studies in Fall 2021. Notably, due to the principal investigator's training in providing multicultural psychotherapy, he recognizes that his experiences, worldviews, and

personal biases may influence his interpretation of the study's findings. Two undergraduate research assistants were included in analyzing the qualitative data of this study. Through a process of group discussions and consensus building, the research assistants assisted with interpreting the findings and ensured the role of research subjectivity. One of the research assistants identified as a Hispanic, cisgender, bisexual man in his early 20s, while the other member of the team identified as a Latina, cisgender, heterosexual woman in her early 20s, as well.

Results

Community health workers and healthcare providers described their knowledge, attitudes, and practices regarding mental healthcare among Spanish-speaking immigrants, including their knowledge of both youth and adults within the community. The healthcare provider focus groups were conducted in English, while the CHW focus groups were primarily conducted in Spanish. Therefore, the CHW focus groups conducted in Spanish required quotations to be translated into English to ensure the results of the study reached a broader audience. Emergent themes from the analysis were categorized using the KAP framework within the knowledge, attitudes, and practice domains and described across the respective participant groups (i.e., healthcare providers and CHWs).

CHWs and Healthcare Providers Knowledge

Within the KAP Model, knowledge encompasses the information and understanding that both healthcare providers and CHWs possess regarding the specific mental health needs of Latino immigrants (Kang & Bagoaisan, 2024; Andrade et al., 2020). This may include an awareness of trauma-related concerns, adverse mental health symptomatology, and barriers to mental healthcare. The following results first examined the knowledge shared by CHWs, which

includes the following two themes: (1) CHWs Knowledge on Non-clinical pathways to mental health recognition, and (2) CHWs Knowledge on incompatibility between mental health infrastructure and community contexts. This is followed by the knowledge held by healthcare providers, which is categorized into three themes: (1) Healthcare providers knowledge on trauma and contextual mental health needs, (2) Healthcare providers knowledge on the influence of multilevel barriers on mental healthcare access, and (3) Healthcare providers knowledge on the institutional incongruence and community mental health literacy.

CHWs Knowledge on Non-Clinical Pathways to Mental Health Recognition. Within the focus groups, a majority of CHWs described how mental health-related issues are significantly misunderstood and rarely recognized through formal clinical pathways within Latino immigrant communities. Notably, CHWs described how psychological distress is often identified through indirect indicators, such as somatic symptoms (e.g., stomach issues), behavioral changes, or involvement from external institutions (e.g., school systems). CHWs share that many Latino immigrants and families are unaware that the issues they are experiencing are a result of mental health issues; instead, they relate their issues to physical ailments or situational-related stressors (e.g., work demands). Furthermore, as a result of limited mental health literacy within the community, the recognition of mental health needs by Latino immigrants becomes a gradual process as the impact of mental health issues starts to influence different contexts over time. To illustrate, Rene, a CHW who has been working with the Latino immigrant community for eight years, stated the following:

> *"Many [Latino immigrant] patients visited doctors complaining of physical ailments, unaware that these symptoms were actually the result of underlying mental health issues. For instance, a [Latino immigrant] patient might present*

> *with headaches and stomachaches, reporting, "Today I felt dizzy," or "Today I can't keep anything down," or "Today my legs are trembling," or "Today my hands are sweating."*

Like Rene, many CHWs noted how the confusion and frustration experienced by Latino immigrants regarding the absence of clear medical diagnoses often leads both healthcare providers and patients to explore other possibilities to explain the symptoms patients are experiencing. Furthermore, CHWs described their experiences on how the mental health needs of Latino immigrant youth commonly go unrecognized until school systems intervene. Indeed, in many cases, Latino immigrant parents are unaware of their child's mental health issues that contribute to behavioral and emotional changes. Justine, a CHW who has been working with the Latino community for two years, shared the following:

> *"For example, there's a lot of talk about schools; perhaps the mothers or fathers aren't educated and don't see the changes in their children, they don't know if they're using substances, so they only seek help when the school calls them in and when a social worker is already involved."*

Similar to the narratives provided by Rene and Justine, other CHWs highlighted that the recognition of mental health issues within the Latino immigrant community is not an immediate process; however, it involves an indirect, multi-system pathway that provides external validation to their experience. Moreover, the results also provide evidence that institutional involvement is critical in identifying mental health-related concerns when both individual- and family-level recognition is limited. This notable pattern identifies a disconnect between how the Latino immigrant population experiences psychological distress and is understood, as well as how it is

formally identified within mental healthcare-related systems. Mental health needs, therefore, often go unrecognized until significant escalations occur and external interventions take place.

CHWs' Knowledge on the Incompatibility Between Mental Health Infrastructure and Community Contexts. Several CHWs shared their narratives on how mental healthcare systems and the Latino immigrant community have a fundamental misalignment. Specifically, CHWs described how the rigid structure of mental healthcare systems is incompatible with serving the needs of the community, not only due to limited resources, but also due to institutional operating norms (e.g., intake process). Consequently, CHWs share how this causes a clash between the Latino immigrant communities' lived experiences and help-seeking behaviors. The misalignment between the community and mental healthcare systems is often seen as underutilization of services; however, in reality, the issue is the influence of institutional inflexibility to properly engage members of the community with the system. Rachel, a CHW with five years of experience working with Latino immigrants, stated the following:

> *"I have realized that within the Latino community, much like the systems themselves, the people are vastly different from those in our home countries. Individuals typically require extensive follow-up or numerous phone calls. Whether to confirm appointments or to have the process explained in greater detail. Unlike, for instance, someone raised here…"*

Furthermore, CHWs further described how misalignment challenges seen between mental healthcare systems and the Latino immigrant community are further exacerbated by structural and procedural expectations embedded within these institutions. For instance, CHWs share how clinic appointment schedules and the complex documentation process required present significant challenges to Latino immigrants, therefore, reducing their engagement with mental

health services. The narrative provided by CHWs presents an illustration of the assumption by mental healthcare systems that Latino immigrants have familiarity with navigating the healthcare system and have the ability to navigate barriers (e.g., stable work schedules and transportation) that might impede care. To exemplify, Eva, a CHW with two years of experience working with the Latino immigrant community, stated the following:

> *"I have seen elsewhere that, to fill out all these forms. They [Latino immigrants] are required to submit all this information online. Not everyone has access to the internet, nor do they possess the necessary education to complete all those forms online."*

Like Rachel and Eva, the accounts of CHWs within the focus groups provide a narrative that shifts the individual burden of Latino immigrant mental health underutilization to a broader systemic incompatibility to serve the needs of the community. Thus, this suggests that addressing the incompatibility seen between the Latino immigrant community and mental healthcare systems involves a process of shifting away from traditional administrative norms to a model that aligns with the context of the community.

Healthcare Providers' Knowledge of Trauma and Contextual Mental Health Needs. Healthcare providers described that mental health concerns within Latino immigrant communities are embedded in trauma and contextual factors. For instance, narratives highlighted the impact of migration-related disruptions (e.g., family separation), acculturation-related strain, and exposure to domestic violence, all of which contribute to persistent and, at times, intergenerational trauma. Healthcare providers noted that distress experienced by Latino immigrants was not always articulated in psychological terms; instead, they manifested as somatic symptoms, such as headaches and stomach-related issues. Furthermore, substance use

emerged as both a coping mechanism and a co-occurring concern within the broader context of chronic stress faced by Latino immigrants. To emphasize the complexities of Latino immigrant life experiences, Martha, a licensed clinical social worker who serves as a senior clinician within an outpatient clinic that serves Latino immigrant clients, stated the following:

> *"What I see as well is the need to address trauma issues related to, you know, trauma, childhood trauma, and trauma in their country of origin, but also related to migration and acculturation issues. Domestic violence is also another prevalent trauma-related issue, but it's very prevalent in the clients that we serve."*

Similar to Martha, other healthcare providers described how the migration process and acclimation to a new culture are significant stressors that drive Latino immigrants to experience mental health-related issues. Specifically, one provider shared that certain life experiences (e.g., stressors) are risk factors that supersede biological disposition to mental health issues, when compared to other populations.

Moreover, healthcare providers noted that these stressors are more pronounced among Latina mothers, who frequently present with elevated stress, anxiety, and depressive symptoms. They described how these parents are not only navigating their own adjustment challenges, but are also managing their children's behavioral concerns and adjustment difficulties within a new cultural context. This dual burden of caregiving and adaptation to a new environment was further compounded by transnational family stressors, such as illness or death of loved ones in their country of origin. Lara, a nurse practitioner working within a community-based clinic that provides physical and mental health services for the Latino immigrant community, states the following:

> "Most that I see are the mothers. So there they [Latina mothers] have anxiety, depression, a lot of stress with their children going through adjustment reactions and behavior problems, and then also experiencing death or sickness of loved ones in other countries, that they are upset that they cannot be with their family members during that time."

Alongside Lara, other healthcare providers illustrate the complex and multilayered nature of psychological distress experienced by the Latino immigration population, which is shaped by caregiving responsibilities, migration-related separation, and ongoing contextual stressors. Taken together, these findings illustrate that mental health concerns among Latino immigrants are shaped by intersecting stressors that result in complex patterns of distress that reflect both individual experiences and broader social and environmental factors.

Healthcare Providers' Knowledge on the Influence of Multilevel Barriers on Mental Health Care Access. Numerous healthcare providers described limitations to mental health care access and engagement due to a myriad of multilevel barriers that intersect between systemic and individual factors. For example, healthcare providers noted various, persistent systemic-level barriers that impede access and engagement for the Latino immigrant community, including a shortage of available mental health services (e.g., limited appointments), limited availability and/or shortage of bicultural and bilingual healthcare providers, and financial/insurance-related constraints that restrict access to care. To highlight the noted barriers stated above, Alejandro, a licensed clinical psychologist and assistant professor of psychology with extensive experience working with Latino immigrants, stated the following:

> *"....I think the lack of financial ability to afford, you know, especially*
>
> *Non-insurance based care insurance provides access in some ways to certain*

> *services, but more and more mental health services are provided out of network. They're provided, you know, on a sliding scale, so insurance doesn't apply. And so Latinos often don't have the financial resources to be able to afford, especially the gold standard care. There's something of a stratification according to ability to pay, like the best healthcare providers are just not going to accept insurance in this market."*

Like Alejandro, other healthcare providers shared their experience with individual-level barriers that restrict the ability of Latino immigrants to seek mental health services. To exemplify these barriers, healthcare providers reported several obstacles that include work-related demands (e.g., inability to take time off), transportation limitations, and time constraints (e.g., incongruent personal availability and clinic operating hours). Joana, a case manager working within a community clinic that provides services for the Latino immigrant community, states the following:

> *"...transportation may be a big thing. And also as she said, the fact of these patients having to miss work to come to mental health services is a big deal."*

Alongside Joana's experiences regarding the Latino immigrant community limitations with transportation and work-related demands. Diana, a chief executive officer for a free-of-charge clinic that provides mental and physical health services for Latino immigrants, further emphasized the complexity of individual barriers faced by the community by stating the following:

> *"…we might want frequent visits, and it's really hard logistically for patients with transportation barriers and childcare barriers, and they just face so many barriers like getting into a healthcare provider's office…"*

Other healthcare providers described systemic-level obstacles that influence underutilization, which include documentation- and insurance-related concerns and age-based disparities in accessing care, specifically noting challenges with Latino immigrant children and adolescents not being able to receive mental health services. Jose, another case manager working within a safety-net community clinic, stated the following:

> *"...something that could help at least children, like make 'em eligible for Medicaid, for mental health services. I don't know, something like that, because definitely, somehow, we can deal with adults. I mean, there are some little services out there, but for children it's really a desperate situation."*

Overall, these findings underscore how mental health care access and engagement among Latino immigrants are constrained by interacting factors at a systemic and individual level, which make available mental health services challenging to access and sustain. These multilevel barriers create significant obstacles to the Latino immigrant community and ultimately contribute to persistent disparities in service utilization within the population.

Healthcare Providers' Knowledge on Institutional Incongruence and Community Mental Health Literacy. Healthcare providers described the disconnect between mental health systems and the Latino immigrant communities they serve. For instance, they shared their experience in recognizing structural limitations, such as the community's limited understanding of mental health and the therapeutic process. Furthermore, healthcare providers noted that Latino immigrants had a limited understanding of how mental health services operated, including expectations for treatment. Nadia, a physician assistant working in a safety-net clinic, stated the following:

> *"They [Latino immigrant patients] don't understand how mental health can impact that and how it can affect your body. So I think that the lack of education about mental health, how it can affect, how it can be treated, and how therapy can be helpful."*

Beyond a limited understanding of the therapeutic process, healthcare providers identified a significant shortage of bilingual/bicultural healthcare providers, as well as culturally-relevant information within their institutions. This systemic limitation, coupled with prevalent mental health stigma within the Latino immigrant community, often influences a pattern of delayed help-seeking. Healthcare providers described how culturally incongruent care leads to less utilization of preventative services; consequently, deferring treatment until a psychological crisis occurs. This institutional gap is evident when healthcare providers describe how this impacts parents seeking mental health services for their children. Jamil, a case manager at a community-based clinic, stated the following:

> *"...let's say for [Latino immigrant] children, and there's no one helping [Latino immigrant] parents with the language, they just can't go too far with that. I mean, the parents need to be involved, the parents need to understand what's going on. The parents need to communicate with those healthcare providers. And if they are not bilingual or they don't have assistance like someone else and an interpreter, or language line."*

Narratives shared by healthcare providers bring to attention a significant misalignment between how mental health systems operate and the cultural context (e.g., cultural values and Spanish-speaking) of the Latino immigrant community. Hence, healthcare providers describe how the absence of bilingual/bicultural staff and culturally-relevant information leads to further

avoidance of mental health service utilization by the community. Ultimately, institutional-level disconnect with the Latino immigrant community it serves can reinforce the patterns seen with the community not seeking help when mental health issues arise.

CHWs and Healthcare Providers Attitudes

The KAP model refers to attitudes as the underlying beliefs, perceptions, and values healthcare providers and CHWs have regarding the mental health service utilization among the Latino immigrants (Kang & Bagoaisan, 2024; Andrade et al., 2020). Furthermore, it also explores what healthcare providers and CHWs believe drives confidence and motivation to seek services with Latino immigrants (Mojtabai et al., 2016; Kang & Bagoaisan, 2024; Andrade et al., 2020). The following results first examined the attitudes held by CHWs, which includes the following three themes: (1) CHWs' attitudes on crisis-dependent entry into mental healthcare utilization, (2) CHWs' attitudes on cultural and relationally related factors impacting utilization, and (3) CHWs' attitudes on the need for prolonged support in maintaining mental health utilization. This is followed by the attitudes shared by healthcare providers, which includes the following three themes: (1) Healthcare providers' attitudes on cultural influences on the provider-patient dynamic, (2) Healthcare providers' attitude on engagement as a rational and prioritized decision, and (3) Healthcare providers' attitudes on perceptions of vulnerability and sociopolitical risk.

CHWs' Attitudes on Crisis-Dependent Entry Into Mental Healthcare Utilization.

Among all CHW focus groups, the narrative of Latino immigrant mental healthcare utilization being described as "crisis-driven" was a common sentiment noted by the participants. Notably, CHWs shared their perceptions that mental health help-seeking behaviors are uncommon behaviors initiated at the onset of psychological distress. Conversely, CHWs share their beliefs

that mental health service utilization involves a process of deferring mental health-related symptoms until they reach a critical threshold that impairs daily functioning and/or destabilizes interpersonal relationships. CHWs characterized the engagement between the Latino immigrant community and mental healthcare systems as "reactive", rather than mental healthcare services being a preventive measure. To illustrate, Irma, a CHW with over a decade of experience working with the Latino immigrant community, stated the following:

> *"I believe people [Latino immigrants] typically seek help only when the crisis has become too external. When others can already see it. Perhaps it affects their performance at work or within the family, or their eating habits. At that point, it becomes very evident."*

Like Irma, the sentiment of mental healthcare utilization being a reactive action that occurs post-crisis was emphasized by many CHWs. Indeed, they shared their beliefs that when psychological distress escalates beyond the privacy of their homes, it triggers the awareness of external systems, such as schools, courts, and primary care providers, to become the catalyst for mental healthcare utilization. CHWs suggested that the value of mental health treatment only becomes a necessity when authoritative-like figures observe the impairment brought on by mental health issues, whereas the individual's decision to seek care is often dismissed. For instance, Aurora, a CHW working within various organizations that assists the Latino immigrant community, shares her perception on how Latino immigrant parents conclude that their children need mental health services. She stated the following:

> *"They [Latino immigrants] seek attention, specifically mental health care, during times of crisis, as well as for children and adolescents when*

> *schools request it, informing parents that the children require that type of assistance."*

Ultimately, the perceptions provided by Irma and Aurora and those shared by other CHWs in the focus groups bring forth the idea that mental health issues are often deprioritized until it manifests into an externalized disruptive factor. While many U.S.-based mental health services operate from a preventative care model, the Latino immigrant community seeks the assistance of these services when functional impairment becomes an unavoidable influence on other aspects of their life.

CHWs' Attitudes on Cultural- and Relational-Related Factors Impacting Utilization. CHWs described their beliefs on how the interpersonal and culturally related factors are significant drivers that propel motivation for Latino immigrants to utilize mental health services. A notable pattern seen among CHWs' responses within the focus groups relates to their perception that the decision-making process for the Latino immigrant community to seek services and maintain treatment has to involve a process of cultural reciprocity by healthcare providers, where healthcare providers actively listen and acknowledge salient cultural factors. By doing so, CHWs believe that this brings a sense of safety for Latino immigrants by inducing feelings related to emotional security, as well as having their cultural values respected within treatment. CHWs, therefore, think that this sense of safety brought into treatment by healthcare providers creates an openness for the community to utilize and sustain treatment. Mario, a CHW who has been working with the Latino immigrant community for two years, states the following:

> *"I think that the manner in which the subject is initially approached. Specifically, how a [Latino immigrant] patient is informed that they have a mental health issue matters significantly. It has a direct impact on how they receive that news. If it is*

> *conveyed in the best possible way, there is, so to speak, no mental block preventing the individual from believing they can overcome the condition they are facing."*

Building on the notion of cultural reciprocity, other CHWs believe that culturally-based gender norms and stigma create significant challenges for Latino immigrants to seek mental health services. For instance, CHWs shared their perceptions that seeking mental health services for Latina immigrant women is more culturally acceptable, as opposed to men, who often delay treatment. To illustrate, Marisol, a CHW with eight years working of experience working with survivors of domestic and sexual violence within the Latino community, describes the "negotiating process" involved to have Latino immigrant men seek treatment. She stated the following:

> *"There is still a certain stigma surrounding mental health professionals. In my opinion, this is particularly true among [Latino immigrant] men. Typically, it is Latina immigrant women who are more open to seeking help from mental health professionals. However, when a [Latino immigrant] man is the one in need of these services, there is often a great deal of denial on his part. When they [Latino immigrant men] do finally go, it is usually because their female partner has issued an ultimatum, practically forced them to go, or insisted so heavily that they finally conceded that they needed that type of treatment."*

Like Mario and Marisol, other CHWs believe that mental health utilization is often influenced by sociocultural factors. Although mental health systems and healthcare providers who practice cultural reciprocity may assist in facilitating and sustaining the utilization of mental health services, the narratives provided by CHWs suggest that mental health systems and

healthcare providers must also contend with sociocultural factors (e.g., stigma and gender-based roles) that can limit the willingness of the Latino immigrant community to engage in treatment.

CHWs' Attitudes on the Need For Prolonged Support in Maintaining Mental Health Utilization. Within the focus groups, many CHWs characterized the utilization of mental healthcare among Latino immigrants as a precarious process, one that requires a substantial effort to maintain. Although CHWs described some of their success stories with assisting the community in initiating services, they believe that this is insufficient to guarantee long-term service utilization. CHWs' narratives commonly describe how competing life demands experienced by Latino immigrants, such as maintaining economic stability and/or childcare-related priorities, supersede their willingness to engage in and sustain mental health treatment. Chelsea, a Latina immigrant CHW with two years of experience working with the Latino immigrant community, shared a narrative describing the lack of follow-up treatment procedures. She stated the following:

> *"That's not true. I've lived through it. I've seen it. There are no doctors. They just talk to you. They hand you the prescription and let you leave the hospital without even explaining the process. Whether there will be any follow-up, any return visit, any monitoring."*

Although Chelsea describes a personal experience regarding her navigating the healthcare system, her sentiment is shared by many CHWs regarding the utility of providing long-term support for Latino immigrants. Especially if maintaining long-term utilization of services is a priority for healthcare providers. Furthermore, to reduce the systemic weight of the mental healthcare system on the Latino immigrant community, various CHWs believe that persistent motivation and guidance are needed for the community to adhere to treatment. For instance,

Amy, a CHW with four years of experience working with Latino immigrants, describes her experience with CHWs' workloads impacting prolonged support. She stated the following:

> *"We've discussed this previously, the act of practically holding the [Latino immigrant] client's hand to guide them through the process. Realistically speaking, how many [community] health workers are actually available to assist and serve as advocates for these [Latino immigrant] clients? Tell me, when and how are we going to be provided with the resources to truly advocate for our [Latino immigrant] clients and help them navigate this process? We would love to have countless hands available to help guide [Latino immigrant] clients. For those who [Latino immigrants] are actively seeking this resource and taking them through the necessary steps. But the reality is that, all too often, we simply cannot. Our current workload does not allow for it. Consequently, rather than empowering these [Latino immigrant] individuals, we face the unfortunate reality where they arrive at the clinic only to find themselves [Latino immigrants] unable to proceed."*

The narratives provided by Chelsea and Amy, in addition to the beliefs described by other CHWs, highlight the importance of Latino immigrants receiving prolonged support to maintain mental health service utilization. Furthermore, the beliefs shared by CHWs also provide vital insight into how the under-resourced community-health-worker field can impact their perception of being able to provide long-term guidance for Latino immigrants as they navigate the mental healthcare system.

Healthcare Providers' Attitudes on Cultural Influences on the Provider–Patient Dynamic. Central to what influences the mental health help-seeking process among Latino

immigrants is the interpersonal dynamic between the provider and the Latino community, which is often shaped by the patient's cultural expectations. For example, healthcare providers described how a perceived lack of cultural understanding by Latino immigrants can become a significant deterrent in seeking mental health services. Furthermore, healthcare providers reported that central to the provider-patient relationship is ensuring that rapport is built to assist with the trust-building process. Healthcare providers shared that the rapport-building involves viewing Latino immigrants through a non-pathologizing lens, which encourages deeper engagement within treatment. Thania, a Latina child psychiatrist working within a county clinic, stated the following:

> *"I would add that even cultural things like emotional expression can be pathologized into a cluster B trait. And so you spend not only a lot of time educating your families, but you also spend a lot of time educating the people around you because you're like, no, that's our culture. We're expressive. I'm not going to pathologize that, and I'm going to stop you right there from naming that, that, because that's not what it is."*

Although the provider-patient relationship was described as central to treatment engagement, healthcare providers also described how cultural values and stigma can shape help-seeking behaviors within the Latino immigrant community. For instance, cultural beliefs about mental health can often influence how symptoms are personally interpreted and whether seeking professional care is an appropriate step to address their concerns. Stigma, which can include a sense of shame and/or judgment, was described by various healthcare providers as creating an internalized effect among Latino immigrants that contributes to delayed treatment. Therefore, leading to Latino immigrants experiencing a significant increase in the severity of

their symptoms. Maria, a doctoral psychology trainee working in various community-based primary care clinics that primarily serve Latino immigrants, stated the following:

> *"And so we often see people when they're at a breaking point. And so I think that's the risk of people having that social messaging and cultural values, but also those barriers that are at a really high risk of other comorbid concerns, or they've been trying to cope and manage the best way they know, which aren't always adaptive. And so just knowing that all the things that were talked about really are further amplified by cultural values in terms of stigma around mental health and seeking mental health care."*

Like Thania and Maria, healthcare providers working with the Latino immigrant community identify the importance of how the interaction between interpersonal and cultural factors influences the community's engagement in mental health services. Notably, healthcare providers accentuate that the trust and rapport between the provider and patient is not a circumstance that occurs solely at the individual level, rather it is influenced by the intersection of cultural beliefs, stigma, and prior experience of misunderstanding and/or marginalization. It is important to note that providing culturally responsive care and not pathologizing culturally relevant emotional expression becomes a critical component for fostering trust, as well as reducing internalized stigma and facilitating earlier engagement in mental health services.

Healthcare Providers' Attitudes on Engagement as a Rational and Prioritized Decision. Beyond the cultural and interpersonal dynamics experienced between healthcare providers and Latino immigrants, healthcare providers describe their patients making calculated choices and experiencing competing life demands. Indeed, healthcare providers shared their perception that mental health is often seen as a secondary concern relative to the immediate

needs necessary for living among the Latino immigrant population. A notable pattern in provider responses is that the decision to defer care among Latino immigrants is not due to patients being "unmotivated" or "non-compliant"; instead, healthcare providers demonstrated an attitude that views treatment avoidance as a rational response to scarcity. Nancy, a Latina pediatrician, stated the following:

> *"I think that's one of my biggest challenges. How do I take care of their mental health when they cannot even have access to their basic needs? And that makes it really challenging sometimes."*

Similar to Nancy, other healthcare providers shared distinct patterns within their narratives that described their beliefs on how Latino immigrant parents often adopt a "self-sacrificing" attitude, where parents place their children's mental health needs above their own. Notably, healthcare providers perceived that Latino immigrant parents seek mental health support for their children as a priority, whereas the parents' own psychological distress is treated as a secondary concern that can be deferred. Jose, a licensed clinical social worker working within a county health clinic, stated the following:

> *"It is for the clients in the Latino population to request services for their children because sometimes it's a request from the school right then. Even though parents also need the services desperately. So I believe they prioritize, you know, getting services for their children."*

These provider perspectives suggest that underutilization of adult mental health services is not related to the indifference Latino immigrant adults feel about mental health. On the contrary, it is a strategic allocation of the limited family resources experienced by the Latino immigrant community. This perspective provides a reframing for the underutilization of mental

health services among Latino immigrant adults by acknowledging the deliberate, protective choice in seeking services for their children and maintaining the economic stability of their family.

Healthcare Providers' Attitudes with Perceptions of Vulnerability and Sociopolitical Risk. Within the focus groups, healthcare providers described their beliefs surrounding the consequences of the sociopolitical climate and vulnerability salient to the Latino immigrant experience. In their responses, healthcare providers shared how Latino immigrant patients may see the healthcare system as not being a site for healing, but rather as a potential point of surveillance and legal risk. Thomas, a physician working within a community-based clinic, stated the following:

> *"I think a lot of times our patients are fearful of asking too many questions because they don't want to raise, put themselves in a position where they're kind of raising scrutiny about themselves, especially if they're undocumented."*

Like Thomas, healthcare providers shared their perception that Latino immigrants, especially those with precarious documentation status, tend to minimize interacting with the healthcare system as a self-protective factor with the intention of being a strategic form of caution. Notably, healthcare providers shared how the realistic fear of interaction is rooted in the possibility of family separation or deportation. Gomana, a community health program manager with three years of experience working with Latino immigrants, stated the following:

> *"I believe we face a lot of our patients who tell us that they don't want to be asked for any type of assistance as they are filing for citizenship or any type of immigration documents. But we do let 'em know that it's fine. They can ask for any type of assistance, and that wouldn't affect their process for documentation."*

The narrative shared by healthcare providers illustrates their perception that institutional mistrust is a dynamic and protective response to the Latino immigrant community's beliefs surrounding the danger of becoming visible within the system. Healthcare providers believe that not until the fear of legal repercussions is reduced will the healthcare system continue to be viewed as a source of risk rather than a resource for healing.

CHWs and Healthcare Providers Practices

In the KAP Model, practice represents the application of clinical and community interventions (Kang & Bagoaisan, 2024; Andrade et al., 2020). This domain explores how healthcare providers and CHWs address barriers such as language, mistrust, and systemic risk impacting the Latino immigrant community. The following results first examine the practices being conducted by CHWs, that includes the following two themes: (1) CHWs' practices with relationship-focused interventions to address underutilization and (2) CHWs' practices with improvisation in resource-limited systems. This is followed by the practices being conducted by healthcare providers, which are categorized into three themes: (1) Relational and culturally centered care, (2) Community-based engagement and education, and (3) Supporting navigation and coordination of care.

CHWs' Practices with Relationship-Focused Interventions to Address Underutilization. Among the CHW focus groups, various participants described how they utilized relationship-focused interventions as a way to mitigate mental health service underutilization among the Latino immigrant community. For instance, CHWs conducted practices that had similarities with the therapeutic relationship - the professional relationship experience between mental health providers and their patients. While CHWs emphasized to members of the community that they were not professional mental health providers, they

described therapeutic techniques, such as active listening and rapport-building, as a way to build their relationship with Latino immigrants. For many CHWs, relational-focused interventions served as a form of transitional support for the community by creating companionship that mitigated psychological distress, while Latino immigrants awaited being connected to formal services. Mary, a CHW with seven years of experience working with the Latino immigrant community, made the following statement:

> *"It involves trying to talk and to build rapport. That trust with the [Latino immigrant] client and to explore other factors that may be impacting their health. Perhaps they are facing issues with food or rent. The goal is to seek out those avenues of assistance to help alleviate the stressors affecting their mental health while the necessary professional help is being secured."*

Through the implementation of relationship-focused interventions, CHWs were able to create a sense of safety among members of the community. CHWs described that creating a sense of safety among Latino immigrants assisted in facilitating more emotional expression, as well as reducing the impact of stigma associated with seeking mental health services. To illustrate, Esmeralda, a CHW with two years of experience assisting Latino immigrants, made the following statement:

> *"…another issue I frequently observe is the stigma. The feeling that "I can't even admit that I have a problem, because... well, what will people think?" Therefore, I believe that offering the opportunity to listen and allowing the other person to speak goes a long way toward dismantling that stigma, and toward helping them realize that they "can" be heard, and that it is okay to acknowledge that they are going through something."*

Like Mary and Esmeralda, other CHWs described the utility of conducting self-disclosure practices to gain the trust of Latino immigrants, which made them more likely to utilize the resources provided by CHWs. To exemplify, Lucia, a CHW with extensive experience working with the Latino immigrant community, made the following statement:

> *"For instance, in my own case, I am a survivor of domestic violence. When I encounter a case involving domestic violence, I tell them [Latino immigrants], 'Look, I know exactly what you're going through. I am a survivor of domestic violence myself.' At that moment, the person feels truly understood. They feel, 'This person gets me. This person knows exactly what I am living through.' This makes it far more likely that the individual will follow up on the various resources provided."*

Among CHW focus groups, relationship-focused intervention strategies catalyze addressing mental health service underutilization among Latino immigrants. By creating a culturally grounded space of trust and emotional safety, CHWs were able to facilitate emotional openness and reduce stigma associated with mental health concerns. As a result, CHWs not only supported members of the community with alleviating psychological distress, but they also increased the likelihood of Latino immigrants utilizing formal mental health services.

CHWs' Practices with Improvisation In Resource-Limited Systems. Due to the systemic limitations of existing mental healthcare services, CHWs described how their practices are continuously adapting to address the needs of Latino immigrant communities. Notably, CHWs shared how they continuously engaged in conducting flexible, solution-focused practices, which included modifying how information is delivered, actively identifying resources, and reading information on mental health symptomatology to better assist the community. As a result of these

practices, CHWs frequently relied upon their network systems, leaning into community/peer connections, as well as institutional contacts to further enhance their ability to support Latino immigrant communities. Heather, a CHW with eight years of experience assisting Latino immigrant communities, made the following statement:

> *"...when I feel limited in my capacity to help. What I do is ask the [Latino immigrant] person to wait a moment while I try to identify available resources by reaching out to all the community promoters I know. I then attempt to either immediately redirect the person, so they aren't left in limbo. Or, I try to empower myself to guide or direct them as far as I can go."*

Like Heather, various CHWs described how their ability to support Latino immigrants often depended on their ability to navigate uncertainty and gather resources in real time. In response to mental health systemic limitations, CHWs shared narratives that provided insight into how adaptive practices extended to providing psychoeducation for community members. However, before providing psychoeducation, various CHWs noted how they take a proactive approach in obtaining mental health-related knowledge by taking courses and/or reading literature on the subject matter. Although CHWs acknowledge that they are not mental health providers, they described the process of providing basic mental health education to Latino immigrants in a manner that is accessible and within a culturally safe environment. Lucy, a CHW with two years of experience assisting Latino communities, shared the following statement:

> *"For instance, in my studio, I have a poster that addresses emotions. Specifically, asking: 'Which emotion is driving you?'. I always like to explain to them that having emotions is normal. That it is normal to feel sad, but it is not normal to feel sad every single day."*

Similar to Heather and Lucy, these findings illustrate that CHWs' practices are distinguished by ongoing adaptations within a resource-limited mental health system. Notable patterns seen within CHW narratives involved a continuous effort in expanding their knowledge on relevant mental health-related information, as well as increasing their resource networks in their efforts to support Latino immigrant communities.

Healthcare Providers' Practice with Relational and Culturally Centered Care.

Consistent across all provider focus groups, a common theme seen in their responses was their description of their interactions with Latino immigrant patients, which is fundamentally grounded in a relationship-centered and culturally responsive approach. Indeed, U.S.-based healthcare-related training puts the therapeutic relationship as a key driver for the success of treatment; however, healthcare providers highlighted that rapport- and relationship-building is a vital step that begins when they first meet their patient, and is a significant practice that is conducted before providing clinical-related interventions. Importantly, healthcare providers conceptualized trust as an intentional and ongoing process to counteract misunderstanding, stigma, and prior experience with marginalization. To illustrate, Brenda, a psychiatrist working with the Latino immigrant community, stated the following:

> *"…that level of trust and understanding, like, oh, this person gets me, this person gets me. They understand. And having just that sense of comfort, you know, one of the things I feel like I often have to do when I first see people is like, look, I'm not asking you about your status because I'm going to go call somebody. It's because I want to know what stresses you out and what stresses your children out. And I even go as far as to say, has anybody been taken out of your home forcefully?*

> *Have your children witnessed it? Have you witnessed this? Because you'd be surprised by the things that people have been through and they're so fearful…"*

Similar to Brenda, healthcare providers shared how culturally responsive care is not limited to having an awareness of cultural differences; instead, it also involves a conscious effort and ongoing process of reframing and validating culturally normative expressions to avoid pathologization. As well as being aware of and affirming adaptive coping strategies utilized by Latino immigrants. Georgina, a mental health trainee working with Latino immigrants, shared her experiences by stating the following:

> *"…just wanted to say I think reassuring patients that a lot of the things that they're doing at home or that they've already started are valid and good systems of support. So when they tell you that they call their friend or they tell you that they're thinking about going back to church, they know that's helped them in the past, just really validating the things they've already started for their mental support and remind them that they're absolutely right, and then we can add this."*

These findings exemplify the utility of intentionally centering the relationship between healthcare providers and Latino immigrant patients. Furthermore, it also supports how culturally responsive care is an ongoing process during treatment. Healthcare providers also described how practicing culturally aligned care factors into creating a sense of safety and trust among Latino immigrants within clinical settings. Notably, healthcare providers shared their experiences within the focus groups related to cultivating a relationship with their Latino immigrant patients; they described how the relationship they built with Latino immigrants became a catalyst in facilitating openness to receiving mental health care. Some healthcare providers described this process by their actions in conducting genuine conversations as a means to understand fears salient to Latino

immigrants (e.g., documentation status) and normalizing behaviors demonstrated by the community.

Healthcare Providers' Practice with Community-Based Engagement and Education. Healthcare providers described how the expansion of access to mental health care among Latino immigrant communities requires a shift from traditional engagement practices when working with the population. Instead, healthcare providers shared the importance of practicing community-centered and relational approaches to increase utilization. For instance, healthcare providers described how shifting from how education (e.g., psychoeducation) is traditionally implemented to a manner that provides education in familiar community settings, integrates existing sources of support, and reduces the power dynamic between the provider and patient, is a valuable step to increasing service utilization. As reflected by Nicole, a Latina mental health counselor working within a community-based clinic, the following was stated:

> *"But with my Latino community, I really try to educate them on what I'm doing, why I'm doing it, why it's important. And then the logistical pieces, right. Things like, you know, how do you fill this medication? How do you call this agency? And if they're still struggling, you know, employing resources within the community…"*

In an effort to increase trust, healthcare providers described how traditional outreach and education practices are not a sole factor that increases awareness of mental health services within the Latino immigrant community. Alternatively, they shared that it is an intentional process of being aware of community norms and providing outreach that aligns with the context of Latino immigrants. For example, healthcare providers described the importance of community relationships in facilitating comfort within the community by attending and participating in

culturally salient events, and/or attempting to converse with Latino immigrants in environments where they seem to be safe. Jenny, a Latina nurse practitioner working within a safety-net clinic that primarily serves Latino immigrants, states the following:

> *"We're going into the apartment complex at [location redacted], also called [location redacted]. We go every other Tuesday in the morning. And I think word of mouth is starting to spread there too, but we have flyers out in the community that say what kind of services that patients can access."*

Similar to Nicole and Jenny, other healthcare providers described how intentional community-based interactions and education provide a novel delivery system to introduce mental healthcare-related information that aligns with the social and cultural context in which Latino immigrant communities live. By providing education (e.g., psychoeducation) in a manner that provides comfort to Latino immigrant patients, utilizing a trusted community space for outreach, and leveraging the use of existing community networks that the community is aware of, mental health-related education becomes more than bringing awareness at the individual level. This process provides the opportunity to foster trust, build familiarity with services, and reduce uncertainty with navigating mental health care services; therefore, leading to increased service utilization.

Healthcare Providers' Practice with Supporting Navigation and Coordination of Care. A notable practice conducted by healthcare providers within the focus groups consisted of supporting Latino immigrant patients with navigating the mental healthcare system. Specifically, healthcare providers described their actions that exceeded traditional care coordination-related tasks and embodied an advocacy role to support Latino immigrant patients as they navigate various mental health-related systems. For example, healthcare providers shared their viewpoints

on how navigation assistance is an ongoing, patient-centered process that ensures the continuation of care for Latino immigrants. As opposed to possibly losing contact with Latino immigrant patients within the system, these healthcare providers extended their guidance by helping Latino immigrants with logistical, linguistic, and institutional-related concerns that impact mental health service utilization. Stephany, a child psychiatrist who works with Latino immigrant families, describes her experience with helping parents in accessing school-based mental health services for their children. She stated the following:

> *"...it's just mind-boggling because you literally have to coach your parents. How do you talk to the school? What do you ask for? Sometimes I've literally sent families with letters [to schools] because I knew that if I tried to get the parent to do it, they weren't going to be able to say it the way that I needed to be said. So I had to send a letter. Sometimes I had to fax the letter so they couldn't say, oh, we didn't get a letter because it was literally sent to you [to schools]."*

Like Stephany, Elizabeth, a clinical social worker, describes her experience with assisting Latino immigrants schedule appointments for follow-up services as a way to increase utilization, she stated the following:

> *...educate them [Latino immigrant patients]. You know, you teach them how to go about many things. How to make the appointment by modeling for them, teaching them how to do things. That helps with increasing, you know, compliance."*

By valuing holistic, patient-centered care, many of the healthcare providers shared their willingness to be proactive by identifying and connecting the Latino immigrant community with new and available resources outside of their clinical setting (e.g., community-based resources). Notably, healthcare providers demonstrated an awareness that other basic needs (e.g., lack of

food) can impede motivation for mental health service utilization. Healthcare providers, therefore, highlighted that effective care coordination involves actively supporting the Latino immigrant community by connecting them with resources that are responsive to their socio-ecological context. May, a Latina psychology doctoral trainee working within a primary care setting, stated the following:

> *"I think some of the important collaborations or just the knowledge of community partnerships are really important in terms of trying to get folks access to some of the other logistical barriers that we were talking about earlier. So, food pantries, where are the food drives happening? Are there drives? Are there caravans that come around with healthcare? How can we provide just how we can offer more access across multiple different areas of people's needs?"*

Cumulatively, these healthcare providers countered traditional practices seen within the healthcare system by embodying an advocacy-driven approach to navigation and care coordination. In an attempt to counteract the logistical, linguistic, and institutional barriers experienced by the Latino immigrant community, the practices conducted by these healthcare providers within the focus groups reflect an in-depth understanding of how the socio-ecological context of Latino immigrants can significantly reduce mental health service utilization.

Chapter 8: Discussion

The present qualitative study explored the knowledge, attitudes, and practices of community health workers (CHWs) and healthcare providers in the mental health service utilization among Latino immigrants. The findings across all three KAP domains note a common reality; Latino immigrants are navigating significant mental health needs within a healthcare system that is not designed to meet their linguistic, cultural, or contextual realities. The key

contributions of these findings emphasize that individual factors do not solely drive the underutilization of mental health services among Latino immigrants; instead, it is a reflection of broader misalignment between how psychological distress is recognized, interpreted, and responded to within the community and formal mental healthcare systems. Although the KAP model emphasizes individual-level determinants of health behavior, the present findings highlight the importance of broader ecological and structural contexts in shaping mental health service underutilization among Latino immigrants. For instance, factors such as systemic barriers, sociopolitical climate, and social determinants of health influence the underutilization of mental health services. Thus, future research may build upon these findings by incorporating ecological and structural frameworks to further examine how multilevel level determinants shape mental health service utilization within Latino immigrant communities.

A key distinction within the knowledge domain is seen in how CHWs and healthcare providers understand and recognize distress among Latino immigrants. While both groups acknowledge that mental health concerns are shaped by complex contextual factors, including migration-related stress and ongoing life challenges, a notable difference emerges in how psychological distress is identified and conceptualized between CHWs and healthcare providers. For example, CHWs' narratives suggest that mental health issues within the community are often indirect and externally mediated (e.g., school systems; Ijadi-Maghsoodi et al., 2024) and manifest through changes in physical health and behavior (Zvolensky et al., 2019). Conversely, healthcare providers take on a trauma-informed, clinical lens that conceptualizes migration-related adversity, chronic stressors, trauma, and life-related burden as key contributors to mental health issues. Healthcare providers predominantly frame psychological distress through clinical constructs such as trauma, whereas CHWs describe distress in terms of ongoing

stressors and negative life events. This suggests that healthcare providers interpret psychological distress through diagnostic frameworks, while CHWs are aware of the continuous and situational adversities faced by Latino immigrants. This distinction provides insight to how clinical terminology may abstract lived experience, whereas community-based perspectives maintain proximity to the contextual lived experiences that shape mental health. These differences may also reflect variations in power, structural location, and epistemological perspectives between CHWs and healthcare providers. For example, CHWs' knowledge is grounded in lived, community-based, and relational ways of knowing, whereas healthcare providers' interpretations are often shaped by clinical training and diagnostic frameworks. Indeed, these differences likely reflect the distinct roles and contexts in which CHWs and healthcare providers operate. More specifically, the differences may be a result of distinct forms of training and knowledge. CHWs are trained as community-based workers whose roles emphasize cultural mediation and relationship building. CHWs, who are seen as trusted members of the Latino immigrant community (Cheney et al., 2026), are often embedded within the communities they serve and attuned to indirect ways psychological distress is experienced (Rosenthal et al., 2021). On the other hand, healthcare providers place utility on their clinical training and trauma-informed frameworks to interpret psychological distress within formal healthcare settings (Parker & Johnson-Lawrence, 2022).

Importantly, both CHWs and healthcare providers identified somatic symptoms as a primary way in which mental health issues are expressed among Latino immigrants. This shared recognition suggests that both groups are attuned to the non-clinical presentation of mental health concerns, where psychological distress is often communicated through physical ailments rather than clinical terminology. Consistent with prior research, this emphasizes the importance

of understanding somatic symptoms as a meaningful indicator of underlying mental health needs (Zvolensky et al., 2019). For healthcare providers, this emphasizes the need to further integrate culturally responsive approaches into assessment and engagement, where recognizing and appropriately interpreting culturally grounded expressions of psychological distress becomes central to care. Furthermore, the shared recognition of somatic symptoms as being linked to mental health-related issues, highlights the importance of culturally responsive and humble approaches to care. The ability to interpret somatic symptoms as meaningful indicators of distress reflect a broad capacity for cultural humility, which has been associated with improved engagement and reduced treatment drop out among Latino populations (Bauer, Balaraman, & Gilmore, 2025). As such, aligning healthcare provider and CHW perspectives within treatment settings in recognizing culturally salient expressions of psychological distress may be critical for enhancing the utilization of services and retention.

Furthermore, the analysis reveals a critical distinction between CHWs and healthcare providers in how they understand the misalignment between mental healthcare systems and Latino immigrant communities. While both groups acknowledge notable systemic barriers that hinder access to care, CHWs distinctly view the mental healthcare system as being fundamentally incompatible with providing services to the Latino community. This perspective may be indicative of the broader systemic issues embedded within the U.S. healthcare system that contribute to low help-seeking behaviors among Latino immigrants (Yearby, Clark, & Figueroa, 2022), including discriminatory practices, language barriers, and culturally-misaligning practices (Dumke et al., 2024; Berger & Peled, 2022). Considering the roles CHWs play, which include assisting Latino immigrants with navigating the system (Mistry, Harris, & Harris, 2021), CHWs witness the incompatibility of the system firsthand as they

attempt to assist the community with accessing services. In contrast, healthcare providers' narrative views the lack of utilization from a standpoint of Latino immigrants already attempting access. Indeed, multiple systemic barriers, such as limited service availability, financial constraints, language barriers, and gaps in mental health literacy, impede access to care for Latino immigrants (Derr, 2015; Lugo, 2024; Morales, 2024). As such, healthcare providers are more likely to understand underutilization as a function of barriers encountered within the system, rather than a reflection of the system's incompatibility with the needs of the community. Consequently, providers put an emphasis on access-related barriers, which highlights challenges within the system, whereas CHWs' perspective reveals how the system design itself may limit engagement before care is ever initiated. Taken together, the inclusion of both CHWs and healthcare providers offers a more comprehensive and culturally relevant approach to understanding Latino immigrant mental healthcare utilization, as each perspective captures a distinct yet complementary approach to service utilization. Notably, by integrating CHWs into an interdisciplinary mental healthcare team, this may enhance cultural humility among members of the healthcare team, improve the alignment between services and community needs, and ultimately increase mental healthcare services utilization.

Within the attitude domain, CHWs and healthcare providers both recognized that mental health service utilization is a complex process that is shaped by a myriad of factors, including cultural, systemic, and contextual factors. For instance, both groups named stigma, competing life demands, and systemic barriers as inhibitors for mental healthcare services utilization. However, there are key distinctions in how CHWs and healthcare providers interpret the process of engagement with mental healthcare services. Based on CHW narratives, treatment utilization is understood as a process that is often reactive, indirect, and sustained through ongoing support,

rather than initiated at the onset of psychological distress. This provides insight into a pattern that treatment utilization is not solely determined by individual willingness, but unfolds through a gradual and context-dependent process influenced by limited familiarity with mental health treatment, stigma, and cultural beliefs. Notably, prior research highlights how stigma and cultural perception of psychotherapy can contribute to delayed help-seeking among Latino immigrant communities (Forcen et al., 2023; Nagy et al., 2025; Fuentes et al., 2024). The present findings bring into light that the utilization of mental health services not only occurs after a certain critical threshold, but Latino immigrants also require sustained support for service utilization to be maintained. This suggests that treatment engagement is an evolving process that unfolds over time. CHWs' perspective highlights that Latino immigrants must first recognize distress, build trust, and navigate competing priorities prior to engaging in formal training. CHWs' characterization as treatment utilization needing to be a "hand-holding" process for Latino immigrants underscores the structural limitations within mental healthcare systems, particularly the lack of continuity and follow-up care necessary to support ongoing mental health service utilization, which may be further exacerbated by workforce limitations (Garcini et al., 2022). Thus, this description indicates that existing healthcare systems are not structured to support the level of continuity and relational engagement required for sustained utilization, placing the burden of maintaining engagement on community-based supports rather than formal systems. This is notable due to CHWs calling for more support systems to assist with their work, specifically noting that more mental health training is needed. While both CHWs and healthcare providers are limited with their work capacity, training conducted by healthcare providers for CHWs can be beneficial with reducing the overall strain on the mental healthcare system.

Furthermore, healthcare providers conceptualized mental health service utilization among Latino immigrants through a clinical/relational lens, noting the importance of trust, cultural understanding, and perceived safety within the healthcare system. Healthcare providers described that Latino immigrant help-seeking behaviors are influenced by multiple factors that were similarly described by CHWs (e.g., stigma); however, healthcare providers bring into account a different perspective, which is prior experience of being misunderstood or marginalized within the system (Espinoza-Kulick & Cerdeña, 2022). To counteract this, they reflect the importance of needing to understand the Latino immigrant experience by developing a sense of trust and rapport. Additionally, the narratives described the necessity of practicing culturally responsive care by noting the importance of avoiding pathologizing of culturally normative expression as a way to foster treatment engagement. This reflects an awareness of misdiagnosis being historically rooted in cultural ignorance, specifically bringing into attention that clinicians need to maintain their awareness of diagnostic criteria and internal biases they may hold that can impact pathologizing culturally relevant expressions (Schwartz & Blankenship, 2014). Adding to this point, the experiences shared by healthcare providers suggest that the underutilization of mental health services is a calculated decision that requires a risk-cost benefit analysis. Due to the systemic barriers Latino immigrants have to navigate, including economic stability and caregiving responsibilities, much of the time these priorities supersede their own mental health needs (Falgas et al., 2017). Within this perspective, seeking mental healthcare services may be interpreted as being individualistic instead of prioritizing the family structure; therefore, going against cultural values, such as familismo (Villatoro, Morales, & Mays, 2014). Moreover, ongoing sociopolitical factors within the U.S., specifically anti-immigrant sentiment and aggressive deportation policies (Young et al., 2022; Friedman & Venkataramani, 2021),

contribute to Latino immigrants not seeking mental healthcare services. Indeed, for the Latino immigrant community, healthcare systems are interpreted as a source of surveillance rather than a place of healing. Within this perspective, healthcare providers conceptualize help-seeking as a rational and context-dependent decision, which is shaped by Latino immigrant patients' evaluations of risk, safety, and competing priorities. This reflects a system-centered approach of understanding utilization, where the focus is on factors influencing willingness to engage once individuals are positioned within formal services. The inclusion of both CHWs and healthcare providers offers a more comprehensive understanding of service utilization. While CHWs illuminate how engagement is initiated within community contexts, healthcare providers provide insight into how engagement is conducted within healthcare systems. Taken together, these findings suggest that mental health service utilization among Latino immigrants is not a singular decision, but involves a dynamic process influenced by cultural values, systemic constraints, and relational factors. While CHWs note how engagement must be cultivated prior to system entry, healthcare providers emphasize systemic factors that influence utilization. These perspectives indicate that underutilization reflects a broader mismatch between system-based models of care and the lived realities of Latino immigrant communities. Thus, allowing the voices of CHWs to be heard within healthcare systems, may contribute to a better alignment between mental healthcare systems and the community.

Lastly, the practice domain described experiences by CHWs and healthcare providers in their efforts to increase mental health service utilization among Latino immigrants. Although both groups aimed to address the mental health needs of the community, they differed on how this was implemented within their roles. For example, findings for CHW narratives suggest that the services they provide go beyond serving as a bridge between Latino immigrant communities

and the formal mental healthcare system (Garica, Sprager, & Jimenez, 2022). Interestingly, in the use of relationship-focused interventions, CHWs implement strategies commonly seen within a therapeutic setting (e.g., active listening/reflection/self-disclosure) to mitigate the impact of psychological distress. By doing so, they served as liaison type roles introducing mental health services and facilitating engagement with the formal mental healthcare system. With the recognition they had of the resource constrained mental healthcare system, many of them adapted to limitations by taking courses/reading literature to enhance their ability to assist the Latino immigrant community. Furthermore, CHWs also took it upon themselves to mobilize community networks and provide real-time problem solving, which suggests their active role with compensating for the structural gaps in the mental healthcare system (Mongelli et al., 2020).

Similar to CHWs, findings suggest that healthcare providers adapt their roles within the structure of the system. Their narratives suggest that their relational approach to treatment and engagement are key contributors to establishing psychological safety; thus, maintaining the utilization of services among Latino immigrants. These practices suggest that healthcare providers are actively working to improve engagement once individuals enter the healthcare system, particularly by addressing prior experiences of stigma, fear, and marginalization. This is apparent by engagement efforts conducted by healthcare providers, which includes going to culturally safe locations to spread information and provide psychoeducation, as well providing care coordination with community resources. This reflects an awareness that traditional models of care are insufficient for addressing the needs of immigrant communities and shifts with how traditional care is provided need to align with the social/cultural context of the community. Furthermore, the distinction between how engagement is operationalized provides the opportunity for CHWs and healthcare providers to partner together and expand services for the

community. While healthcare providers contribute clinical expertise and system-based interventions, CHWs provide community-related expertise that is culturally grounded. As such, integrating CHWs into interdisciplinary mental healthcare teams may address gaps in how engagement is initiated and sustained, which ultimately leads to more consistent services utilization of mental healthcare among Latino immigrants.

Implications and Future Directions

The findings of the present study have several important implications for clinical practice and the delivery of mental health services among Latino immigrant communities. First, the results emphasize that increasing access to care is insufficient to address underutilization. Indeed, mental health service utilization is dependent on how well services align with the cultural, relational, and contextual realities of the Latino immigrant community. As demonstrated across KAP domains, engagement is not a singular event but a multistep process that involves recognizing psychological distress, developing a relationship and trust, navigating systemic barriers, and sustaining the utilization of services. Notably, a key implication is the need to integrate CHWs into interdisciplinary mental healthcare teams. As illustrated in the findings, CHWs play a critical role in facilitating early engagement by building trust, identifying distress through non-clinical means, and providing ongoing relational support. In contrast, healthcare providers primarily operate within formal care systems and focus on engagement once individuals have entered treatment. Thus, integrating CHWs into clinical teams results in bridging the noted gap by supporting engagement prior to and throughout treatment; therefore, enhancing continuity of care and reducing premature termination of treatment. The integration of CHWs within an interdisciplinary framework may involve embedding CHWs into behavioral health teams, where they have the ability to collaborate with healthcare providers to support care

coordination, psychoeducation, and follow-ups with the community. These findings have implications for reimbursement-based models by expanding and sustaining interdisciplinary approaches that integrate CHWs to address the mental health needs of the Latino immigrant community. Additionally, findings emphasize the importance of cultural humility within care and provider-patient interactions. Training programs for healthcare providers should emphasize cultural humility, including recognizing cultural salient expressions of distress, avoid pathologizing culturally normative behaviors, and encourage engaging in ongoing self-reflection regarding bias and power dynamics. The findings also highlight important diagnostic implications for clinical assessment and case conceptualization. Healthcare providers must place importance to somatic presentations of distress due to psychological issues possibly being expressed through physical symptoms. As such, healthcare providers should consider incorporating culturally responsive screening tools, such as the Center for Epidemiologic Studies Depressions Scale (CES-D), while also interpreting results within the cultural context of Latino patients' experiences. Greater awareness of somatic expressions of psychological distress may reduce misdiagnosis and facilitate earlier identification of mental health needs among Latino immigrant communities. The findings also have implications for work force development. CHWs demonstrated a willingness to expand their knowledge of mental health through self-directed learning, yet also reported limitations in training and capacity. This suggests a need for structured mental health training programs for CHWs that are tailored to their role as community-based providers.

Future directions for research emerge from this study. Although the present study provides valuable insight from CHWs and healthcare providers, future research should incorporate the perspective of Latino immigrants themselves to further contextualize these

findings and validate identified themes. Including the voices of community members would strengthen the understanding of how individuals experience engagement and underutilization for mental health services. If possible, future studies should examine the effectiveness of integrating CHWs into interdisciplinary mental healthcare teams. Both mixed-methods and quantitative studies would be useful in assessing outcomes such as treatment utilization, retention, and symptom improvement when CHWs are integrated as part of a healthcare team. Future research may also further examine how epistemological frameworks of healthcare providers and CHWs shape interpretations of mental health needs and influence engagement and intervention strategies within Latino immigrant communities.

Limitations, Strengths, and Conclusions

The study has several limitations that suggest directions for future research. First, although CHWs are respected members of the Latino community and some healthcare providers also identified as Latino, the study relied on qualitative data that reflects the perspectives of the respective participants rather than direct experiences of Latino immigrants. Despite the focus group interviews with healthcare providers and CHWs indicating important pattern-level determinants of mental healthcare underutilization, the absence of Latino immigrant voices limits the ability to fully capture the lived experience of accessing care. Future work, therefore, should prioritize incorporating the perspectives from Latino immigrants to better understand mental health service utilization within the community. Nonetheless, CHW and healthcare provider perspectives do provide valuable insight into system- and community-level dynamics; however, they may not fully capture how Latino immigrants personally experience mental health needs, barriers, and service utilization. Second, the sample was drawn from a single geographic region in the U.S. mid-Atlantic, which may limit generalizability of the findings to other Latino

immigrant communities with differing sociopolitical contexts, resource availability, and cultural compositions. Additionally, the variability in training, organizational roles, and years among CHWs and healthcare providers may have influenced the perspective shared within the focus groups. Third, although focus groups allow for rich, interactive discussion, they may also introduce social-related biases, where participants might present their experiences that align with professional/social expectations.

Despite limitations, the present study offers several notable strengths. First, a key contribution of this study is the application of the Knowledge, Attitudes, and Practices (KAP) Model to examine provider and CHW narratives surrounding mental health services underutilization among Latino immigrants. Unlike individual-level frameworks, the KAP model illustrates underutilization within a broader interaction of how knowledge, attitudes, and practices operate across personal, cultural and institutional levels. Thus, this provides a comprehensive lens to investigate the underutilization of mental health services within the Latino immigrant community. The current research also incorporated a community-based participatory research approach to enhance the cultural validity of this study by incorporating community stakeholders throughout the research process. Indeed, the research team provided the results of the study to community stakeholders to gain feedback and comments regarding the findings.

The study also uniquely integrates perspectives from both CHWs and healthcare providers, which is a significant strength and contribution to the literature. By including both groups, the study captures complementary perspectives on mental health services utilization that are often examined separately. This dual perspective provides a more comprehensive understanding of how treatment utilization unfolds within the Latino immigrant community.

Importantly, the present study underscores how CHWs and healthcare providers offer distinct, yet complementary perspectives on mental health services utilization among Latino immigrants. Their perspectives offer a more comprehensive understanding on how Latino immigrant individuals access and navigate mental health services. The findings emphasize the value of integrating CHWs into interdisciplinary mental healthcare teams to bridge the gap between the community and mental healthcare system. The findings support that leveraging both community-based knowledge and clinical expertise may enhance the continuity of care and sustain utilization of services among the community over time. Ultimately, addressing mental health disparities among Latino immigrants requires approaches based on relational dynamics, cultural humility, and are grounded on the lived realities of the community. This study provides a foundation for future research and practice that emphasizes more equitable access to mental healthcare for the Latino immigrant community.

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Appendix A: Community Health Workers Focus Group Questions

Thank you for coming to the Latinx/o community health worker focus group. Today, we will discuss the needs of the Latinx/o community in the [*redacted*], which includes [*redacted*]. We are also going to discuss access to care, including barriers and facilitators to seeking care for mental health needs for Latinos. But first, I would like to know who is here…

[Go around and have key informants introduce themselves and describe years as a promotor, organization, and/or working with the Latinx/o community]

Now, I'd like to talk about the mental health needs of the [*redacted*]…

- What are the most common mental health needs for the Latinx/o community you see as a promoter?

Now, I'd like to talk about your experiences as a community health worker working with the Latinx/o community in the [*redacted*]…

- What are the top challenges you, as a promoter, face in helping the Latinx/o community with mental health issues?
- What have you found works best with your Latinx/o clients to help them improve their mental health?
- What changes would you make in mental health services in the [*redacted*] area so that they better serve the Latinx population?
- Who do you partner or collaborate with to address the mental health needs of the Latinx/o community in the [*redacted*]?

Now, I'd like to talk about access to mental healthcare services that you would like to see as a community health worker for the Latinx/o community in the [*redacted*]…

- At what point do you see Latinxs/os seeking care for their mental health?
- What can be done to increase Latinos' utilization of mental healthcare? What resources need to be developed/increased to address the mental health needs of Latinxs/os in the [*redacted*]?
- What are the barriers to seeking mental health care for Latinxs/os What strategies do you use to overcome barriers to seeking mental health care for Latinxs/os?
- What helps Latinos to seek mental healthcare when needed?
- How do community health workers facilitate Latinos to seek mental health services?

Those are all the questions I have. I want to thank you for taking the time to share your thoughts with me. Is there anything important that we didn't talk about?

Appendix B: Providers Focus Group Questions

Thank you for coming to the Latinx/o mental health care providers focus group. Today, we will discuss the needs of the Latinx/o community in the [*redacted*], which includes [*redacted*]. We are also going to discuss access to care, including barriers and facilitators to seeking care for mental health needs for Latinos. But first, I would like to know who is here…

[Go around and have key informants introduce themselves and describe years in their profession, organization, and/or working with the Latinx/o community]

Now, I'd like to talk about the mental health needs of the [*redacted*]. When describing the Latinx community, please be specific in your answers to any subgroup of the Latinx population, such as age group or national origin.

- What are the most common mental health needs for the Latinx/o community you see at your organization?
- What are the risks related to the mental health issues in the Latinx/o community?
- What are the challenges Latinxs/os face in improving their mental health?

Now, I'd like to talk about your experiences as a mental health provider working with the Latinx/o community in the [*redacted*]…

- What are the top challenges you, as a professional provider, face in helping the Latinx/o community?
- What have you found works best with your Latinx/o clients to help them meet their mental health needs?

Now, I'd like to talk about access to mental healthcare services that you would like to see as a mental healthcare provider for the Latinx/o community in the [*redacted*]…

- At what point do you see Latinxs/os seeking care for their mental health?
- How can healthcare agencies help Latinxs/os feel comfortable in accessing mental healthcare services?
- What resources need to be developed/increased at your organization to address the mental health needs of Latinxs/os in the [*redacted*]?
- What are the barriers to seeking mental health care for Latinxs/os that you see at your organization?
- What strategies have you used to overcome barriers to seeking mental health care for Latinos?

Those are all the questions I have. I want to thank you for taking the time to share your thoughts with me. Is there anything important that we didn't talk about?