TeleBehavioral Health 501 Training Series

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Behavioral Health Institute (BHI)

Training, Workforce and Policy Innovation Center

The Behavioral Health Institute is a Center of Excellence where innovation, research and clinical practice come together to improve mental health and addiction treatment.

The BHI brings the expertise of Harborview Medical Center/UW Medicine and other university partners together to address the challenges facing Washington's behavioral health system through:

- Clinical Innovation
- Research and Evaluation
- Workforce Development and Training
- Expanded Digital and Telehealth Services and Training

The BHI serves as a regional resource for the advancement of behavioral health outcomes and policy, and to support sustainable system change.

Northwest Regional Telehealth Resource Center (NRTRC)

Telehealth Technical Assistance Center

The NRTRC delivers telehealth technical assistance and shares expertise through individual consults, trainings, webinars, conference presentations, and the web.

Their mission is to advance telehealth programs' development, implementation, and integration in rural and medically underserved communities.

The NRTRC aims to assist healthcare providers, organizations, and networks in implementing cost-effective telehealth programs to increase access and equity in rural and medically underserved areas and populations.

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Speaker Disclosures

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DISCLAIMER

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Working with Interpreters via Telehealth

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Attribution & Disclaimer

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Conflicts of Interest

- The presenters have no conflicts of interest to disclose.

Objectives

1

Define Language Access and why it is important for our work via telehealth

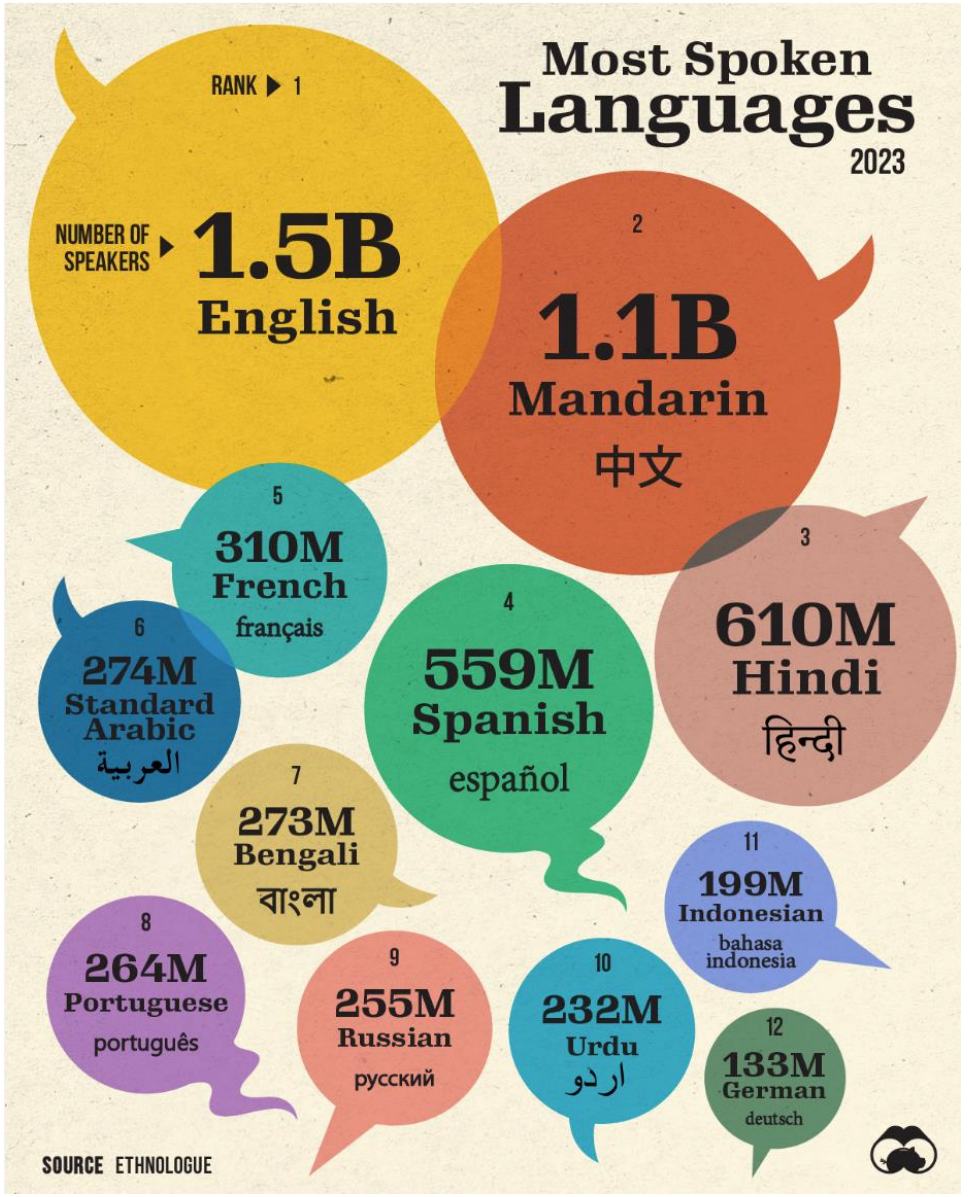
2

Describe the role of interpreters and types of interpretation

3

Offer specific tips and recommendations for working with interpreters via telehealth

Telehealth can still create disparities if we forget **Language Access**



Definition of Limited English Proficiency (LEP)

Individuals who do not speak English as their primary language and who have a **limited ability to read, write, speak, or understand English** may be Limited English Proficient, or "LEP," entitled to language assistance with respect to particular type of service, benefit, or encounter.

–U.S. Department of Justice

What is Language Access?

Language access consists of ensuring that persons who:

- have **limited or no English** language proficiency (LEP), or
- are **Deaf or Hard of Hearing**

…can access information, programs, and services at **an equitable (not just equal) level** to English-proficient, hearing individuals

Language Access Laws

https://jeenie.com/news/language-access-laws-comprehensive-guide/

Interpreter vs Translator

Interpreter

Someone who converts an ORAL or SIGNED message from one language to another.

Translator

Someone who converts a written text into another language, in WRITING.

Role of an Interpreter

Facilitate communication (“Conduit”)

Represent information accurately

Clarify understanding

Uphold confidentiality and ethical standards (e.g., HIPAA)

Serve as cultural brokers

Advocate when deemed necessary

Type of Interpretation

1. **Consecutive Interpretation**: Interpreter remains silent, listens to first speaker relay entire message; then interpreter relays the message to the second speaker in the appropriate language.
   - Most used in psychotherapy.
2. **Simultaneous Interpretation**: Interpreter relays the speaker's message while the speaker is speaking, following only a few words behind.
   - Emergency situations
3. **Sight Translation**: Requires that an interpreter read a document written in one language and then read it aloud in another.
   - Prescriptions, discharge summary, etc.
4. **Summarization**: When a person speaks for a lengthy time and with permission, summarizes key points of the message.
   - Not recommended in a mental health setting

Modality of Interpretation

- Phone-based Remote Interpreting
  - Call-in phone number (e.g., Language Line, Voice, etc.)
- Video-based Remote Interpreting
  - Connect via video within the videoconference platform or through a stand-alone app
- In-person Interpreting
  - An interpreter comes into the room with the therapist and interprets

*Interpreter Services Company should sign a confidentiality/non-disclosure agreement with the mental health organization prior to providing interpretation services for clients.

Phone-based interpreters via telehealth

1. Therapist calls interpreter services phone line via therapist's office phone or cell phone.
2. Interpreter services then calls the client and connects with the therapist via a 3-way call.
3. Therapist connects to client via videoconference platform (e.g., Zoom, Doxy.me, etc.).
4. Therapist and client see each other via the videoconference platform, but mute their microphones and speakers. The audio is heard through the phone.

Video-Based interpreters via telehealth

Connect via video within the videoconference platform

- Procedures will depend on the specific Interpreter Services Company used
- Therapist will provide a link to their videoconference therapy room or session and the interpreter will join via the link (i.e., 3-way video call with clinician, client, and interpreter)

Connect through a stand-alone app (e.g., Stratus Video)

- Can be loaded onto most computers, tablets, or smartphones.

Tips: Before the Session

- Call / connect with interpreter services first and orient interpreter to telehealth session
  - Using videoconferencing to connect to patient
  - Purpose of session
  - Length of session
  - Any therapy terminology you will be using
  - If you will be sharing docs from your screen – what are they

Tips: During the session

- Once you connect to client, orient them to using the interpreter
- Use short sentences
- Pauses between sentences (to allow interpret to interpret)
- Look directly at client when speaking (not at interpreter)
- Ask client if they can they hear interpreter clearly
- Avoid using jargon and overly complicated terms
- Avoid using slang & idioms (e.g., hit it out of the park)

Tips: After the session

- Document the use of interpreter services in your session notes
  - *Example: Client's primary language is Spanish. Session completed with assistance from Language Line. Interpreter Maria #246263.*
- Debrief with interpreter

Additional Tips & Recommendations

- If the patient does not answer the call:
  - Don’t hang up with interpreter, use them to help you leave a voicemail message
- Ask the interpreter for feedback

Only use **professional** interpreters

- Do **not** use clients' family members, friends or other community members to interpret.
  - Clinician can not be sure that their message is being delivered accurately
  - Client may be missing vital information
  - The act of interpreting for a loved one can be distressing for a family member or friend
- Using a child to interpret is particularly problematic because it can "parentify" the child, putting them in a position of taking care of their parent and disrupting the family hierarchy.

Important Considerations for deaf and hard of hearing populations

- Not all will utilize American Sign Language (ASL)
  - Example: Spanish speaking Deaf person
- Do not assume lip reading or written language is appropriate
- Consult with an interpreter with expertise in working with these populations
  - You may need to request a Certified Deaf Interpreter (CDI)- Interprets ASL to a more gestural communication that can be widely understood by people from various backgrounds
- You may need multiple interpreters (ASL→ CDI)
- Seek understanding of the client/family's cultural perception toward being deaf or heard of hearing
- Care to not make assumptions about cognitive abilities or diagnosis without proper access to language access

Table 2. Summary of interpretation and telehealth based challenges and recommendations to address challenges faced.

Challenges	Recommendations
Internet Connectivity	• Disable interpreter video, after they introduce themselves • Explore back-up or alternative telehealth meeting platforms • Provide patients with data hotspots for better supporting the connection with all three parties • Ask frequent questions and use summative statements to check for content comprehension
Building rapport	• At the first appointment, have a collaborative conversation about treatment misconceptions, prior interpretation experiences, feelings or concerns about using interpretation, and strategies to ease interpretation • Clarify the role of interpreters versus the therapist or others involved, such as case managers • Have the patients identify a virtual meeting space with minimal distractions • Disable interpreter video, after they introduce themselves • Frequently use summative and reflective statements, based on the information that is interpreted from patients, to help ensure that information is not lost through the interpretation process
Multiple Interpreters	• Have the interpreter introduce themselves and their role in maintaining the patients' confidentiality at the beginning of each session • Meet with the interpreter before each session to orient them to the case and get their input on anything that may support interpretation throughout the session • Meet with the interpreter at the end of each session to debrief on the session and discuss any difficulties the interpreter faced • Become familiar with your options for interpreter services, how interpreters can be scheduled, and the training and competency of available services

Gusler et al. (2022): Implementing Telehealth-Based TF-CBT with Support of Interpretation: A Case Study, Evidence-Based Practice in Child and Adolescent Mental Health, DOI: 10.1080/23794925.2022.2042875

Resources

1. National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care: https://thinkculturalhealth.hhs.gov/clas
2. *Gusler et al. (2022): Implementing Telehealth-Based TF-CBT with Support of Interpretation: A Case Study, Evidence-Based Practice in Child and Adolescent Mental Health* *https://www.tandfonline.com/doi/full/10.1080/23794925.2022.2042875*
3. Novotney, A. (2020). In other words: Psychologists increasingly work with interpreters to provide services to those who speak other languages or are hard of hearing: Here are the practical and ethical issues to consider. Monitor on Psychology, 51(1). *https://www.apa.org/monitor/2020/01/career-other-words*
4. Miller, A. B., Hahn, E., Norona, C. R., Treves, S., St. Jean, N., Gassen Templet, L., McConnell, S., Chang, R., Abdi, S. M., and Ford-Paz, R. (2019). *A Socio-Culturally, Linguistically-Responsive, and Trauma-Informed Approach to Mental Health Interpretation.* Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress
5. Best Practices for Mental Health Interpreters Working with Hispanic and Latinos Webinar- https://www.youtube.com/watch?v=fAI47G6V-24

Thank you!
Q&A

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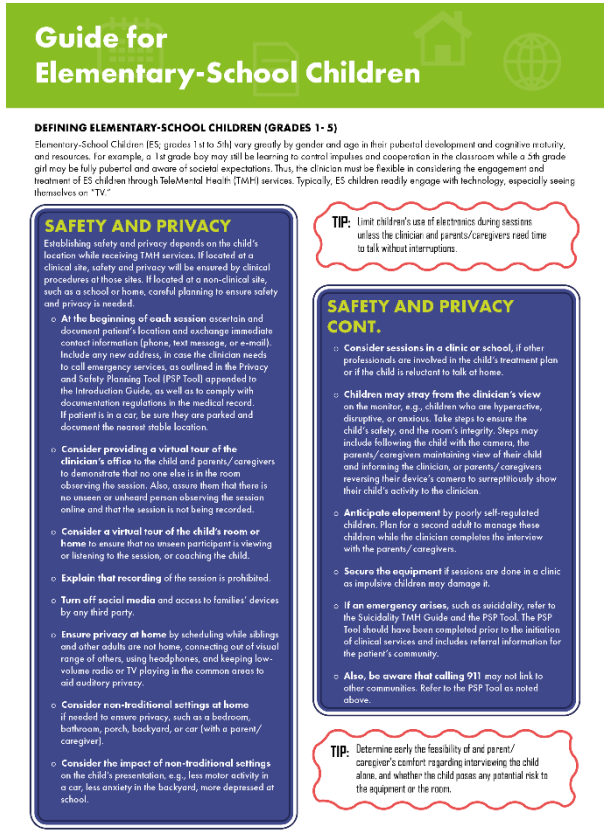
Additional Information & Resources

TeleMental Health Guides for Infancy to Young Adults

Guides (8)

- Infancy and Toddlers
- Pre-schoolers
- Elementary School Children
- Middle School Youth
- High School Teens
- Young Adults
- Neuropsychological Testing
- Suicidality



Guide for Elementary-School Children

DEFINING ELEMENTARY-SCHOOL CHILDREN (GRADES 1- 5)

Elementary-School Children (ES; grades 1st to 5th) vary greatly by gender and age in their pubertal development and cognitive maturity, and resources. For example, a 1st grade boy may still be learning to control impulses and cooperation in the classroom while a 5th grade girl may be fully pubertal and aware of societal expectations. Thus, the clinician must be flexible in considering the engagement and treatment of ES children through TeleMental Health (TMH) services. Typically, ES children readily engage with technology, especially seeing themselves on "TV."

SAFETY AND PRIVACY

Establishing safety and privacy depends on the child's location while receiving TMH services. If located at a clinical site, safety and privacy will be ensured by clinical procedures at those sites. If located at a non-clinical site, such as a school or home, careful planning to ensure safety and privacy is needed.

- **At the beginning of each session** ascertain and document patient's location and exchange immediate contact information (phone, text message, or e-mail). Include any new address, in case the clinician needs to call emergency services, as outlined in the Privacy and Safety Planning Tool (PSP Tool) appended to the Introduction Guide, as well as to comply with documentation regulations in the medical record. If patient is in a car, be sure they are parked and document the nearest stable location.
- **Consider providing a virtual tour of the clinician's office** to the child and parents/caregivers to demonstrate that no one else is in the room observing the session. Also, ensure them that there is no unseen or unheard person observing the session online and that the session is not being recorded.
- **Consider a virtual tour of the child's room or home** to ensure that no unseen participant is viewing or listening to the session, or coaching the child.
- **Explain that recording** of the session is prohibited.
- **Turn off social media** and access to families' devices by any third party.
- **Ensure privacy at home** by scheduling while siblings and other adults are not home, connecting out of visual range of others, using headphones, and keeping low-volume radio or TV playing in the common areas to aid auditory privacy.
- **Consider non-traditional settings at home** if needed to ensure privacy, such as a bedroom, bathroom, porch, backyard, or car (with a parent/caregiver).
- **Consider the impact of non-traditional settings** on the child's presentation, e.g., less motor activity in a car, less anxiety in the backyard, more depressed at school.

TIP: Limit children's use of electronics during sessions unless the clinician and parents/caregivers need time to talk without interruptions.

SAFETY AND PRIVACY CONT.

- **Consider sessions in a clinic or school,** if other professionals are involved in the child's treatment plan or if the child is reluctant to talk at home.
- **Children may stray from the clinician's view** on the monitor, e.g., children who are hyperactive, disruptive, or anxious. Take steps to ensure the child's safety, and the room's integrity. Steps may include following the child with the camera, the parents/caregivers maintaining view of their child and informing the clinician, or parents/caregivers reversing their device's camera to surreptitiously show their child's activity to the clinician.
- **Anticipate elopement** by poorly self-regulated children. Plan for a second adult to manage these children while the clinician completes the interview with the parents/caregivers.
- **Secure the equipment** if sessions are done in a clinic as impulsive children may damage it.
- **If an emergency arises,** such as suicidality, refer to the Suicidality TMH Guide and the PSP Tool. The PSP Tool should have been completed prior to the initiation of clinical services and includes referral information for the patient's community.
- **Also, be aware that calling 911** may not link to other communities. Refer to the PSP Tool as noted above.

TIP: Determine early the feasibility of and parent/caregiver's comfort regarding interviewing the child alone, and whether the child poses any potential risk to the equipment or the room.

TELEMENTAL HEALTH GUIDE FOR ELEMENTARY-SCHOOL CHILDREN

Case Example

Abdul is a 10 y/o Afghani refugee boy who presented with his mother due to the school's concern with his inattention and distractibility in class, restlessness and difficulty staying seated, yelling out answers impulsively, and falling behind academically. The Mother noted similar difficulties in the home, especially regarding homework. Both parents worked and lived in an urban neighborhood with poor transportation options, so they agreed to home-based TMH. The family used their smartphone for the sessions, with adequate, but not optimal, cell reception. Sessions were held in the parent's bedroom, for privacy. An older sister watched the siblings in another room or took them for a walk.

Abdul was readily engaged over the smartphone and told of his favorite videogame, his love of Legos, and his best friend at school, as well as the injustices of his siblings. The clinician conducted the interview by alternating between the mother's history and the child's input.

Even with the spotty connectivity, the clinician appreciated Abdul's good verbal skills, intellect, charming personality, as well his impulsive intrusiveness and mild mid-facial and guttural tic. To assess his gross motor skills, the clinician asked Abdul to do some movements, including some dance movements. He was awkward and had difficulty cooling down once wound up. To assess his fine motor skills, and to keep him occupied in order to obtain the mother's history, Abdul was asked to draw a picture of his favorite animal. He impulsively scribbled something and quickly returned to the smartphone to show his artwork: not an animal, but he enthusiastically told of its meaning, demonstrating his creativity and knowledge.

The clinician then asked Abdul to play with his Hot Wheels in front of his mother, allowing more time with the mother while monitoring Abdul. He did so, fairly quietly for a while, then became increasingly louder, and then disruptive. At various times, Abdul's mother quietly flipped the smartphone's camera to allow observation of Abdul's play without his knowledge. He did show symbolic play, although somewhat aggressive with the Hot Wheels breaking off some wheels.

Then, the clinician sent an ADHD rating scale and an anxiety rating scale to the older daughter's tablet so that the mother could complete these behavior reports in another room while the clinician spent some individual time with Abdul. The mother also logged into the school's website to check Abdul's grades, missing assignments, and the teacher's recent comments. Meanwhile, the clinician observed Abdul's play and engaged him verbally regarding his Hot Wheels. The clinician asked Abdul to trace his favorite Hot Wheel car and write the name of it along with his name on top of the paper. He showed some difficulties with tracing and penmanship but had correct spelling. He showed increased tic movements while engaged in this task.

The clinician made a diagnosis of ADHD with a concern about a fine motor disability and tics. They wrote a treatment plan on the "White Board" that included: a) the clinician requesting completion of behavior rating scales from selected teachers, to be uploaded into the clinician's website portal; b) making the child a "Focus of Concern" under Public Law 94-142 for further school evaluation and possibly special education services, and c) developing a structured plan for homework including turning it in reliably; and d) the mother reviewing the treatment plan on the website and reading information about ADHD treatment, including using behavior charts. As the family did not have a printer, the clinician also sent a hard copy of the treatment plan and readings. They made a plan for the mother to meet alone with the clinician in a week to set up a behavior program and discuss the relevance of a medication trial, consistent with evidence-based treatment for ADHD.

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uwcolab.org/tmh-guides

Additional Free Resources for Washington State Behavioral Health Providers

EDUCATIONAL SERIES:

- UW Traumatic Brain Injury – Behavioral Health ECHO
- UW Psychiatry & Addictions Case Conference ECHO
- **UW TelePain series**

PROVIDER CONSULTATION LINES

- **UW Pain & Opioid Provider Consultation Hotline**
- Psychiatry Consultation Line
- Partnership Access Line (pediatric psychiatry)
- Perinatal Psychiatry Consultation Line

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