Mid-America (HHS Region 7)
MHTTC Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Addressing Linguistic Diversity in Pediatric Integrated Care

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UNMC MUNROE-MEYER INSTITUTE

SAMHSA Substance Abuse and Mental Health Services Administration

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The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

- Strengths-based and hopeful
- Inclusive and accepting of diverse cultures, genders, perspectives, and experiences
- Healing-centered/ trauma-responsive
- Inviting to individuals participating in their own journeys
- Person-first and free of labels
- Non-judgmental and avoiding assumptions
- Respectful, clear and understandable
- Consistent with our actions, policies, and products

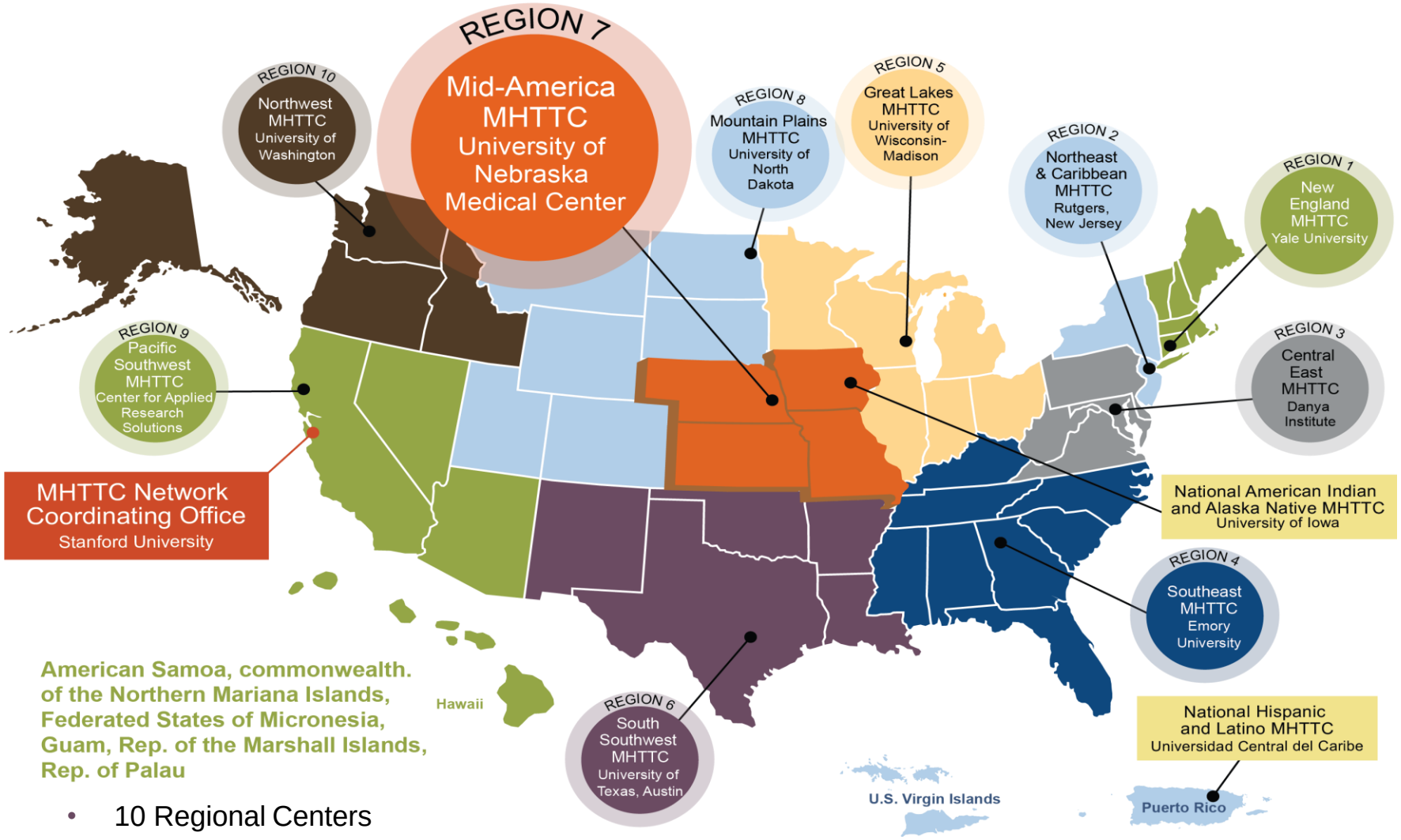
Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

Announcements

- This webinar is being recorded
- All attendees are automatically muted
- Submit questions any time during the webinar
- Each participant will be emailed a certificate of completion for this webinar next week

What is the Mid-America MHTTC?

- Funded by the Substance Abuse and Mental Health Services Administration
- 5-year grant awarded to Dr. Joseph Evans at the University of Nebraska Medical Center
- Aligns mental health systems and professional competencies with evidence-based practices
- Primary target states: Missouri, Iowa, Nebraska, and Kansas - but available to any provider(s).
- Provides free/low cost training and technical assistance on topics leading to effective behavioral health practice



- 10 Regional Centers
- National Hispanic & Latino Center
- National American Indian and Alaska Native Center
- Network Coordinating Office

Specialized Training Topics

- **Integrated behavioral health in primary care**
- School mental health ***
- Serious mental illness
- Behavioral health workforce development

Integrated Behavioral Health in Primary Care

Our MHTTC staff have 20+ years of experience integrating behavioral health into primary care in 40+ rural, suburban, and urban sites

MHTTC: Providing Training and TA in Integrated Care

QUALITY INDICATORS OF INTEGRATED BEHAVIORAL HEALTH IN PRIMARY CARE

EVIDENCE-BASED BEHAVIORAL HEALTH INTERVENTIONS FOR CHILDREN AND ADULTS APPLIED IN INTEGRATED CARE SETTINGS

TECHNICAL ASSISTANCE ON IMPLEMENTATION OF INTEGRATED CARE

ONLINE AND IN-PERSON COURSES FOCUSED ON INTEGRATED CARE AND SPECIAL TOPICS IN PEDIATRIC AND ADULT SERVICES (IN DEVELOPMENT)

Trey Andrews, PhD, LP

Dr. Trey Andrews is an assistant professor at the University of Nebraska-Lincoln in the Clinical Psychology Ph.D. program and is joint-appointed in Psychology and Ethnic Studies. He earned his Ph.D. in Clinical Psychology in 2014 from the University of Arkansas. As a graduate student, he helped solidify an integrated care practice that was in its second year and re-establish an additional site at an FQHC. He completed his internship (2014) and NIMH-funded postdoctoral fellowship (2016) at the Medical University of South Carolina with a focus on traumatic stress. While there, he laid the groundwork for integrated primary care practices in conjunction with family practice resident training and consulted with a local FQHC that was beginning its integrated care program. He now supervises students at an FQHC in Nebraska and has previously supervised students in another primary care clinic in Nebraska. Overall, the majority of the clinical services he provided and supervised have occurred in Spanish with Latinx populations. Beyond his practical experience, he has collaborated and led the publication of multiple research articles evaluating equity in primary care.

Kay Bond, PhD, LP

Kay Bond, LP, is the co-founder of Tidal Integrated Health, Inc., and co-director of Behavioral Pediatrics in Primary Care at NOVA Behavioral Healthcare Corporation in Goldsboro, NC. Dr. Bond is passionate about providing high-quality behavioral health services to young people and their families in rural, low-income, and underserved communities. She is also an experienced behavioral health supervisor. Most recently, Dr. Bond established two pediatric integrated behavioral health clinics designed to increase children's access to behavioral health treatment and reduce the stigma involved in participating in therapy. Dr. Bond's clinical and research interests include sleep, elimination disorders, and disruptive behavior and noncompliance. In addition, Dr. Bond is interested in integrating behavioral health into primary care practices and clinical supervision. She earned her Ph.D. in Pediatric School Psychology at East Carolina University in 2016, and she completed her internship and fellowship in Behavioral Pediatrics/Integrated Primary Care at the Munroe-Meyer Institute at the University of Nebraska Medical Center in 2018.

Gloria Gonzalez-Kruger, PhD, LMFT, LIMHP, LIMFT

Gloria Gonzalez-Kruger, PhD, is an associate clinical professor who is currently serving as the director of clinical services at Drexel University Couple and Family Therapy Clinic. She is a graduate of Michigan State University, where she earned her two master's degrees, one in Family and Child Ecology and the second in Marriage and Family Therapy. Her doctoral degree is in Family and Child Ecology with a specialization in Marriage and Family Therapy. She was an assistant professor at the University of Nebraska-Lincoln in the Department of Family and Consumer Sciences and the Marriage and Family Therapy program. Most recently, she was the director of behavioral health at a primary care clinic that is a Federally Qualified Health Center (FQHC), OneWorld Community Health Centers, Inc. This clinic provided integrated primary/behavioral healthcare to minority, underserved and marginalized populations. As a clinician, clinical supervisor, community advocate, educator, family scientist and researcher, her goal is to engage in activities that ultimately contribute to enhancing the quality of life of people in minority, under-served, vulnerable and marginalized communities. Her focus has been on increasing access, utilization and delivery of culturally relevant and competent educational and health-related services that serve to decrease health disparities and improve or enhance the overall well-being of individuals, couples and families across the life cycle.

Learning Objectives

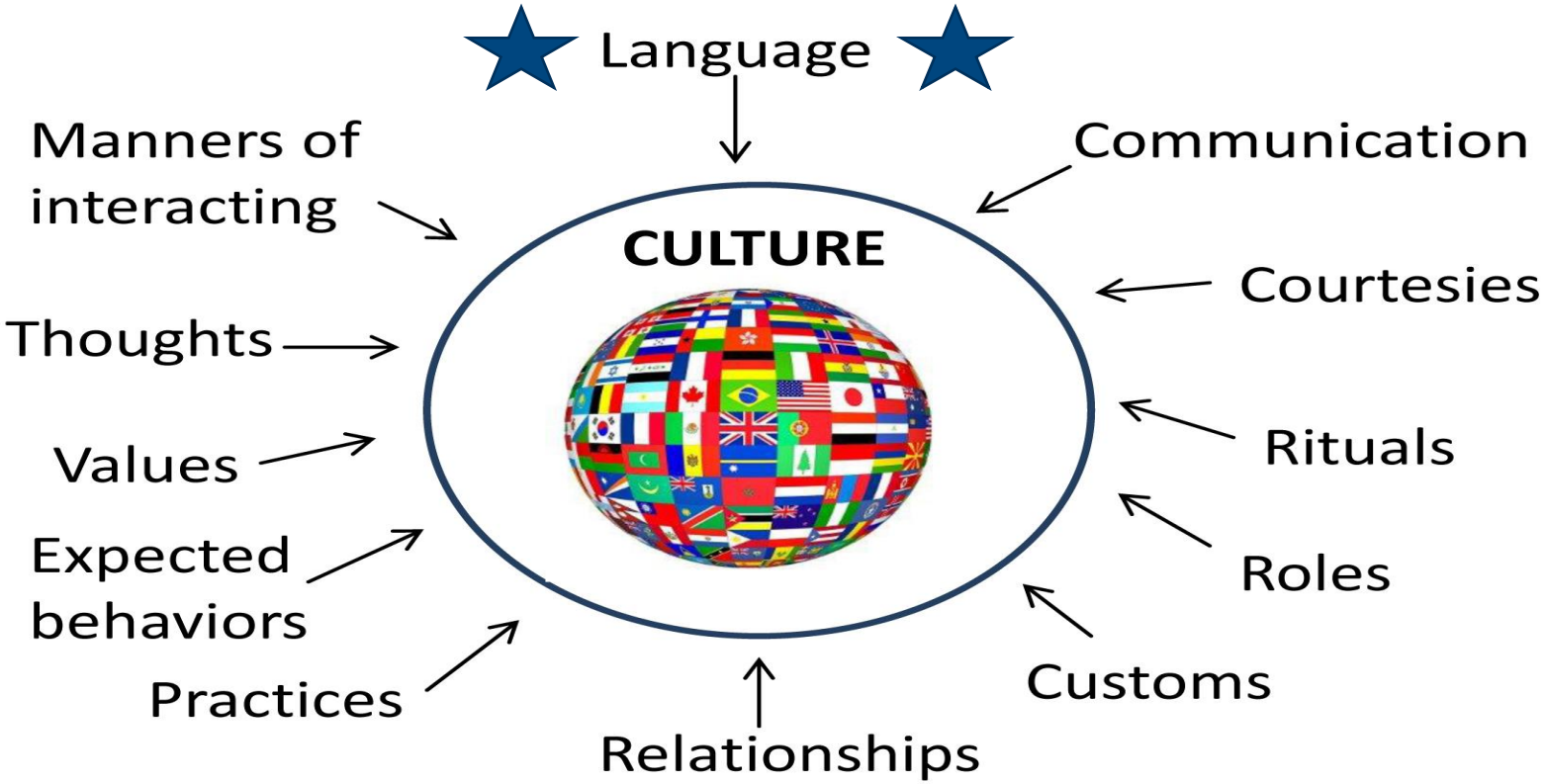
- ✓Describe barriers to care due to inequalities in linguistic abilities when providing mental health services within an integrated healthcare system
  - ✓Describe ways low-English proficiency is a barrier to care
  - ✓Describe workforce inequalities in linguistic abilities

- ✓Discuss how various interpreter models and functions help to overcome the challenges of meeting linguistic and cultural needs within the pediatric mental health integrated system of care

- ✓Discuss recommendations to consider when working with interpreters to address pediatric mental health needs.

”Of all the forms of inequality, injustice in health care is the most shocking and inhumane.“— Dr. Martin Luther King, Jr.

Defining Cultural and Linguistic Competence (CLC) in Patient Care



[Cultural and Linguistic Competence in Patient Care (dfwhcfoundation.org)]

Organizational Linguistic Competence

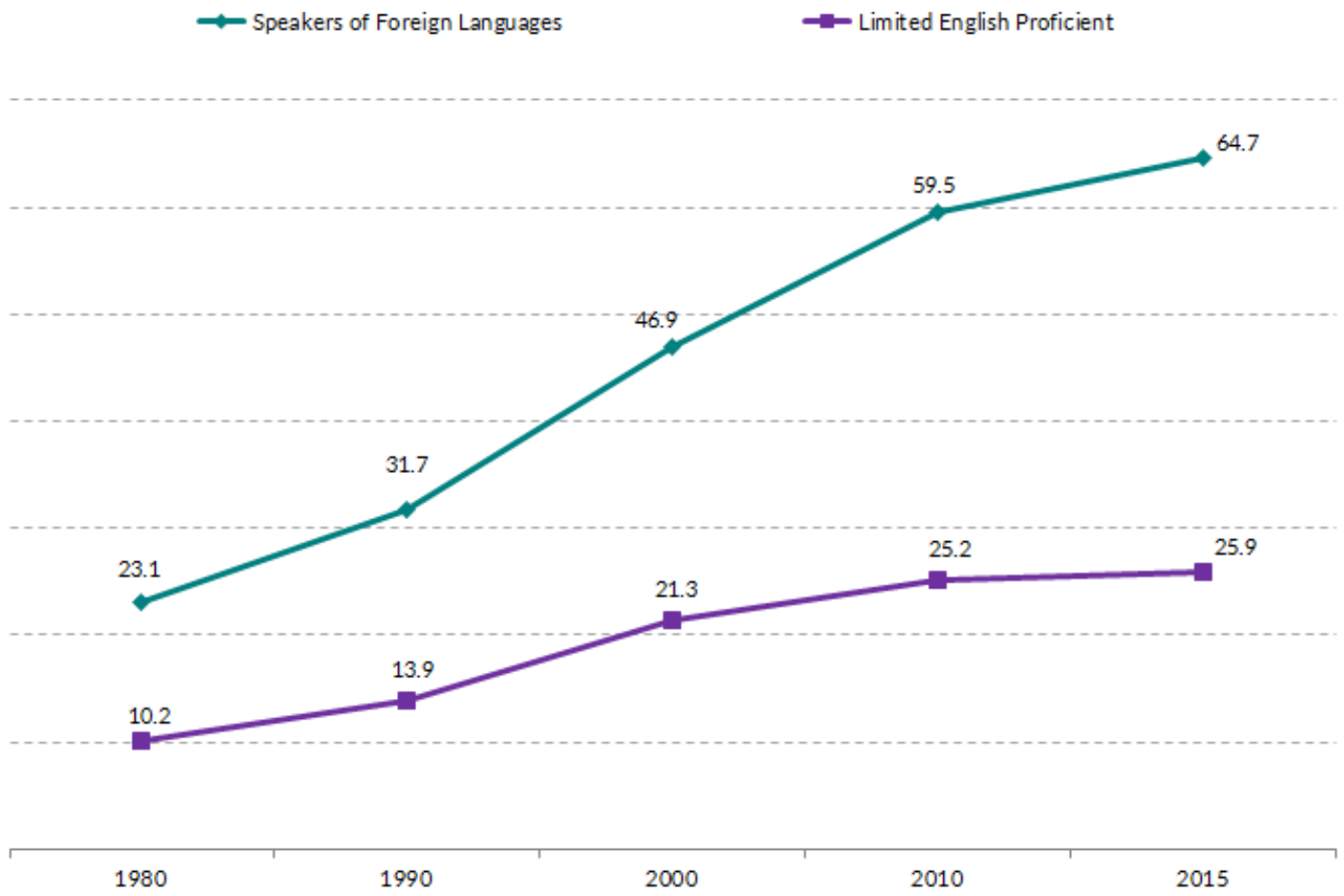
- Extends to entire organization, not just individuals
- Moves beyond just speaking the language
- For true linguistic competence, organizations must provide:
  - Readily available, culturally appropriate oral and written language services
  - To LEP individuals
  - Through bilingual/bicultural staff, trained medical interpreters, and qualified translators.[4]

Scope of the Problem

Figure 1. Speakers of Foreign Languages and LEP Population, 1980-2015

- *Note:* The 1980 decennial Census was the first to ask respondents about their level of English proficiency.

Source: MPI tabulations from the U.S. Census Bureau's 1980, 1990, and 2000 Decennial Censuses and 2010 and 2015 ACS.



Workforce Inequities in Linguistic Abilities

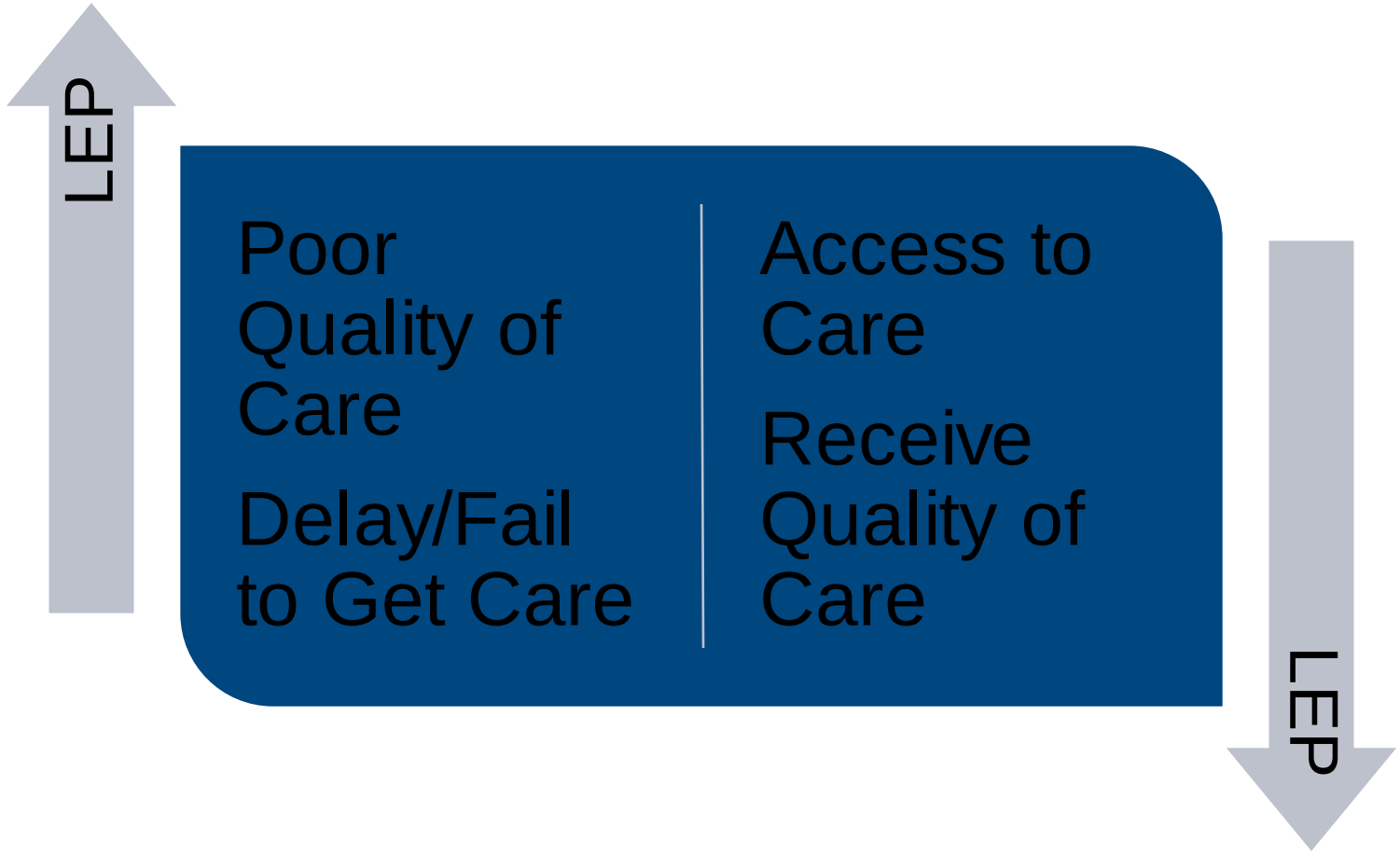
- Over 350 languages are spoken in the United States
- 20% of primary and secondary students are English language learners (ELL)
- 80% of ELL students' first language is Spanish, followed by Vietnamese and Hmong speakers
- 22% of primary and secondary students speak Spanish at home.
- Thus, the need for non-English-language mental health services in the US is substantial.

Experiential Data

- Story of an Encounter

Linguistic Barriers to Care

Health Care for Racial and Ethnic Minorities in the U.S. - LEP



Limited English Proficiency (LEP) - Child or Caregiver(s): Why Does it Matter?

- Youth: most rapidly growing diverse sub-population (race, ethnicity, national origin, immigration, and SES, language)
- Barrier for access to healthcare services
  - Challenge to identify patients who require language assistance
  - Faulty communication (e.g., scheduling through appointment)
- Client-Provider Relationship – Can limit
  - Emotional engagement
  - Development of trust, openness
  - Provision of client-centered care

Limited English Proficiency: Lower Quality of Care

- Interpretation
  - Lack of interpreter and/or translation services
  - Less-than-adequate interpretation services
  - Informal, untrained interpreters (e.g., family members, staff)
- Assessment and treatment implementation
- Knowledge and understanding of child or parent
- Psychoeducation and interventions
- Partnering in health care decisions

Communication and Language Assistance

- Offer language assistance not just for those with LEP and/or other communication needs
- Educate clients on language assistance services (verbally and in writing)
- Use professionals competent in providing language assistance
- Provide easy-to-understand print and multimedia materials and signage for your client population/s
- Assess and respond to health literacy needs

Primary Care Self-Assessment Checklist

- Promoting Cultural And Linguistic Competency Self-Assessment Checklist for Personnel Providing Primary Health Care Services
- Primary Care Self-Assessment Checklist (georgetown.edu)

Workforce Inequities in Linguistic Abilities

The workforce cannot presently meet needs for linguistic diversity

Only 10.8% of health service psychologists provide services in a language other than English

- 5.5% in Spanish
- 1.1% in French
- 3.7% in any other language

Workforce Inequities in Linguistic Abilities

- In rural areas they gap between bilingual providers and the overall population is greater.
- The population of Asian and Latinx Americans is growing rapidly, especially in the western states.
- Rural mental health providers tend to be to be White, Male and provide services in English.

Long-Range Solution

- Improve the pipeline of linguistically and culturally competent mental health providers
  - Treat bilingualism and biculturalism as a valued skill in the same way as academic records, research experience, etc.
  - Provide ample opportunity to train in multilingual settings. Examples of programs that emphasize this.
    - University of Miami (Counseling Psychology Ph.D. and Counseling M.Ed.)
    - University of Texas, Rio Grande Valley (Clinical Psychology Ph.D.)
    - Texas State University
    - William James College
    - Our Lady of the Lake University
    - Alliant International University
    - Antioch University

Developing Cultural and Linguistic Competence

- Emphasis on
  - Developing awareness and skills
  - Process of cross-cultural interactions
  - Communication styles
  - Decision-making approaches
  - Family processes
  - Cultural mistrust
  - Experiences of prejudice, racism, and sexism

Short-term Solutions

- Using medical interpreters
  - In rural areas, use of video conference interpreting services and telephone-based interpreting services may be especially helpful.
  - Forming standing relationships with local interpreting services helps to iron out some of our mental health jargon.

- Language immersion programs as continuing education.

Interpreter Models and Suggestions

- Even if bilingual, most of us will need an interpreter at some point
- Translation vs interpretation
  - Translation is linguistic equivalence
  - Interpretation is cultural equivalence
- Phone vs. in-person
  - Phone violates a lot of typical interpretation recommendations
  - In-person (or at least simultaneous telehealth) interpretation is ideal for culturally appropriate services

Interpretation Models and Suggestions

- Medical vs. Mental health interpretation
  - Medical interpretation allows interpreter to add explanations or change wording as appropriate
  - In medical interpretation, they often do not give feedback to provider regarding expanded explanation
  - Medical interpretation typically has little need or ability for pre-session planning
  - All of these can be more problematic in mental health interpretation
  - Both interpreters should have some basic knowledge of the disorders being addressed

Interpretation Models and Suggestions

- Simultaneous vs. consecutive interpretation
  - Simultaneous is extremely hard and typically requires specialized training
  - Also typically not appropriate for mental health settings because the interpreter can’t usually ask questions
  - Consecutive interpretation is the “back and forth” model, where you or the client speaks, then the interpreter speaks

Recommendations for Working with Medical Interpreters

- Most of us in primary care won't have trained mental health interpreters
- Will use available mental health interpreters
- Important to recognize differences in training
- May or may not involve mental health
- Many topics might be challenging for them
  - Ex. Vicarious trauma

The Basics: Dos and Don’ts

- Don’t look at the interpreter, Do look at the client/patient
  - You may have an aside with the interpreter and this also makes that behavior more apparent
- Do speak in brief phrases (1-2 phrases), not long explanations
  - Goes back to consecutive interpretation vs. continuous
- Do treat them as an equal professional
  - They have specialized training and their job is hard
- Do ask the interpreter questions and clarifications, don’t assume that they know how to communicate everything
  - Medical interpreters, like everyone else in society, may not always know how to phrase sensitive mental health topics

Beyond the Basics

- The “pre-session”
  - If at all possible, meet with the interpreter 10-15 minutes before the session
  - Warm hand offs are different, but still try to do some pre-planning
    - Some clinics may allow you to keep the same interpreter from the medical visit
  - Discuss goals for the session
  - Identify areas of potential difficulty (e.g., how will you assess traumatic event exposure?)
  - Encourage them to ask questions if they’re uncertain about how to interpret a phrase
  - Remind them that our words are our medicine

Beyond the Basics

- During the session
  - Be sure to introduce the interpreter and ask for permission to work with the interpreter during the session
  - Have the interpreter reassure the patient regarding confidentiality
  - Ask questions if it seems like they: 1) have a large discrepancy between how much you said and how much they said or 2) look confused, unsure, or uncomfortable
  - Keep side conversations to a minimum and focused on accurate and culturally appropriate communication

Beyond the Basics

- The Post-session
  - Debrief with the interpreter asking about any areas they found challenging
  - Address any issues you found challenging, including any areas where you think interpretation may have gone wrong
  - Problem solve any identified areas for future sessions (with that patient or with others)
  - Discuss plans for future sessions and follow ups, including potentially blocking their schedule if possible

Beyond the Basics

- Develop a strong Relationship with your regular interpreters
  - Organize “lunch and shares” to promote education and exchange
  - Include them in team meetings, even if 10-15 minute check ins for problem solving
  - Ask questions about mental health explanations BEFORE you have to for a session
  - Encourage them to ask you questions
  - Especially for interpreters new to mental health, understand they may have stigma or feel uncomfortable asking about sensitive mental health issues
    - This may or may not be a cultural difference.

Additional Tricks of the Trade

- Collected wisdom and opportunities for Q&A

References and Resources for Working with Interpreters

- *Found in Translation.* (2010) Toni DeAngelis, APA Monitor. https://www.apa.org/monitor/2010/02/translation
- Searight, H. R., & Searight, B. K. (2009). Working with foreign language interpreters: Recommendations for psychological practice. *Professional Psychology: Research and Practice, 40*(5), 444–451.
- *Dos and Donts: Guidelines for Clinicians Working with Interpreters in Mental Health Settings.* New York State Psychiatric Institute Center of Excellence for Cultural Competence. https://nyculturalcompetence.org/wp-content/uploads/2014/04/DosANDDonts_V5_4-22-14.pdf
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Questions?

Coming Home to Primary Care Pediatric Integrated Health Series

Last Friday of each month, 12-1pm Central Time

- March 26, 2021: Equity Considerations in Rural Communities and Reservations
- April 30, 2021: TBA
- Recordings will be made available

https://mhttcnetwork.org/centers/mid-america-mhttc/coming-home-primary-care-pediatric-integrated-behavioral-health

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