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Abstract

Identifying and determining the language competence of bilingual social workers and other medical providers has not been a priority among medical systems, both in the United States (USA) and globally (Jih et al., 2015; Quan, 2010; Rubin, 2016). This manuscript and literature review will focus on bilingual social workers in the United States, their challenges in meeting the needs of clients with limited English proficiency, and emerging themes of language competency and ethical service delivery.

Introduction

In the United States, an estimated 80% increase in populations with limited English proficiency (LEP) occurred between the years of 1990 to 2015, representing roughly 26 million individuals (Ryan, 2013; U.S. Census Bureau, 2015, 2017). More recent statistics indicate over 65 million USA residents speak a language other than English at home (Zeigler & Camarota, 2017). The magnitude of growth creates complexities contributed to by language barriers and the paucity of operational guidelines addressing service delivery to those with LEP (Arroyo, 2019). The provision of care is more daunting when added challenges to service quality are complicated by language competency, legal adherence, and other ethical considerations (Cook et al., 2013).

Responding to the language needs of people seeking medical services is a federal mandate in the USA (Exec. Order No. 13166, 2000). People with limited English proficiency (LEP) requesting medical services in their preferred language have the right to be offered language services by qualified and certified translators or interpreters. Decisions about language competence among bilingual medical providers have been based on external, bidirectional, and implicit perceptions of language skills. Without a specific metric to quantify or qualify language competency, aptitude to deliver bilingual services is merely assumed for various reasons. For social workers, such assumptions lead to ethical challenges which intersect assessment, treatment, and disposition protocols.

Bilingual social workers need to consider and evaluate their language skills and advocate for the language needs of people who are LEP. The recognition of discrete differences between social and professional language competence leads to addressing language complexities among bilingual social workers. For social workers demonstrating competency in social and professional language, equitable compensation needs consideration to address power differentials across micro, mezzo, and macro systems.

In the past ten years, the idea of providing holistic medical care has promulgated the interdisciplinary literature. For certain we have established that integrated health care is more effective, efficient, and beneficial to people seeking medical services as well as for medical organizations and medical providers (Coventry et al., 2015). Holistic care encompasses interdisciplinary teams from medical clinicians, pharmacists, and nursing, but for this piece the focus is on social workers. Creating conceptual intervention plans for medical care makes sense, but implementing these models often poses challenges with resource allocation, training and language skills competence of medical providers, and sustainability of integrated services (Fairburn & Cooper, 2011). One specific challenge for effective integrated healthcare is language and language competence.

What exactly is language competence, how is it assessed, and who is monitoring compliance? Bilingual social workers using two languages to provide social work services must clearly understand all of the six NASW (2015) Ethical Standards but particularly NASW's Ethical Standard 4 – Social Workers' Ethical Responsibilities as Professionals, Standard 4.04 – Dishonesty, Fraud, and Deception and Standard 4.06 – Misrepresentation. Regarding bilingual social workers, then, clear operational definitions of terms such as bilingualism, language

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competence, language proficiency, and language fluency must be established. One of the aims of this manuscript is to increase awareness among bilingual social workers to assess their language skills to align with "competence" in bilingual social work practice. Another aim of this manuscript is to discuss the professional needs of bilingual social workers and provide guidance to change oppressive systems preventing professional growth. To frame this discussion, the results of research focused on language self-efficacy and ethical-professional needs of bilingual social workers will be reported in a later section.

In subsequent sections, we expand on concepts related to stated aims of increasing awareness for bilingual social workers and language competencies, of pertinent professional needs, and recommended guidance for professional growth toward goal attainment. Relevant notions and impressions regarding language self-efficacy in practice and the use of ethics language introduce foundational concepts often taken for granted as seen in research. The discussion of bilingualism in social work and its importance to best practices ensue and support the authors' objectives.

Continued discourse parses the discrete differences in past approaches with distinctions made for translation and interpretation, as well as their appropriate applications. To highlight some ethical implications, a section clarifies the added need to protect clients with LEP and the industry standards to which social workers are beholden. Finally, recommendations construe responsibilities and professional needs at various strata to include the individual practitioner, their employers, the profession and related organizations, and educational considerations.

Language Self-Efficacy and Ethics Language

Language self-efficacy is the process of self-evaluating one's language skills. A study by Arriaza (2015) showed that although most of the 302 participants rated their writing and verbal skills in a language other than English fairly high, the majority of the participants reported questioning their language skills in professional settings. This specific finding is important because it directly intersects ethics. This intersection, however, is often implicit because unless the perceived bilingual social workers' language skills have been questioned, the brief awareness of language self-efficacy is overshadowed by the reward of communicating with another person in a different language. These dynamics are reinforced by others behaviorally, cognitively, and emotionally.

Similar studies have since echoed the doubt some bilingual mental health students have in their language self-efficacy (Alvarado et al., 2019). Through this study, 11 participants described their experiences as bilingual student counselors, most of them rating their self-confidence low for bilingual client interactions compared to the same students' practical sessions in English. Contributing factors included lack of resources, unfamiliarity with various nuances of same-language peoples from differing cultures, and the absence of bilingual education toward professional aims.

The therapeutic alliance is fostered when attunement and engagement have the benefit of better communication. Through such alignment, the clinician assesses, implements, and evaluates the systems or domains from a client-centered approach. There is better understanding of presenting issues and potential causal relationships through the holistic lens and the application of the biopsychosocial model (Henningsen, 2015). Added complexities arise in the presence of language barriers. There is value in having a bilingual social worker at an agency or hospital, for example, but such value must be connected to language proficiency. Ethical considerations emerge when bilingual social workers do not assess or evaluate their language skills to work in a language other than English. The same, of course, applies to the places of employment hiring perceived bilingual healthcare providers.

Ethics can simply be defined as rules that guide social workers to protect people and to do what is right and what is wrong. The challenge is that unless social workers are engaging in ongoing supervision, these guidelines to determine what is right and what is wrong go unnoticed and undiscussed by perceived bilingual social workers. Thereby, ethics direct social workers to make difficult decisions. These decisions can be much more difficult to make when a language barrier exists and specifically when language skills among bilingual social workers have not been established. It is unfair to expect bilingual social workers to include yet another layer to their already high caseloads, busy

schedules, and complicated cases.

Arroyo (2019) conducted a study of bilingual participants that included social workers from Spanish and American Sign Language backgrounds. Some complications of linguistic barriers and access to qualified bilingual providers resulted in adverse outcomes, including two deaths. In part, the scarcity of bilingual social workers and other health care personnel contributed to gaps in practice. However, recruitment in areas less populated by clients with LEP is challenging (Olcon et al., 2018). Additionally, there is no incentive currently, despite increased caseloads with added administrative tasks. The *Code of Ethics* (NASW, 2017) entreats social workers to actively engage in research, training, and the dissemination of knowledge, but too little is available regarding the support and training of bilingual social workers.

For social workers identifying as bilingual, an explicit call is being made to have their language skills assessed. Providing services in a language other than English in the United States requires language proficiency. Many language organizations are focusing on applied linguistics that are well-positioned to assess speaking, writing, reading, and listening language skills. Malpractice and ethical issues surface when social workers practice outside of their standards of practice.

Specific to social work practice within integrated teams, mental health clinics, community hospitals, emergency departments, and private practices, the essentiality of assessing the language preference of patients is not simply important, but it is an ethical imperative (Weisz et al., 2015). The same applies to bilingual social workers using a language other than English to provide social work services. The profession of social work has been based on the values of service, social justice, dignity and worth of the individual, importance and centrality of human relationships, integrity, and competence (NASW, 2017). These values provide a guide for social workers' conduct. Given that this code of ethics serves as "guidance," it can be open for personal interpretation. For example, although the word "competence" is mentioned 13 times in the NASW's (2017) Ethical Standards, lack of operationalization and measurable outcomes increases ambiguity and the potential for malpractice.

As already discussed, language is a complex, flexible, socially constructed phenomenon. Within integrated healthcare systems, it is essential to explore and understand the common language being used by the interprofessional team as well as the language being used to interpret and translate such medical services to the consumers. This becomes even more worrisome and problematic when the consumer is identified as having limited English proficiency (LEP). Medical service provision to people with LEP is often fragmented and inefficient because of language barriers (Durbin et al., 2017).

These language barriers are grounded in power differentials between patients and medical providers, fast-paced medical care systems, lack of effective and sustainable language resources, and integrated team members regularly used as expert translators and interpreters. Also, inadequate communication between patients with LEP and medical providers has been linked to lower access to healthcare (Smith, 2009; Derose & Baker, 2000). For 20 years researchers have established that patients with LEP report fewer physician visits and lower use of preventive care after controlling for factors such as health insurance, literacy, having a regular medical provider, and socioeconomic characteristics (Jacobs et al., 2001; Sarver & Baker, 2000; Smith, 2009; Woloshin et al., 1997).

The need to further understand bilingualism among social workers is also grounded in the increased numbers of people speaking two or more languages in the United States. In 2016, the Center for Immigration Studies reported that the 2016 Census Bureau data showed that approximately 65.5 million United States residents spoke a language other than English at home. Specific to Spanish-speaking, the Census Bureau data showed that in 2016 a total of 40.5 million people spoke Spanish at home. When people seek medical services, researchers have established that the majority prefer language-concordant healthcare providers because trust is enhanced between the patient and the healthcare provider (Jih et al., 2015). However, as previously stated, language competence is not operationalized simply by stating that someone speaks another language. Language competence intersects culture, generation, acculturation, assimilation, and education.

Regarding education, for instance, it is

important to acknowledge that in the United States, the majority of healthcare providers learn, process, and retain professional knowledge in English. After all, most of these healthcare workers have completed their education and training in English. Taking technical and professional information from English and processing it in another language requires training and experience in translation and/or interpretation. Cultural variations of meaning also contribute to communication challenges. Words may have different meanings across cultures, countries, generations, and education.

The word "guagua" for example in Chile has been used for "baby" but in many Caribbean countries the word "guagua" is used for "bus." Bilingual proficiency requires ongoing education, training, and clinical supervision for professional growth. Supervision in bilingual social work requires the supervisor to have professional language competency in tandem with the supervisee and, of course, the client (Perry & Sias, 2018; Verdinelli & Biever, 2009). Bilingual graduate social work students, for example, experienced frustration and added burdens to their knowledge attainment when managing bilingual clients but without bilingual supervision (Arroyo, 2019; Lopez & Torres-Fernandez, 2019).

To state that a social worker, for example, is bilingual is simply insufficient. Social workers who speak another language and would like to use their second language in social work practice must seek and secure specialized training to be qualified translators and/or interpreters (Lusk et al., 2014). Procuring such language qualifications is essential to respecting patients/clients/ consumers' civil and human rights.

The rationale for explicitly discussing bilingualism in social work practice and specifically addressing the professional needs of bilingual social workers originates from a review of the literature where this issue has not been appropriately addressed. Castaño et al. (2007) discussed perceptions of over 100 Spanish-speaking clinicians who desired more formal training regarding bilingual service delivery. Studies and narratives have documented the need to understand the use of language in social work practice (Engstrom et al., 2009; Engstrom & Min, 2004). However, research has primarily focused on language abilities among service seekers and not explicitly on the language skills of the providers (Acevedo et al., 2003).

In fact, the earliest account found in the literature regarding bilingualism dates back to 1997 when Musser-Granski and Carrillo discussed the use of paraprofessionals in mental health services and in 2013 when Arroyo (2019) discussed language self-efficacy among bilingual social workers. These authors specifically discussed issues for hiring, training, and supervising paraprofessionals but not licensed or professional social workers. Very little has been written about language competence among bilingual social workers (Arriaza, 2015).

Perhaps the challenge has been that in the United States, bilingual social workers have been perceived as being linguistically competent in both English and in a second language (Marrs Fuchsel, 2015). We have not been socialized to question language competence in social work practice. This perceived bilingual competence happens in a bidirectional and implicit manner and without questioning language skills. Both the social worker and the person making such assumptions have an equal responsibility to examine claims of language competence. Questioning language skills is an ethical imperative.

However, because these assumptions are often implicit, mechanisms to explicitly assess the language competence of social workers, for example, have not been explored or rarely discussed upon employment offers. Thus, perceived language competence without attesting to such competence can be dangerous. Despite federal policies requiring medical systems to provide qualified interpreters and translators for people identified as LEP or for people requesting to have services provided in their preferred language, gaps in services continue to exist (Smith, 2009).

Interpretation versus Translation

The words interpretation and translation have commonly been used interchangeably to describe some kind of language process or language event. Many false assumptions have been made regarding these terms. In fact, these terms are operationally and academically different. The main difference between interpretation and translation is in the delivery. Interpretation involves a process of facilitation of meaning in a verbal or sign language manner. Interpretation

involves real time meaning.

Although there are various types of interpretation, simultaneous and consecutive interpretation are perhaps the most relevant to the discussion of the ethics of bilingual social work practice. Simultaneous interpretation takes place when an interpreter attempts to translate another person's messages in real time and as quickly as possible. The interpreter and the person speaking are often hearing speaking at the same time. Conversely, consecutive interpretation is the process where the interpreter collects verbal or sign language information and pauses in between messages to interpret. At times, the interpreter may take notes or coach the person communicating in a different language to stop at various intervals to provide the interpreter with an opportunity to deliver content effectively.

On the other hand, translation is the process of taking content in one language and documenting the meaning in another language in written formats. Without a doubt, it becomes apparent that both simultaneous and consecutive types of interpretation require different skills, expertise, and education. Universities across the United States offer undergraduate and graduate degrees to scholars interested in pursuing a degree in language-related skills. In recent years, medical interpreters and translators have been involved in research to determine best practices.

Researchers Hsieh and Kramer (2012) determined that a utilitarian approach to interpreters' roles and functions became counterproductive and dangerous and instead recommended for medical interpreters to be perceived as active members of the treatment team. These researchers also recommended perceiving interpreters as "smart technology (rather than passive instruments)" (Hsieh & Hong, 2010, p. 158). Moving away from this utilitarian approach to a more active and strengths -based approach will require conscious awareness to clarify the roles that interpreters and translators play in biopsychosocial and spiritual care.

Protection of People with Limited English Proficiency

Title VI of the Civil Rights Act of 1964 prohibits discrimination against people based on national origin, and it includes language discrimination. Federal mandates require organizations and medical providers to receive federal funds to provide language services. Recent efforts to protect the rights of people identified as LEP also include the U.S. Department of Health and Human Services National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) first printed in 2001 and revised in 2014 (Estrada & Messias, 2015). In 2000 former President Bill Clinton issued Executive Order 13166 "Improving Access to Services for Persons with Limited English Proficiency" (Arroyo, 2019).

In 2010, Section 1557 of the Patient Protection and Affordable Care Act (ACA) was enacted to "prevent discrimination of people on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities" (HHS, 2022, p1), and it provided protection for individuals identified as LEP. Section 1557 of the ACA was important because it shifted the language from providing "competent" interpreters to "qualified" interpreters.

In the United States, these federal mandates and other mezzo-level policies provide direction to medical organizations to respect the rights of people identified as LEP by securing qualified interpreters and translators. Unfortunately, these language services have not been provided consistently or even delivered by qualified interpreters or translators (Canenguez & Nunes, 2016). It has been reported that one third of hospitals in the United States are not currently providing language services (Schiaffino et al., 2016). Between 2005 and 2009, 33 malpractice medical cases were identified by California's School of Public Health research (Quan, 2010).

Researchers reported that in these cases, healthcare providers had failed to give patients access to competent interpreters and that the language barrier was involved. Specific to social work practice, providing biopsychosocial and spiritual care in the patient's preferred language becomes an ethical matter. Oftentimes, social workers are involved in life-or-death decisions such as in emergency departments, hospices, crisis situations, and advanced care planning. When a language difference exists between a patient and a social worker and language services are not considered or offered, ethical situations can emerge when such perceptions are not examined or questioned by both the observer and the social worker who is perceived as bilingual.

The perception is bidirectional, with first the social worker perceiving their bilingual language skills as proficient enough to deliver biopsychosocial services in two languages. This perception also originates externally by individuals, groups, and organizations perceiving other people who speak another language as being bilingual. These decisions regarding language competence are regularly made implicitly without evidentiary conclusions of actual language competence. There is a need to understand implicit dynamics and power differentials existing within the boundaries of ethical decision making when language differences exist between and among social workers and service seekers. Language competence among medical providers, including social workers, is an ethical obligation.

Language efficacy has not been a part of the standard of practice despite explicit mandates to consider cultural variables, including language, by social work professional organizations. Therefore, identifying feasible recommendations to enhance the capacity of social workers who speak another language is needed. These recommendations will be presented by discussing individual, professional, and society's responsibilities.

Recommendations

The Responsibility of Individual Practitioners

First and foremost, social workers providing services in more than one language must pause and consider avenues to evaluating their language skills before continuing to engage clients/patients in a second language. This goes beyond a simple recommendation, because the word "recommendation" is usually perceived as one having an option. When it comes to professional social work practice, the word "recommendation" needs to be replaced with "mandate" or "policy" to affect the change needed to avoid malpractice and ethical dilemmas.

We know that patients generally prefer to have medical services delivered by language concordant providers (Villalobos et al., 2016). Social workers are included in this category. Yet, social workers who may not be qualified to deliver social work services in a language other than English continue doing so without explicitly establishing language skills from a language self-efficacy perspective. Perhaps power differentials intersect the client-provider professional relationship, diminishing opportunities to establish language fluency, language competence, and language skills.

When these power differentials go unaddressed and/or acknowledged they can compromise the effective delivery of social work services (Hsieh & Hong, 2010) in a language other than English, thereby posing ethical challenges in practice. Potential power differentials also exist between social workers and employment systems. Once it has been established that an identified social worker is "bilingual" without evidence of such qualification, it may be difficult to challenge the reality that the social worker may not be bilingual in a clinical setting, for example.

Yet, others around will continue to perceive the social worker as possessing language skills that could be helpful at the agency. These kinds of situations are dangerous to consumers and need to be addressed across various systems of practice. It is well documented that health care disparities are higher for those with LEP (Arroyo, 2019; Capps et al., 2016; Engstrom et al., 2009). At this individual level, social workers must be responsible for assessing their social work practice competence, which includes methods of communication.

When speaking a second language, the social worker may advocate for additional training, compensation, and supervision in the second language (Lusk et al., 2014; Olcon et al., 2018; Sevilla et al., 2018). A large body of literature has recently established a connection between language and emotions (Dewaele et al, 2019; Boudreau et al., 2018; Lorette & Dewaele, 2018), which further provides evidence of the complexity of incorporating a second language when providing social work services. These intricacies play an important role because of potential miscommunication. Words and their meanings are not synonymous across all Spanish-speaking countries, for example. Language complexities and differences exist within a country, city, or even local areas. In Guatemala, for instance, it has been documented that there are over 50 living languages with 21 (Rubin, 2016) of them being recognized as national languages.

The Responsibility of the Social Work Profession

The responsibility of the social work profession, as outlined in the NASW Code of Ethics, is to support the growth of social work professionals as well as the profession itself. Within this responsibility, as previously discussed, the NASW has specific guidelines for effective, evidence-based, culturally competent, and ethical social work practice. Regarding culturally competent services, the social work profession and all credentialing bodies and organizations have a responsibility to provide explicit direction to bilingual social workers on how to best negotiate or infuse language skills in their practice. Such guidance and support can be disseminated at national conferences such as the Council on Social Work Education (CSWE), the NASW Annual Conference, and many other organizations leading the social work profession. The NASW has explained that it is the responsibility of the individual social worker to make sure their practice skills are congruent with minimum standards of practice.

The six Ethical Standards by the NASW help social workers clarify their ethical responsibility to clients, society, the profession, colleagues, practice settings, and ethical responsibility to the broader society. The following excerpt from the NASW Code of Ethics summarizes the purpose of the code:

...a code of ethics sets forth values, ethical principles, and ethical standards to which professionals aspire and by which their actions can be judged. Social workers' ethical behavior should result from their personal commitment to engage in ethical practice. The NASW Code of Ethics reflects the commitment of all social workers to uphold the profession's values and to act ethically. Principles and standards must be applied by individuals of good character who discern moral questions and, in good faith, seek to make reliable ethical judgments. (NASW, 2017, p.1)

The NASW's Ethical Standard 4 explains social workers' responsibility as professionals. Ethical Standard 1 also applies to language self-efficacy and the role of bilingual social workers. Under Ethical Standard 1.05, Cultural Awareness and Social Diversity, the NASW states that social workers "should assess cultural, environmental, economic, mental or physical ability, linguistic, and other issues that may affect the delivery or use of these services" (NASW, 2017, p.1). However, it is unclear how social workers are supposed to "assess" the "linguistic issues…that may affect the delivery or use of these services" (NASW, 2017, p.1) without explicit and formalized training to do so.

This matter intersects with ethical practices because without a direct dialogue to increase bilingual social workers' awareness of their language skills, malpractice and ethical challenges often emerge. Changing the narrative to include unambiguous guidelines for considering language self-efficacy among bilingual social workers is needed. It is important to pause now and reiterate that this paper aims to increase awareness and not to single out any specific entity.

The social work profession has evolved by considering new perspectives, asking different questions, and exploring enhanced practices. These practices must be delivered with a clear awareness of professionals' language skills. The simple recommendation to include language such as "qualified" interpreters and translators is missing from professional guidelines to support bilingual social workers' self-awareness and to offer opportunities to explore avenues for enhancing their language skills to meet the minimum qualifications to offer social work services in more than one language. Advocacy is one of the central tenets of the social work profession, and now it must be used to advocate for systems that would support training, supervision, and compensation of bilingual social workers.

Professional Needs of Bilingual Social Workers

Bilingual social workers need compensation, support, guidance, and training if they make the decision to use their additional language as a skill when providing social work services. In terms of skills, bilingual social workers must complete a self-inventory or self-assessment of their language skills. Guided by the NASW (2015) Code of Ethics, competence is needed when providing social work services in other languages other than English. Language skills involve speaking, listening, writing, and understanding. Qualified entities must assess both receptive and expressive language skills.

It is insufficient to derive that one is prepared to provide bilingual social work services simply by stating that one speaks another language; this

is a form of malpractice. A formal assessment of language skills must be established to determine that a social worker's language skills meet qualifications to provide services in another language. Private organizations offer such qualifying tests to assess professional language skills. Cultural diversity, acculturation, assimilation, and other variables are also important to consider when providing services to diverse communities. These areas intersect the discussion of this paper and could be addressed separately from various theoretical perspectives and models. For this paper, the discussion of language remains focused on the actual language skill.

To assess the language skills of bilingual social workers, employer support is required. Many bilingual social workers provide services within large organizations. There is no standard of practice or national organization to examine and assess bilingual social workers' language skills (Anderson et al., 2018). Organizations are encouraged to assess the language skills of bilingual social workers upon hiring them and to further support their ongoing training to maintain their language skills. Bilingual social workers must be provided with opportunities to attend continuing education courses and any other additional training to enhance and sustain language qualifications. These language skills must be reassessed as recommended by the organization providing the certification.

The language skills of bilingual social workers must align with employment responsibilities, reimbursement, caseload, and supervision. A clear employment contract is recommended to explicitly indicate if the bilingual social worker will be providing services in another language and the extent of such services. For example, a social worker may have the skills to complete a psychosocial assessment but not provide ongoing support or treatment. This explicit notation on employment contracts protects the social worker as well as the organization from liability. These parameters on minimum standards and standards of practice are needed to avoid malpractice and ethical matters.

Regarding caseload, if bilingual social workers are used in a bilingual manner to provide services, organizations must establish clear guidelines for caseload equity. Establishing benchmarks for case assignments is essential. These discussions can take place with treatment teams, supervisors, and colleagues. Educating others that work with families who speak another language often requires extra time and is also important to consider. Regarding what has been discussed as "drive-by" interpretation and translation, consultations should be avoided to prevent crossing practice boundaries and the potential for malpractice. The use of impromptu translation with family or nonclinical personnel presents complications and ethical issues requiring further consideration. Best practices would preclude such informal use, especially if doing so presents a conflict of interest, such as with family providing interpretation.

The issue of translating or interpreting something for another colleague during these "drive-by" types of consultations places the bilingual social worker at risk for possibly misinterpreting, mistranslating, or misdiagnosing. Furthermore, the social worker is exposed to potential dual relationships or conflicts of interest, both of which are against the *Code of Ethics* (Arroyo, 2019; NASW, 2017). Due to language intricacies, cultural differences, and different cultural attributes, it is important to promote access to qualified language services within the agency instead of quickly attempting to translate or interpret. Setting these limits may require training for colleagues as well as having qualified translation and interpretation services available.

Compensation is a word typically not associated with bilingual social work practice. It is fair to consider and advocate for additional compensation for qualified bilingual social workers. Their language skills must be compensated. These language skills often save money for organizations that may be mandated by federal guidelines to provide language services. Compensation can vary from support to attending training, conferences, or workshops; offering and providing financial compensation; and in other forms such as scheduling flexibility to focus on self-care and clinical supervision. Providing these kinds of compensation for using language skills is truly a matter of respecting the skills of a qualified bilingual social worker as well as maintaining a level of rigor when delivering social work services.

One area that has not been addressed in the literature is supervision. Due to the proliferation of recent research, previously discussed, on the link between emotions and language, it is prudent

to consider offering qualified bilingual social workers supervision in the second language. Because bilingual social workers may process cognitive and affective (emotional) information in the second language, it seems cogent to offer supervision in the language that is used for the provision of services. The quality and rigor of (clinical) supervision may fluctuate or be affected by the language being used. More research is needed.

Summary

The primary purpose of this writing is to empower bilingual social workers, organizations offering social work services, professional organizations, and society, in general, to be respectful and consider the language skills of bilingual social workers. The discussion about malpractice and ethical challenges encountered by bilingual social workers can be further discussed by engaging systems to explicitly consider the significant role of bilingual social workers. At the micro level, bilingual social workers are encouraged to evaluate their language skills for social work practice at every level and dimension. At the mezzo level, organizations are encouraged to carefully evaluate the roles and responsibilities of bilingual social workers and support the continuing education of their language skills. Crafting explicit standards of practice will protect both the social work provider and the organization.

On a larger scale, bilingual social workers are encouraged to advocate for fair and equitable employment compensation and policies to support their professional growth. Connecting with researchers engaged in this topic of bilingual social work practice may provide opportunities for these social workers to affect change at their local level—the place where they work. The ethical responsibility of competence is central to the discussion of the professional and ethical needs of bilingual social workers. To affect change on a social problem, such as the provision of equitable, ethical, and effective bilingual social work services, we must first understand the problem. Advocacy to protect, respect, and empower bilingual social workers is needed across various systems, but the most pressing is at the organizational level. We must continue understanding and reacting to the implicit and explicit challenges faced by bilingual social workers.

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