Improving Access to Mental Health Services Includes Breaking Down Language Barriers

Health Equity

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For the 25.1 million people in the U.S. who self-rate their ability to speak English as less than "very well," communicating with providers at the doctor's office can be a significant challenge. This is especially true for children with mental and behavioral health conditions. Last month, PolicyLab researcher and pediatrician at Children's Hospital of Philadelphia's (CHOP) Refugee Health Clinic Katherine Yun, MD, MHS, PolicyLab researcher and senior psychologist Marsha Gerdes, PhD, and Director of Language Services at CHOP Gabriela Jenicek had a commentary published in *JAMA Pediatrics* that outlines the challenges and opportunities to breaking down language barriers when delivering behavioral health services for children with limited English proficiency (LEP). We sat down with all three authors to further explore some of the main ideas in their commentary.

Q: The LEP community includes refugees and other immigrants who have fled armed conflict and persecution, survivors of natural disasters, and victims of anxiety surrounding immigration enforcement, which we all know can lead to mental and behavioral health conditions. What barriers do LEP children face when seeking services for behavioral conditions?

Dr. Gerdes: Just hearing you list the challenges that children and their parents who are immigrants or refugees face is a good reminder of the stress. We know that the impact of stress is huge on adults and children. LEP children are prevented from seeking services in a number of ways: the intake process, the unprepared mental health workforce and the challenge of finding willing service providers.

It really takes a very persistent and fearless parent, along with the support of the professional who refers them, to obtain services. Just think about the first phone call a patient makes to a provider—I have heard parents say that they got hung up on when they did not speak English. I have heard that parents were concerned when the first questions they were asked were about the child's documentation and insurance. When I have called or emailed behavioral health care providers on behalf of patients, I have heard them say "Oh, we don't have any bi-lingual staff" or "I think it would be better for the child and family to be sent someplace else" or "we are just not set up for that." When I have suggested the use of interpretation, either live, telephone or video, behavioral health care staff sound interested, but then back off by saying "we just don't have that ready."

In my work that involves developmental assessments of young children, I struggled to use interpreters until I sat down with my team to make a plan. In my work with toddlers and preschoolers, we had to think through lots of details like where the interpreter should stand, how to stay within guidelines of standardized testing and how to interpret for me, the family and the child in the same session. Once the program coordinators, the interpretation department, and the family understood when interpretation was needed and how an interpreter could work best with a toddler and the family, things went better. CHOP did a workshop specifically on the role of interpreters in

mental health treatment. Now, no matter who is arranging or doing the interpretation, we all have a shared understanding of the role of the interpreters—and why they matter.

Q: One of the most common solutions to overcome language barriers is to provide bilingual providers. What are the limitations of this approach?

Ms. Jenicek: There are many great benefits of bilingual providers, such as direct communication with patient and family and the ability to build relationships and trust. However, there are also limitations related to language proficiency and formal interpretation of simply using bilingual providers to improve language access.

Based on the Affordable Care Act final rule (Section 1557) that the U.S. Department of Health and Human Services (HHS) issued in May 2016, “bilingual/multilingual staff must demonstrate to the Hospital that they are proficient in English and at least one other spoken language, including any necessary specialized vocabulary, terminology and phraseology, and be able to effectively, accurately, and impartially communicate directly with individuals with limited English proficiency in their primary language.” That means that bilingual staff, including providers, need to be tested for language proficiency.

We also need to keep in mind that bilingual clinicians are not allowed or qualified **to interpret,** even if they have been tested for language proficiency. So if they are working with a bilingual psychologist or clinical social worker, LEP patients and families will still need access to qualified interpreters in order to communicate with front desk staff and other members of the care team.

Dr. Yun: In addition, one of the biggest barriers is that we simply don’t have enough bilingual mental and behavioral health providers. LEP families in the U.S. speak over 100 different languages. Bilingual care is not a realistic solution for everyone.

Q: As a provider, how have you seen telephonic and video interpretation services transform your ability to serve LEP patients with mental and behavioral conditions?

Dr. Yun: At the most basic level, telephonic interpretation is a literal "life line" for my patients. Without phone-based services, they wouldn't be able to call our clinic to schedule appointments or request advice. As a simple example, imagine being a parent who doesn't speak English but who worries that a new ADHD medication their child is on is causing some side effects. Being able to call your doctor's office right away is important, and telephonic interpretation makes that possible. For patients who speak selected languages, a program called "CHOP Speaks Your Language" is also particularly helpful. It connects them directly to an interpreter who can then help them navigate the often complicated, English-only phone answering messages and voice prompts used by many clinics.

It's pretty shocking, but I once had a provider tell me that they couldn't see a patient I had referred for behavioral health care because the office didn't have an in-person interpreter for their language and didn't have a contract for phone interpretation. I had another tell me that they didn't think any LEP kids needed mental health care, since they never scheduled appointments with them. Those really stuck with me. As providers, we can’t overlook the importance of having infrastructure and training for language access at each point of contact with patients and families, starting with the phone and the front desk. We need to pay more attention.

Video interpretation makes a huge difference once patients get through the door. For one thing, the service used by CHOP has very short wait times, access to many "rare" languages, and often allows you to work with the same interpreter across multiple visits. I now feel that I "know" some of our video interpreters, and it gives me a lot of confidence that communication is going to work well during the visit. I think patients and families also like seeing a familiar face, and I suspect that seeing body language and facial expressions makes a difference. For example, I've had many parents tell me that they feel rushed during phone interpretation: the interpreters are trying to help by speaking quickly, but this can intimidate some families. With the video, parents can tell that even when an interpreter may be speaking quickly, their facial expression is still patient and

unhurried.

At our clinic, the staff now joke that the video remote interpretation computer is my "best friend." It's silly, but it speaks to how much our staff and patients value these resources.

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