

Early Childhood Behavioral Health Integration in Pediatric Primary Care

Serving Refugee Families in the Healthy Steps Program

Melissa Buchholz
Collette Fischer
Kate L. Margolis
Ayelet Talmi
University of Colorado

Abstract

Primary care settings are optimal environments for providing comprehensive, family-centered care to young children and their families. Primary care clinics with integrated behavioral health clinicians (BHCs) are well-positioned to build trust and create access to care for marginalized and underserved populations. Refugees from around the world are a growing population in primary care settings, presenting with unique needs and circumstances. Early childhood integrated BHCs (e.g., Healthy Steps [HS] specialists) can support these families and the medical providers who care for them. This article describes a refugee family and their young child who were seen by an HS specialist in pediatric primary care. Several themes emerge that are relevant to working with this special population in the context of pediatric primary care.

Pediatric primary care is an accessible, comprehensive, nonstigmatizing setting frequented by young children and their families early and often in life. Young children are typically seen for well-child care in the first few days of life and then a minimum of 11 recommended times over the first 3 years (Hagan, Shaw, & Duncan, 2008). Well-child visits offer prime opportunities to support young children's physical, emotional, and social health in the context of their families and communities. Primary care providers promote optimal development, considering multiple impacts on a child's well-being including environmental factors, behavioral health concerns, and psychosocial issues. Families in need of psychosocial support, including refugee families, are more likely to visit their child's pediatrician than they are to access behavioral health services in the community.

Behavioral health providers, integrated into primary care clinics, can augment and enhance routine medical care by extending the breadth and scope of primary care to include a focus on psychosocial well-being and behavioral health issues (Kaplan-Sanoff, Talmi, & Augustyn, 2012; Talmi, Stafford, &

Buchholz, 2009). Supports may include screening protocols (e.g., developmental, pregnancy-related depression; Health Team Works, 2014), case consultation (e.g., addressing specific concerns in the context of a medical visit), and health promotion/prevention activities (e.g., providing anticipatory guidance; implementation of the Healthy Steps for Young Children program, Barth, 2010). The combination of these activities creates a comprehensive medical home approach for young children and families, ensuring that their needs are addressed and coordinated.

Even families who are at risk for marginalization by traditional systems of care are likely to bring their young children to the doctor's office. Medical professionals align with traditional norms of most cultures, making accessing medical services a normative and destigmatizing method of seeking care for all aspects of well-being. Traditional mental health treatment, in contrast, is often less common or even stigmatized in many cultures, so families may be less likely to access these services. When a Healthy Steps (HS) specialist is integrated into primary

care, families are more likely to access behavioral health consultation services.

The refugee population is a group that is growing in size and is in need of appropriate, culturally sensitive, accessible, family- and community-centered care. Refugee adults come to this country with a myriad of experiences, many of them traumatic, that shape parenting experiences and approaches (Ater, 1998). The trauma that refugee parents experienced often has an intergenerational impact on their children (Miller & Rasco, 2004), potentially affecting attachment, parenting confidence, and behavior management.

Given the heightened psychosocial risk facing refugee families, often due to circumstances that qualified them for refugee status, this population has unique and complex support needs that are sometimes unavailable or difficult to access. As a result of poverty, language differences, isolation, and mental illness, refugee families face significant health disparities (Berry, Bloom, Foley, & Palfrey, 2010; Cacari-Stone, Viruell-Fuentes, & Acevedo-García, 2007; Semple, 2015). Medical homes, especially those that include behavioral health clinicians (BHCs), are uniquely positioned to address many of these health disparities (Becker Herbst, Margolis, Millar, Muther, & Talmi, 2015; Bunik & Talmi, 2012) and ensure the needs of children of refugee families are identified, addressed, and coordinated within families' communities. Above all, working with refugee families necessitates coordinating care across systems, creating a community "village" that attends to the importance of building supportive relationships around children and families.

The following example describes one refugee family's experience in their newborn infant's medical home. This story exemplifies the need for careful coordination and consideration of cultural nuances that impact the well-being of both the infant and the family. All names and identifying information about the family have been changed to protect patient confidentiality.

Asad's Story

Asad was a 5-day-old Somali boy who came to a primary care clinic for a newborn visit. His mother, father, and a Somali interpreter (provided by the hospital that houses the primary care clinic) accompanied Asad at this visit. Asad's medical provider was a first-year pediatric resident. The provider expected this visit to be straightforward: check his weight, review feeding and voiding, pregnancy-related depression screening, and review family's "questions or concerns." He was surprised to uncover a very complex situation: mother in severe pain from a cesarean delivery, breastfeeding difficulties, problems accessing resources (e.g., Woman, Infants, and Children [WIC]), and a family of refugees from Somalia who had limited social support. The provider was concerned about maternal mental health as Asad's mother was tearful and both parents seemed to have an endless number of questions. The provider struggled to address all of these things in the context of a 15-minute visit with the family. He saw a healthy baby but also knew that the family's complex psychosocial needs posed significant

risk factors to continued healthy development. In the interest of time, and recognizing that addressing these psychosocial needs was outside his scope of medical practice, the provider consulted with the HS specialists who were part of the care team. See the Key Concepts for Working With Refugee Families box for information on some of the methods, goals, and tactics the HS specialists use.

Key Concepts for Working With Refugee Families

While working with refugee parents with young children in the context of primary care, Healthy Steps (HS) specialists keep the following key concepts in mind:

Coordination With Medical Providers

It is essential to develop a coordinated approach to working with refugee families and to supporting the medical providers in managing the stress that accompanies the treatment of this population. The provider's decision to consult the behavioral health clinician (BHC) in this case offered both the family and the provider a comprehensive approach to treatment. Had the provider not consulted the BHC, critical information may not have been discovered.

Trust

Establishing trust with a refugee family is critical to successful treatment. This often occurs by providing continuity of care, listening to the family's story, being flexible with the family's needs, and helping with challenges the family may be facing. HS is designed to promote trust and enhance primary care services for all families and can be especially helpful for families with complex psychosocial histories.

Language and Interpretation

Refugee families have the right to communicate in their native/preferred language. Interpretation in the context of medical settings should convey both the intricacies of language as well as the cultural nuances of what is being communicated (Commonwealth of Massachusetts, 2010).

Parallel Processes

Parallel processes often occur when treating refugee families. Providers may experience isolation and desperation in their attempt to meet the needs of their patient while the refugee family experiences their own level of isolation and desperation. It is important to be aware of potential parallel processes to ensure that they don't negatively impact patient care.

Somatic Complaints

Refugee parents have often experienced unthinkable trauma. These experiences may result in increased somatic concerns and a search for explanations that potentially lead to increased health care usage.

Meeting Families in Their Homes

HS allows for home visits with families. Yet entering someone's home involves intimacy and trust. Introducing home visits to refugee families should be approached gently and with humility due to a variety of factors that may make trust of outsiders a challenge. Although it is an opportunity to meet the family in their natural environment, care must be taken to ensure that the family is comfortable with having someone outside of their community into their home.

Coordination With Providers Across Services and Sectors

Coordination with all providers involved in a refugee family's life is important and necessary when delivering care in a medical home. Providers might include social work, parent mental and/or physical health providers, social services, WIC, etc. It is also critical that all providers take into consideration the impact of the family's experiences on their decisions, reactions, and emotional responses.



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Well-child visits offer prime opportunities to support young children's physical, emotional, and social health.

After discussing the family's background with the provider and rest of the care team, the BHC met with the family. The HS specialist offered to enroll the family in the Healthy Steps for Young Children program (Barth, 2010), and they agreed to participate. The HS specialist began to develop a trusting relationship with the family in order to provide them with comprehensive services within the context of their medical home.

The HS specialist continued to see the family at Asad's second newborn visit and additional medical visits to monitor his weight over the next several weeks. The provider was concerned that Asad was not gaining weight quickly enough. The HS specialist learned more about the parents' refugee status, their exposure to civil war, and their time spent in refugee camps. Asad's mother's mental health history was also disclosed. His mother has struggled with posttraumatic stress disorder for many years and had been receiving psychiatric treatment from a community provider for several years. The HS specialist noted that connection to mental health services was a strength, especially considering the complex system of care that refugees must navigate in order to obtain such services. The parents also disclosed a history of infertility and feelings of exuberance over the birth of their new baby—another strength. However, their excitement was clouded by Asad's mother's "stabbing pain" and "weakness in the legs" that had been worsening since the delivery. Holding in mind (a) the pediatrician's urgent concern (Asad's poor weight gain) and (b) Asad's mother, who often choked back tears and grimaced in pain, the HS specialist was motivated to address both concerns in the context of medical visits. The family disclosed that they have

not been successful in scheduling an appointment with the mother's physician, stating that the schedulers they had spoken with did not seem to appreciate their urgent concerns. Language barriers also seemed to be creating a challenge. During Asad's second newborn visit, the HS specialist worked with the live interpreter, provided by the hospital, to help the family schedule a same-day appointment with mother's physician.

Although the live, hospital-provided interpreter was helpful in coordinating care, the more nuanced parts of the discussion—interpretation of medical, cultural, and psychological themes—were often difficult for the parents, interpreter, provider, and the HS specialist to communicate with clarity. Phrases often needed to be repeated, rephrased, and clarified. For the HS specialist, who had worked extensively with interpreters in the past, the flow of communication of this visit felt especially complex. At a time when the need for careful communication is critically important, the HS specialist worried that this interpreter was incorrectly interpreting cultural themes. The interpreter oftentimes seemed disconnected in the room and did not appear to interpret what the parents were saying in full. When asked to provide cultural interpretations, the interpreter struggled with his role as cultural broker, causing many cultural nuances to feel unclear. Asad's parents seemed to rely more on their conversational use of English, but it made for less of an in-depth discussion. Above all, however, words were not needed for the HS specialist to begin to understand and connect with these first-time parents' mixed experiences: exuberance, somatic pain, and anxieties, all which punctuated the visit.

The conversation shifted to a discussion about how feeding was going. Again tearful, the mother explained that—despite previously working with lactation consultants—she was not producing enough milk and was mourning the loss of her expectation to breastfeed. The HS specialist helped the mother name this as a loss and empathized with the difficulty of having to feed and bond with the baby in a different way than planned. Both mother and father had many questions about how to bottle feed. They were unsure about what type of formula to buy and did not have a clear understanding about how to use WIC. Again, with the help of the interpreter and through communication with the WIC specialist, the HS specialist clarified that the family would have to return the breast pump provided by WIC in order to start receiving formula and helped them schedule a next-day visit with WIC. During a clinic visit, the HS specialist watched as the parents demonstrated mixing the formula and reassured them that they were doing it correctly. At each visit, Asad's parents thanked the HS specialist and provider profusely for their time and support. They were comfortable enough with conversational English that the interpreter did not need to translate the spoken good-byes. They often left the clinic smiling and nodding, suggesting increased parental confidence and competence about the next steps. The HS specialist reflected on a parallel process as she herself felt confident and competent in having provided Asad's pediatrician and parents with support during office visits and having connected the family to outside services.

In the weeks that followed, Asad, his family, and the interpreter returned to the clinic for regular weight checks. His parents started to show concerns about bowel movements and worried about constipation. They required multiple reassurances that his stooling patterns were typical and were coached about the frequency and amount of feedings as a priority for his healthy growth and development. Asad's physicians noted that his weight gain was less than optimal and required more frequent weight checks. With each weight check, the HS specialist spoke with the provider and the family, each time hearing concerns about constipation from the parents and concerns about weight gain from the pediatrician. At one point, Asad's mother shared her greatest worry with the HS specialist—that Asad's constipation was causing him terrible pain and that his stomach would "explode." The HS specialist wondered what the mother's fear that her baby's stomach would "explode" could mean for a woman who has experienced significant trauma in war, refugee camps, and moving and adapting to a new country. Both parents seemed increasingly worried with each visit. They did not understand why the doctors were not using medicine to fix the constipation and pain that their son was experiencing. The provider and HS specialist, with the help of the interpreter, tried to help the family understand the baby's condition as "fussiness." The parents insisted that Asad was constipated and were reluctant to explore soothing techniques, other than medication.

Meanwhile, the HS specialist consulted with the provider and learned that he was growing more and more concerned about Asad's poor weight gain. Thorough exams suggested that there were no physical reasons for his somewhat atypical stooling patterns. His poor weight gain was concerning but did not reach the level of requiring hospitalization. The resident confided in the HS specialist that of the many patients he followed, this was the only one who kept him up at night. He and the HS specialist wondered together about how the parents' concerns of constipation may have impacted how they fed him. Of the many worries that the parents expressed in the past, one was about the possibility of overfeeding Asad. The parents demonstrated an understanding of proper feeding techniques. Still, questions remained regarding how the parents' worries were impacting feeding at home and what might be getting lost in cultural and linguistic translation.

Over the next several weeks there was an increase in sick visits to the primary care clinic combined with almost weekly visits to the emergency room for concerns about constipation. Asad's mother presented as completely exhausted at clinic visits and the parents repeatedly asked for help—medicine for Asad and someone like a midwife to provide on-going respite. Asad's parents had limited social support because much of their family were separated and lived in other parts of the world. The HS specialist consulted with the clinic's social worker to determine if respite support was available. The parents rejected child care options and were resistant to participating in a home visiting program where a stranger would come to their home for an hour each week. They explicitly requested more intensive, round-the-clock care. The HS specialist and clinic social



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Parenting a newborn is a challenge, especially when the child exhibits fussiness, poor weight gain, and feeding and/or voiding challenges.

worker informed the family that, unfortunately, such services were not available to them. The HS specialist reflected on how this family, new to this country, may interpret the lack of support available to them as an unwillingness of the system to support them.

In her capacity as an HS provider, the HS specialist considered the opportunity to plan a home visit with the family to further explore their experience of parenting. The HS specialist was aware that a home visit would not allow for interpreter services and thus would rely on Asad's parents' conversational use of English. The HS specialist suggested the home visit option to Asad's parents, explaining, and apologizing, that an interpreter would not be present, and they were agreeable. Although they were resistant to starting a new home visiting program with an unfamiliar provider in the community, they were more open to the idea of welcoming a familiar provider that they trusted into their home. The HS specialist considered carefully the benefits and risks of providing a home visit without the support of an interpreter and ultimately decided that the benefits to the family outweighed the risks. The family had become comfortable with her at their frequent visits in the clinic, and she believed that this relationship would help buffer language barriers.

At the home visit, the HS specialist first met with the father and Asad, as mother was on her way back from her own doctor's visit. The HS specialist used plain language and pictures to converse about Asad's development thus far, while the baby slept nearby. Through his conversational English, the father and the HS specialist were able to communicate. His beaming smile told it all as he discussed the couple's struggles with infertility and how Asad was an unexpected blessing for him and his wife. When Asad's mother returned she was smiling and seemed at ease in her own home. Her health had improved after more regular visits with her own doctors. She described enjoying being home with the baby—but that it was also hard work for her, as the baby kept her busy throughout the day (feeding, repositioning, changing diaper, sleeping). As the home visit concluded, the HS specialist reflected on relationship building,

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trust, continuity, and the importance of using humor to break down linguistic and cultural barriers.

Several weeks later the family continued to express concern about constipation and reported an increase in crying from Asad. The HS specialist offered to do another home visit, this time with a specific focus on the fussiness. Again, this visit was conducted without an interpreter. The atmosphere of this visit was much less positive than the first. The mother could not look at Asad and held intense worry all over her face. The mother was clearly overwhelmed by her role as a new mother and was not confident in her ability to meet Asad’s needs by herself. The HS specialist explored maternal mental health during this visit and learned more about Asad’s mother’s psychiatrist. Mother smiled as she disclosed details of her long-term work with this psychiatrist, a professional highly respected by both parents. The HS specialist suggested future communication with the psychiatrist for care coordination and the parents agreed. The HS specialist obtained a release of information at a later clinic visit when an interpreter was present. At the end of this home visit the HS specialist reflected on the feelings of worry and the look of terror in mother’s eyes whenever Asad became fussy. The HS specialist wondered about a history of loss and how crying may have triggered past experiences.

The HS specialist reached out to Asad’s mother’s psychiatrist and learned more about her history; exposure to trauma, isolation from her community, and chronic somatic complaints. They discussed the potential benefit of connecting Asad and his mother with a dyadic therapist who could support the mother with connecting with her infant in supportive and nurturing ways. In addition, the HS specialist and the psychiatrist discussed challenges with interpretation for this family. The psychiatrist shared information about the interpreter she used when meeting with Asad’s mother. The HS specialist reached out to the hospital’s interpretation services and the director was very invested in making sure this family had access to an interpreter who would adequately interpret sensitive and critical conversations in the context of Asad’s medical visits. They were able to work together to request that the same interpreter

the mother used for her psychiatry appointments would also attend Asad’s visits in the pediatric clinic.

In the weeks and months that followed, Asad’s visits to the clinic appropriately reduced. Both parents’ anxiety about constipation had decreased, and they were feeling more confident as new parents. This change was likely due to support from the mother’s therapist and the HS specialist working with the family. He and his parents arrived for his 4-month well-child visit and the parents were visibly more relaxed and engaged with Asad. His parents attributed these improvements to his mother’s increased psychotropic medications, less constipation, HS specialist home visits, and visits from out-of-town relatives. The interpreter the family had used at mother’s psychiatrist appointments accompanied them to these clinic visits—an interpreter who appropriately communicated medical information to the family and helped the medical providers decode cultural nuances of the family’s questions and concerns. The HS specialist continued to work on arranging dyadic treatment for Asad and his mother (using appropriate interpretation services so that treatment can occur in her preferred language), knowing that her trauma history will likely impact her relationship with Asad as he continues to grow and develop. The HS specialist continued to support the family and build a trusting relationship, keeping in mind their complex history. She also provided support to the medical home and to residents and attending physicians who provided medical care for Asad, emphasizing the importance of using a trauma-informed lens to provide care while always considering their refugee status and immigration history.

Conclusion

Asad and his parents’ experiences are not unique. This story describes a refugee family attempting to parent their first child in the context of an incredibly complex psychosocial environment: history of trauma, mental illness, current disparities, and community isolation. Parenting a newborn is a challenge, especially when the child exhibits fussiness, poor weight gain, and feeding and/or voiding challenges. Parenting as a refugee presents a host of additional challenges that may amplify struggles that first-time parents may experience. Some of these challenges may include, but are not limited to, a history of previous trauma and loss, minimal resources for obtaining supports, isolation from family and country of origin, barriers to relying on family supports, and acculturation. Therefore, it is essential to surround refugee families with support that is comprehensive, culturally informed and responsive, family-centered, community-based, and accessible.

Pediatric primary care is an optimal setting for offering support to refugee families in a trusted environment. Although refugee families may need to access care and services from many different agencies and organizations, primary care settings can help coordinate services and facilitate navigation of a complex system of care. In addition, primary care settings with integrated early childhood BHCs are uniquely suited to serve as a medical home (Talmi et al., 2009). As was the case with Asad’s

family, BHCs can spend additional time with a family during clinic visits, uncovering important components of their history that will certainly impact parenting. Further, the Healthy Steps for Young Children program (Barth, 2010; Buchholz & Talmi, 2012) takes a strength-based, health promotion approach, which is especially helpful to families who are marginalized, isolated, and lack access to care. The infant mental health approach is inherently culturally sensitive (St. John, Thomas, & Noroña, 2012) and can provide a framework for cultural responsiveness with refugee families.

Numerous themes emerge when working with refugee families: coordination with medical providers, language and interpretation, parallel processes, somatic complaints, meeting families in their homes, and coordination across services and sectors, to name a few. It is critical to serve these families in the context of their communities while keeping in mind complex past experiences, present challenges, and future plans. It is easy for providers to become overwhelmed with the complexity of serving refugee families, yet it is also important to be mindful of the many strengths and resilience factors that families possess. Resiliency was certainly a factor with Asad's family, and this was critical to keep in mind as "the village" worked together to provide high-quality care and to promote Asad's growth and development in the context of his family.

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Learn More

Websites

Healthy Steps for Young Children
www.healthysteps.org

EthnoMed: Integrating Cultural Information Into Clinical Practice
www.ethnomed.org

Centers for Disease Control and Prevention
Guidelines for Mental Health Screening During the Domestic Medical Examination for Newly Arrived Refugees
www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/mental-health-screening-guidelines.html

Melissa Buchholz, PsyD, is an assistant professor in the Department of Psychiatry at the University of Colorado School of Medicine and is a supervising psychologist in the Child Health Clinic at Children's Hospital Colorado. She is the director of the Healthy Steps program in Colorado and is responsible for the expansion of the program across the state. She also directs the Healthy Steps program at the Children's Hospital Colorado. She is faculty with Irving Harris Program in Child Development and Infant Mental Health at the University of Colorado Denver. She is interested in the integration of mental health into primary care settings and, more specifically, on practices that promote health and early intervention for young children and their families in the context of pediatric primary care.

Collette Fischer, PhD, is a postdoctoral fellow with the University of Colorado Denver's Irving Harris Program in Child Development and Infant Mental Health. She has extensive experiences in early childhood development and mental health, including an infant mental health predoctoral internship at the Institute for Child and Family Health in Miami, Florida, and graduate-level clinical training and research at the University of Wisconsin-Madison. Currently, she is working with Project CLIMB/Healthy Steps, along with other interdisciplinary teams affiliated with the University of Colorado Denver and Children's Hospital Colorado.

Kate L. Margolis, MS, PhD, is an assistant professor of psychiatry at the University of Colorado Denver School of Medicine and a bilingual pediatric psychologist at Children's Hospital Colorado. Dr. Margolis is a supervising psychologist for the integrated behavioral health program within the pediatric primary care training clinic at Children's Hospital Colorado where she directs the Mi Bebé y Yo group for Spanish-speaking caregivers and their infants and provides services to families with children birth to 3 years old as a specialist in the Healthy Steps for Young Children program. Dr. Margolis' clinical and research interests include culturally sensitive integrated pediatric primary care, infant and early childhood mental health within primary care, and the recruitment/retention of Spanish-speaking health care trainees and professionals. She is involved in systems/advocacy work related to health care reform, and specifically promoting the integration of mental health in pediatric primary care medical homes.

Ayelet Talmi, PhD, is an associate professor of psychiatry and pediatrics at the University of Colorado School of Medicine. Dr. Talmi is the program director of Project CLIMB, an integrated behavioral health services program in pediatric primary care. She is the associate director of the Irving Harris Program in Child Development and Infant Mental Health. Her research and clinical interests focus on early childhood mental health in pediatric primary care settings and on systems of care for babies and young children with special health care needs. Dr. Talmi is a graduate ZERO TO THREE Leaders for the 21st Century Solnit Fellow.

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