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New York State Psychiatric Institute
Center of Excellence
for Cultural Competence

Language Access Needs in New York State Office of Mental Health Facilities Prior to Implementation of Expanded Language Access Strategies in 2011-2012

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Acknowledgements

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The images used in this report do not represent individuals who are associated with mental health issues in any way. They are shown for aesthetic purposes only.

Executive Summary

The New York State Office of Mental Health (OMH) administers the state's public mental health system, which serves as a safety net for New York's diverse population[1,2]. OMH provides comprehensive mental health treatment to children and adults with a variety of mental disorders. NY State has the third-highest percentage (13%) of persons with Limited English Proficiency (LEP) in the U.S, and persons with LEP are less likely than those who are proficient in English to receive and engage in mental health care[3,4]. Language barriers can lead to misunderstandings and result in incorrect diagnoses and ineffective or harmful care[6,7], as well as difficulties with treatment and medication engagement and adherence[8,9,10,11]. Due to the diversity in the state, OMH has long been on the forefront of language access. Numerous initiatives have been introduced in NYS, and in OMH specifically, since 2011, including NYS Executive Order 26, the OMH Cultural and Linguistic Policy 502, and many other activities to promote language access in OMH facilities (described more fully in Section C). As part of these efforts, OMH wanted to know the status of language access at its "baseline" state, that is, prior to the onset of these activities. Thus, OMH commissioned the New York State Psychiatric Institute Center of Excellence for Cultural Competence (NYSPI-CECC) to survey facilities about current language access practices at the time of data collection. In the meantime, OMH moved ahead with expanded efforts to promote language access, even while baseline data was being collected. For example, as findings were being generated, they were shared with the BCC, and BCC used the findings as they developed their materials and trainings, as described in Section C. Therefore, this report represents the status of OMH at the time of data collection (June 2011-April 2012), as OMH was starting to implement these initiatives. This baseline benchmark will allow OMH to measure progress going forward.

This survey interviewed representatives of clinical units in OMH programs to learn about the state of language access and the barriers and challenges to the provision of language access services. We surveyed all programs in facilities operated by OMH, for a total of 142 programs across 26 facilities delivering clinical services, and worked with the clinical director of each unit to determine the most appropriate program staff member to respond to the survey. Of all programs surveyed, 135 responded, resulting in a response rate of 95%.

The survey finds that OMH serves a linguistically heterogeneous population. OMH programs report high levels of use of bilingual clinicians and professional interpreters. However, survey results indicate that, in the survey time period of 2011-2012, the use of family and friends as interpreters as well as provision of services in English to LEP individuals was still substantial, particularly in programs that served few LEP individuals and programs outside of the New York City metropolitan area. Barriers to the use of professional interpreters included needing additional staff training on the use of interpreters, communication concerns with telephone interpreters, and time constraints. The new activities of OMH to improve language access were designed to address these constraints.

Program representatives indicated an interest in exploring emerging technology to increase language access, including the use of web-based video interpretation and having the interpreter take on a more active role in the clinical encounter (i.e., instead of merely acting as a conduit and providing a complete conversion of information without any additions, interpreters may also clarify information, provide cultural explanations, and act as an advocate).

During and after the collection of data for this report in 2011-2012, OMH used preliminary findings from this data analysis, in consultation with NYSPI-CECC, to develop a number of policies and procedures to increase language access, including compliance requirements, standardized training and compliance reporting, tools to facilitate reporting, translations of legal forms and vital documents, and listings of available resources, including interpreter resources. A full listing of recent OMH activities to promote language access is described in Section C. This report recommends that these activities continue and expand, in

order to build on OMH's investment in language access, and help services improve continuously over time. A listing of recommendations is included in Section D, including:

- Continue language access initiatives in OMH facilities including mandated reporting.
- Continue disseminating resources throughout the OMH system, and ensure that services provided by OMH are utilized, particularly by programs serving few LEP individuals and programs outside of the NYC metropolitan area.
- Promote new methods for providing language access services.

Introduction

New York State (NYS) has a culturally and linguistically diverse population, with nearly one in seven NYS residents (13%) classified as limited English proficient (LEP)[1]. The NYS public mental health system serves as a safety net for low-income, uninsured, and other vulnerable New Yorkers and provides comprehensive mental health treatment to children and adults with a variety of mental disorders[2]. Across the United States, persons with LEP are less likely than those who are proficient in English to receive and engage in mental health care[4]. As NYS has the third-highest percentage of limited English proficient persons in the US, the state, and particularly OMH, has long been on the forefront of language access. Numerous initiatives have been introduced in NYS and in OMH specifically since 2011, including NYS Executive Order 26, OMH Cultural and Linguistic Policy 502, and several other activities to promote language access in OMH facilities (described more fully in Section C)[3]. Language barriers can lead to misunderstandings and result in incorrect diagnoses and ineffective or harmful care[6,7], as well as difficulties with treatment and medication engagement and adherence[8,9,10,11]. These concerns have prompted OMH to focus on ways to promote effective language access.

The NYS Office of Mental Health (OMH), which administers the public mental health system, has a long-standing commitment to providing language access for persons with Limited English proficiency, including those who are deaf or hard of hearing. OMH defines persons with LEP as "individuals who do not speak English as their primary language and have a limited ability to read, speak, write, or understand English"[12]. Language access for persons with LEP is governed by federal, state, and local laws, as well as regulations from OMH, the NYS Department of Health, hospital accreditation bodies such as The Joint Commission (TJC), and the National Standards on Culturally and Linguistically Appropriate Services (CLAS). Furthermore, effective communication with persons who are deaf or hard of hearing and also require interpreter services is provided in accordance with the Americans with Disabilities Act (ADA). Legal and regulatory requirements for language access are constantly changing, indicating a need for healthcare providers to have an up-to-date policy on providing language access services that adheres to legal standards and meets best practice guidelines. Given these changing requirements, a comprehensive listing is beyond the scope of this report. The Office of Minority Health in the US Department of Health and Human Services supports a website which summarizes initiatives, policies, and laws governing language access services[13].

In October, 2011, NYS Governor Andrew Cuomo highlighted the importance of language access in state operations by instituting Executive Order 26[12], implemented on a rolling basis to be completed by October, 2012. Executive Order 26 mandates that interpreters be provided to all LEP individuals and that vital documents and written material be translated into the six most common languages spoken by LEP persons in New York State (currently Spanish, Chinese, Russian, Italian, Korean, and French/Haitian Creole). These state-wide initiatives are not limited to OMH; a 2013 survey of LEP individuals in several NY state agencies (though not OMH) conducted by the Center for Popular Democracy and Make the Road NY found that, although language access needs have improved since the implementation of Executive Order 26, there are still significant language access needs in some state agencies[14].

Although Executive Order 26 does not explicitly outline language access policies for individuals who are deaf or hard of hearing, the ADA does mandate that programs and services be made accessible to these individuals[15]. In addition, in May, 2012, OMH instituted Cultural and Linguistic Competence Policy Directive 502, which establishes reporting requirements to ensure that OMH facilities are in compliance with language access and cultural competence, including access for persons with LEP and for those who are deaf or hard of hearing[16]. In 2011-2012, OMH responded to language access needs by exploring language access resources through numerous activities, for example, by implementing a language access coordinator at each facility to ensure compliance with all federal, state, and regulatory requirements;

expanding staff training; translating all legal and vital documents into nine languages (including the six specified by Executive Order 26); establishing a process for filing and resolving complaints; and several other activities described more fully in Section C. Furthermore, OMH supports language and cultural competence through its Bureau of Cultural Competence and two Centers of Excellence for Cultural Competence at the Nathan Kline Institute (NKI-CECC) and the New York State Psychiatric Institute (NYSPI-CECC).

As part of the expanded efforts to increase language access, particularly in 2011-2012, OMH wanted to know the status of language access at its "baseline" state, that is, prior to the onset of many of these activities. To this effect, OMH commissioned NYSPI-CECC to survey facilities about current language access practices at the time of data collection. In the meantime, OMH moved ahead with expanded efforts to promote language access, even while baseline data was being collected. Therefore, this report represents the status of OMH at the time of data collection (June 2011-April 2012), as it was starting to implement these initiatives. This baseline benchmark will allow OMH to measure progress going forward.

A. Study Methodology

We surveyed, in 2011-2012, all programs in facilities operated by OMH (OMH also regulates, certifies, or oversees over 4,500 other programs which were not included in our sample)[18]. In conjunction with clinical directors at each facility, we identified 142 programs across facilities that met the inclusion and exclusion criteria for our survey. (At the time of data collection, OMH was comprised of 27 facilities, but the Nathan Kline Institute was excluded from our sample as all of their programs are research-based and we excluded research-based programs from all facilities.) With the help of clinical directors, we defined each program as a separate unit or clinic within a facility that provides a particular type of service to a distinct population (e.g., an inpatient unit) and/or is located in separate physical spaces (e.g., different buildings). For example, two outpatient facilities (the Audubon and Inwood clinics) of the NYSPI were counted as separate programs, even though they serve very similar populations, because they are located in separate buildings and areas of Northern Manhattan. Other examples of distinct programs include inpatient, outpatient, day treatment, forensic, and mobile crisis services. Programs may serve children and adolescents, adults, or a combination of both. In addition to research-based programs, we also excluded school-based, substance abuse-only, and residential programs, because these programs deliver very specialized services and therefore may not be representative of the needs, policies, and practices of the OMH system as a whole.

The NYSPI-CECC designed a survey instrument (available in Appendix III). The survey consisted of open and closed-ended questions on program-level characteristics, including the overall age distribution, types of services provided, percentage of the population with limited English proficiency, the most common languages spoken by LEP individuals, and means of service provision to those individuals. An initial pilot test of our survey was conducted with 3 programs in May, 2011. The survey was fielded from June, 2011 to April, 2012, and each program representative was instructed to answer the questionnaire based on the last 12 months of that program. The most appropriate program staff member from each program was identified in conjunction with clinical directors to serve as that program's representative. We achieved a 95% response rate, with 135 out of 142 programs completing the survey. The Institutional Review Board (IRB) at NYSPI deemed this project exempt from review, as we were examining program-level data and not assessing personally identifiable health information of program representatives or individuals served. We assured subjects that the responses from individual programs would not be identified in the analyses; therefore, results are aggregated to the state or regional level in this report.

The aims of the survey were to determine:

1. What is the linguistic and regional distribution of the LEP population served by OMH facilities?
2. To what extent are best practices for language access being implemented at OMH facilities, and what barriers exist to the delivery of best practices?
3. What are the preferences and challenges related to format of interpretation (e.g., in-person, telephonic, or web-based) and role of the interpreter (e.g., conduit, clarifier, cultural broker, or incremental and flexible, including advocate)?

In this report, we review the findings of each Aim, and then conclude with recommendations to assist OMH programs in overcoming the barriers and challenges identified in providing language access services.

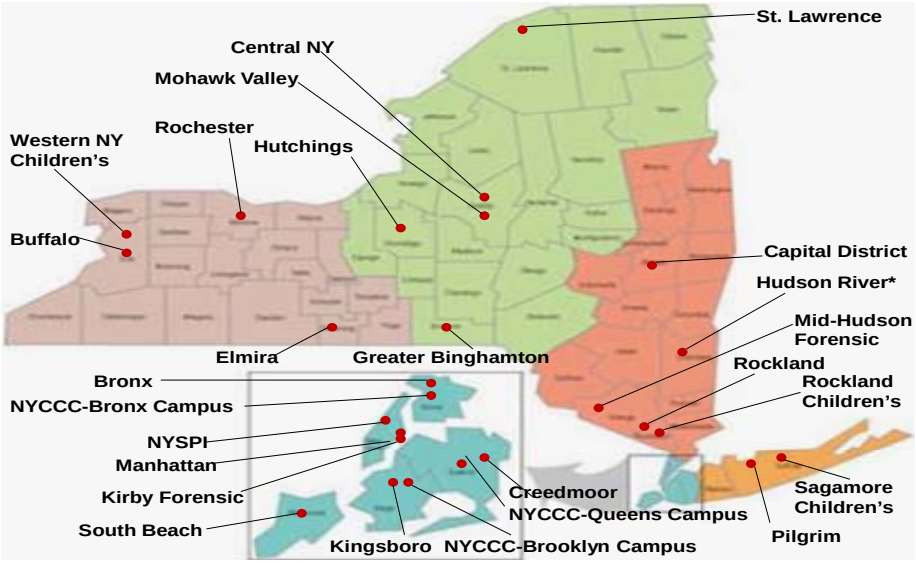
B. Findings

Aim 1: What is the linguistic and regional distribution of the LEP population served by OMH facilities?

Figure 1 shows a map of NY State, with regions delineated and OMH facilities identified. The 26 facilities we surveyed are also indicated. OMH has five regions: New York City, Long Island, Hudson River, Central, and Western. For confidentiality reasons, we combined New York City and Long Island into one region, given the small number of facilities in Long Island. The percentage of LEP individuals in OMH facilities, by region, is as follows:

- New York City and Long Island: 23.5%
- Hudson River: 11%
- Central: 4.6%
- Western: 5.8%

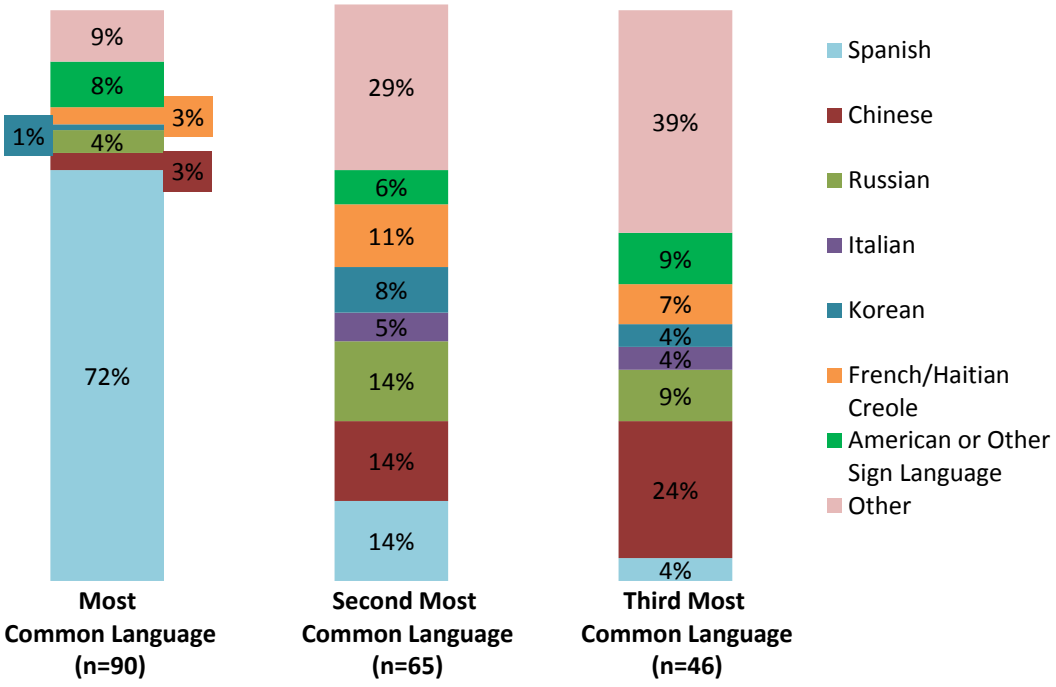
Figure 1. NY State, by region



Source: http://www.omh.ny.gov/omhweb/suicide_prevention/regional
Note: Nathan Kline Institute not surveyed because it includes only research-based clinics
*Hudson River closed in 2012

Figure 2 shows the top languages spoken by limited English proficient individuals at OMH programs, as reported by program representatives. Representatives were asked to indicate the most common, second most common, and third most common languages spoken by their LEP population. Notably, in nearly one out of ten programs, the most common language spoken by LEP individuals is not one of the six most common languages in NY State, indicating substantial diversity among the LEP population.

Figure 2. Most Common Languages Spoken by OMH LEP Population over Last Year



Other languages include: Albanian, Arabic, Armenian, Bosnian, Farsi, French, Greek, Hindi, Japanese, Nepalese, Polish, Portuguese, Slovakian, Thai, Turkish, Ukrainian, Vietnamese, Yiddish, and Yugoslavian.

The different numbers of programs (as indicated by "n=" under each bar in the above figure) reflect the fact that progressively fewer programs reported a second and third most common language among their LEP population. In this report, Chinese includes Mandarin, Cantonese, and Fujianese, as not all programs were able to differentiate which Chinese language was spoken by their Chinese-speaking population and so we combined all Chinese languages into one category.

- The most common language reported was Spanish, with 72% of programs naming it as their top language.
- The current top six languages in NY State, which are based on 2010 Census data and included in Executive Order 26, are well represented, yet there are still substantial numbers of other languages spoken by the population served by OMH.
- American or Other Sign Language is also very prevalent.

The diversity of languages spoken by individuals with limited English proficiency indicates a high need for the use of interpreters, as having adequate numbers of bilingual

clinicians for all languages spoken by LEP individuals would be challenging for most programs. Therefore, clinicians and staff need to understand how to access and use interpretation services for their LEP population served.

Aim 2: To what extent are best practices for language access being implemented at OMH facilities, and what barriers exist to the delivery of best practices?

The U.S. Department of Health and Human Services Office of Minority Health authored a 2001 report, *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, outlining standards for providing culturally and linguistically appropriate services (CLAS)[19]. In 2013, the Department of Health and Human Services released *National Standards for CLAS in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice*, which provides updates and enhancements to the original CLAS standards[20]. These 15 standards include items governing language access specifically (standards #5-8) that are based on Title VI of the 1964 Civil Rights Act and the 1990 Americans with Disabilities Act.

In accordance with CLAS standards, best practices for providing services to individuals with LEP are:

1. Bilingual providers
2. In-person trained interpreters
3. Telephonic interpreters if services are required immediately or for infrequently encountered languages

CLAS standard #7 emphasizes the necessity of ensuring that individuals who provide language services meet a certain level of competence, as "untrained family, friends, minors, and staff often do not possess the necessary skills to provide meaningful language services" (p. 87). Relying on individuals without interpreter training can lead to increased misunderstandings, dissatisfaction, omission of vital information, misdiagnosis, inappropriate treatment, and safety issues[20]. Confidentiality is compromised when an untrained interpreter is used, and individuals may be reluctant to divulge pertinent information in the presence of a friend or family member. Untrained interpreters may also overestimate their language proficiency in one or both languages and may be unfamiliar with clinical terminology, leading to a higher number of interpretation errors[21].

Additionally, the National Association of the Deaf (NAD) released a 2008 report, *Position Statement on Mental Health Services for People who are Deaf or Hard of Hearing Supplement: Culturally Affirmative and Linguistically Accessible Mental Health Services,* outlining best practices for deaf and hard-of-hearing individuals receiving mental health care[22].

Best practices are:

1. Bilingual providers
2. Qualified sign language interpreters with specialized mental health interpretation experience

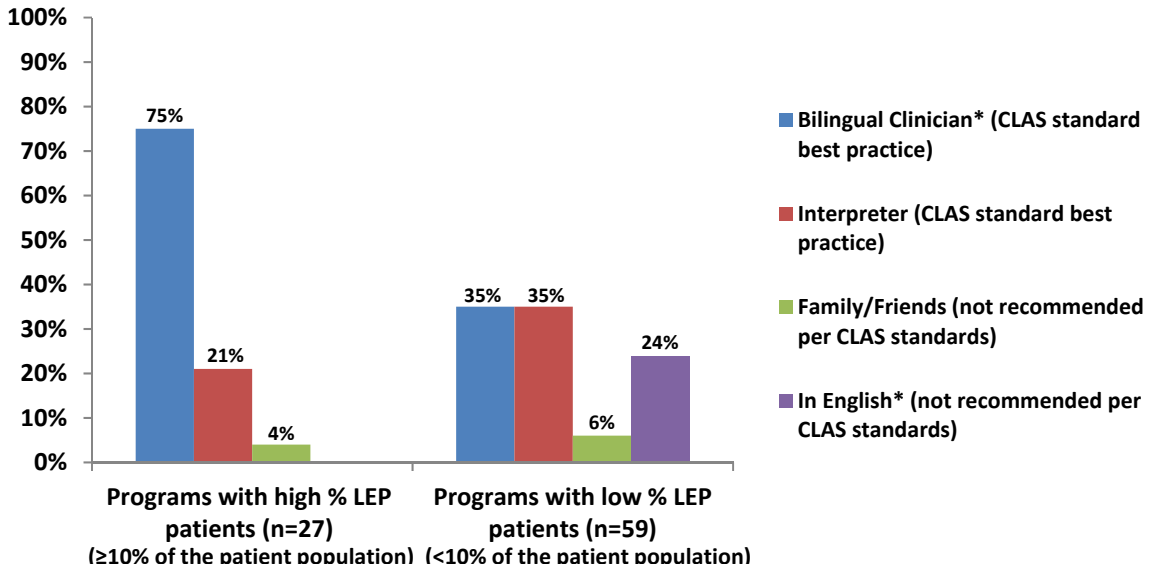
NAD also notes that use of family and friends should be avoided due to lack of impartiality, unfamiliarity with medical terminology and interpretation methods, and difficulties in communicating highly sensitive medical information or under duress[23].

We asked program representatives to describe the ways that services were provided for a program's most common language spoken by their LEP population. This question enables us

to assess the extent to which best practices for language access are being utilized. We analyze this for the most common language spoken by LEP individuals in each program, as CLAS standard best practices may be most often applied for frequently used languages (e.g., a program may be more likely to have clinicians who are bilingual in Spanish than who are bilingual in Polish). This has been observed in a number of settings across the country. For example, one national hospital survey found that while over three-quarters (78%) of hospitals were able to provide interpreter services in their Emergency Department within 15 minutes during business hours for the most common language served by the hospital, less than half (48%) could do so for the third most common language[24].

In this portion of the survey, if a program's most common language spoken by LEP individuals was Spanish, then we inquired whether services are most often provided for Spanish-speaking individuals by bilingual clinicians, interpreters, family/friends, or if services are provided in English. Results indicate that, among programs serving a high percentage of LEP individuals, 75% report that services are most commonly provided by bilingual clinicians for their most common language (Figure 3). For this analysis, we eliminated those programs that had no LEP individuals at the time of data collection and included only those programs whose population served included at least some LEP individuals (n=90, numbers may vary slightly due to missing data). Full results of this analysis are shown in Figure 3.

Figure 3. Most Frequent Way Services Provided for the Language Most Commonly Spoken by LEP Patients over the Last Year, by Program



***p≤.01**

Note: We performed Kruskal Wallis tests to assess whether these differences were statistically significant. Statistically significant differences by high LEP versus low LEP programs were found for the use of bilingual clinicians and services in English. No significant differences were found for the use of interpreters or family and friends.

- Notably, programs with a high proportion of individuals with LEP (≥10% of the population served) stated that their most common means of service delivery for their most common language was bilingual clinicians (75%), while only 35% of programs with a low proportion of individuals with LEP (<10% of the population served) reported bilingual clinicians as the most common means of language access. This difference among programs with high versus low proportions of individuals with LEP was statistically significant (p<.01).
- Conversely, 24% of programs with a low proportion of individuals with LEP (<10% of the population served) reported services in English as the most common means of service

provision for the most common language spoken by individuals identified as LEP, compared to 0% of programs with a high proportion of individuals with LEP (≥10% of the population served). This difference among programs with high versus low proportions of LEP individuals was statistically significant (p=.01).

- There were no statistically significant differences in the use of interpreters or family and friends as the most common means of service provision for the most common language among programs with high versus low proportions of individuals with LEP.

We also assessed regional differences in the most common means of service provision for a program's most common language spoken by LEP individuals in order to ascertain whether there were differences among programs located in regions with larger percentages of LEP individuals (i.e., NYC and Long Island) versus regions with smaller percentages of LEP individuals (i.e., Hudson River, Central, and Western). Full results of this analysis are shown in Table 1. For example, among programs in New York City and Long Island, 85% of programs reported that they most commonly used bilingual clinicians to deliver services to individuals who speak the most common language of LEP individuals in their population (usually Spanish), while only seven percent of programs in the Central region reported that they usually use bilingual clinicians in such cases.

Table 1. Most Frequent Way Services Provided for Language Most Commonly Spoken By LEP Individuals Over the Past Year, by Region

	Bilingual Clinician*	Interpreter*	Family/Friends	In English*
NYC & Long Island	**85%**	**9%**	**3%**	**3%**
Hudson River	**32%**	**42%**	**11%**	**16%**
Central	**7%**	**67%**	**7%**	**20%**
Western	**20%**	**30%**	**0%**	**50%**

***p<.01**

Note: We performed Kruskal Wallis tests to assess whether these differences were statistically significant. Statistically significant differences across regions were found for the use of bilingual clinicians, interpreters, and services in English. No significant differences were found for the use of family and friends.

- Programs located in regions with smaller percentages of LEP individuals demonstrated higher provision of services in English. In the Hudson River, Central, and Western regions, 16%, 20%, and 50% of programs, respectively, report that the most common means of service provision for their program's most common language spoken by LEP individuals is providing services in English. During the study period, these percentages were statistically significantly higher than the proportion of programs in NYC and Long Island that served individuals in English.
- Compared to the NYC & Long Island regions, the Hudson River, Central, and Western regions report less use of bilingual clinicians as the most common method of service provision, but higher levels of provision of services via interpreters. These regional differences were statistically significant during the study period.
- Although no statistically significant differences were found across regions for the use of family and friends as interpreters, 11% of programs in the Hudson River region reported the use of family and friends as most common method of service delivery for the most common language spoken by the LEP population of the program. In the Central, NYC & LI, and Western regions, 7%, 3% and 0% of programs, respectively, reported use of family and friends as the most common service delivery method for the most common language.

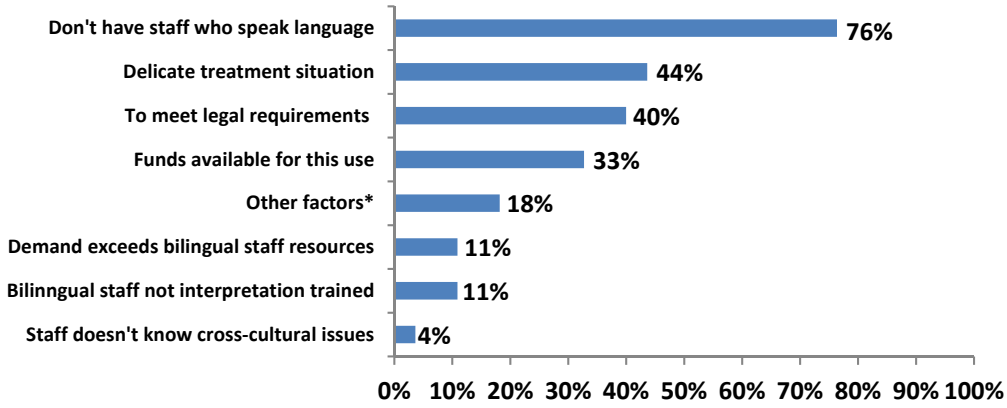
- Programs in New York City and Long Island, which have a large number of available bilingual providers, do not frequently utilize interpreters or provide services with family/friends acting as interpreters or in English.

Analyses by programs with low versus high proportions of LEP individuals and by region suggest that the use of non-best practices (e.g., use of family and friends as interpreters and services in English) may be attributed to a program's language access capacity rather than strictly the preference of the LEP individual served. Programs with low proportions of LEP individuals and programs outside of New York City and Long Island reported higher rates of services in English as the most common means of service delivery for the most common language of their LEP population. While these programs likely have less access to bilingual clinicians and in-person interpreters, the provision of services in English and the use of family and friends during the study period were still inappropriate, and programs needed more guidance on know how to access and utilize trained interpreters in order to meet standards of best practices for providing care to LEP individuals. BCC increased its training efforts and other language access efforts during and after this study's data collection partly in response to this type of data. For example, as the use of family and friends became known to OMH, training was added specifically to address this issue; the training program includes a video that indicates the pitfalls of using family and friends as interpreters.

Reasons for Use of Professional Interpreters

In order to ascertain why programs utilize professional interpreters, we surveyed staff-identified factors for the use of professional interpreters, by program. Programs could select more than one factor. The majority (76%) of programs stated that they did not have staff who spoke the language needed. In addition, programs chose myriad other factors, including aspects of the clinical or treatment situation, to meet legal requirements, and/or because they had funds available. Several programs indicated that they had bilingual staff, but the number of individuals needing interpretation services exceeded the ability to meet the demand, that bilingual staff were not specifically trained in interpretation, and that staff were not knowledgeable about cross-cultural issues. Full results are shown in Figure 4.

Figure 4. Percentage of Programs Who Agreed with Factor, among Programs Reporting Use of Professional Interpreters (n=55)



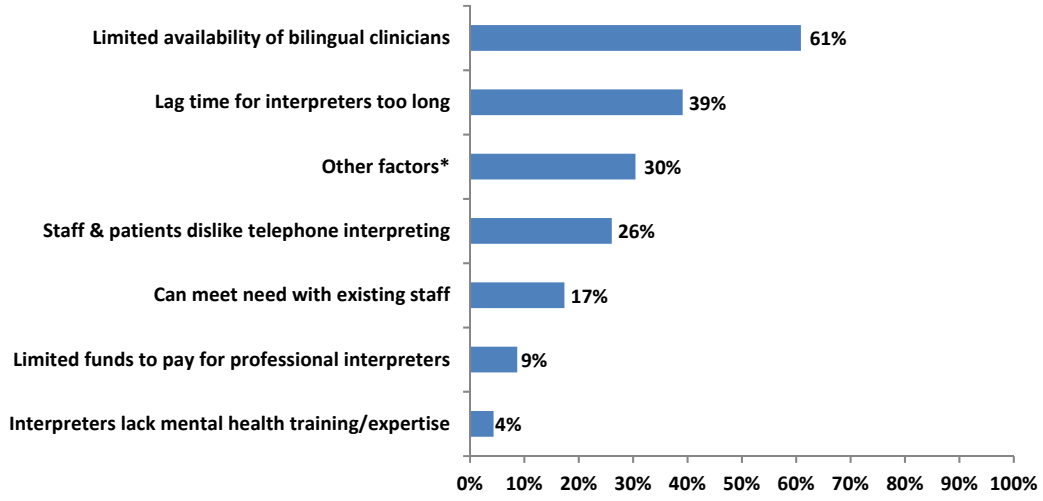
Note: Question limited to programs that reported the use of professional interpreters. Program representatives could select more than one factor, so cumulative percentage exceeds 100%.

***Other factors as specified by program representatives: bilingual staff not available at all times, clinical considerations, interpretation provided by professional staff members, need to complete formal assessments, specific language proficiency varies across staff, need for ASL interpretation for deaf individuals**

Reasons for Use of Non-Clinical Bilingual Staff

We also examined why programs utilized non-clinical bilingual staff as interpreters, by program. Programs could select more than one factor. Sixty-one percent of programs identified the limited availability of bilingual clinicians as a reason for the use of non-clinical bilingual staff. In addition, programs chose myriad other factors, including lag time for professional interpreters, dislike of telephone interpreting among staff and among individuals served, ability to meet rare needs of interpretation with existing staff, limited funds to pay for professional interpreters, and a lack of mental health training and expertise among professional interpreters. Full results are shown in Figure 5.

Figure 5. Percentage of Programs Who Agreed with Factor, among Programs Reporting Use of Non-Clinical Bilingual Staff (n=23)



Note: Question limited to programs that reported the use of non-clinical bilingual staff as interpreters. Program representatives could select more than one factor, so cumulative percentage exceeds 100%.
***Other factors as specified by program representatives: non-clinical staff may have better rapport with individual and be more consistent than outside interpreter, staff will interpret when immediate response is needed and bilingual clinicians are not available, individual will not agree to telephone interpretation.**

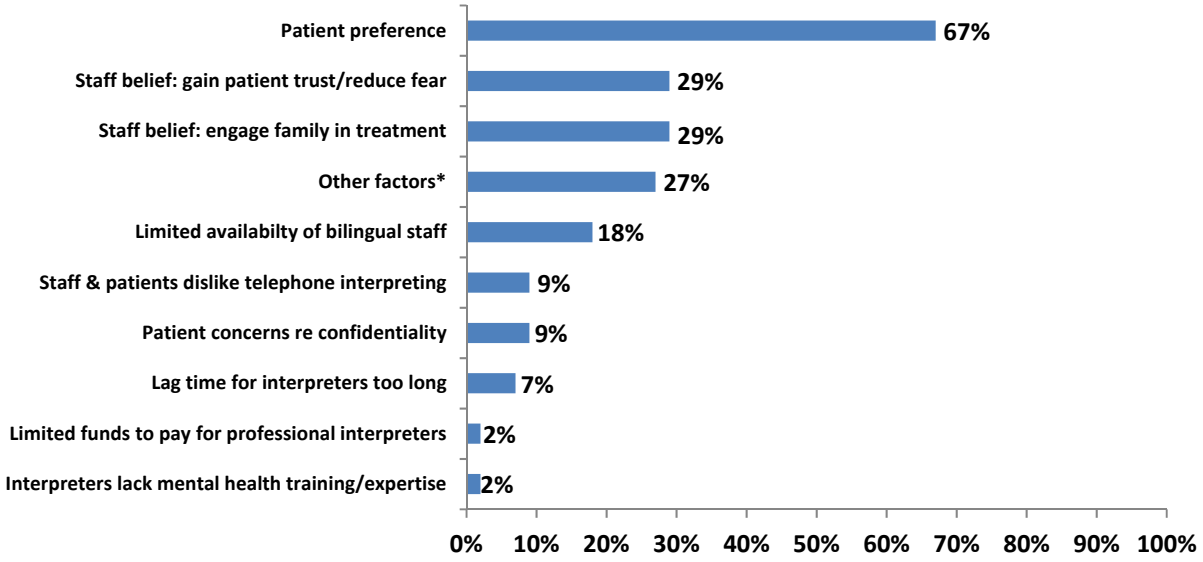
Reasons for Use of Family and Friends

In order to ascertain why programs utilize family and friends as interpreters, despite the recommendations against the use of this practice, we surveyed staff-identified factors for the use of family and friends, by program. Programs could select more than one factor. First and foremost, it should be noted that the percentage of programs that use friends and family as interpreters is lower than the national average. Of the 90 programs that reported serving some LEP individuals, 45 indicated ever using family and friends (50%). In a national survey of hospitals, 62% of hospitals reported the use of family and friends as interpreters[24].

In our survey, of the programs that reported ever using family and friends as interpreters, 67% identified preference of the individual served as one reason for use of family/friends. In addition, programs chose myriad other factors, including beliefs that this practice would increase an individual's trust and reduce fear or engage theindividual's family in treatment. Other factors selected included a limited availability of bilingual staff, dislike of telephonic interpretation among staff and among individuals served, and concerns about confidentiality. Only 2% of programs noted limited funds for professional interpreters, indicating that use of family or friends is not due to financial constraints. Full results are shown in Figure 6. As noted previously, the

OMH language access reforms of 2011-2012 encourage facilities to also have access to professional interpreter services, even if the individual requests to have a family member or friend interpret.

Figure 6. Percentage of Programs Who Agreed with Factor, among Programs Reporting Use of Family and Friends (n=45)



Note: Question limited to programs that reported the use of family and friends as interpreters. Program representatives could select more than one factor, so cumulative percentage exceeds 100%.
***Other factors as specified by program representatives: convenience, expedience, used for informal social visits or arranging visitor passes, and family greets clinician and calms individual.**

OMH Staff Training Activities: 2012-2013

Based on the need for additional staff training, OMH established a staff training and reporting process in 2011-2012. In each facility, the designated language access coordinator (LAC) and education training director coordinates staff training in the provisions of Executive Order 26. All current OMH employees received the initial training by December, 2013, and receive annual training on an ongoing basis. New employees receive this training during New Employee Orientation. Rates of staff training are reported to the BCC. The BCC, on behalf of OMH, then completes an annual Compliance Report to the Governor's Office.

Barriers to Use of Interpreters

Programs serving LEP individuals also identified a number of barriers to the use of interpreters at the time of data collection (that is, prior to the introduction of the new OMH language initiatives). The most common barriers cited at the time were: the need for additional staff training (38%), not enough time available (26%), and that telephonic interpreters are constrained in their ability to assist with engagement and rapport building (25%) (Table 2).

Table 2. Barriers Cited for Use of Interpreters, Among Programs with Any LEP Individuals

	Percentage of Programs Reporting Barrier:			
	Strongly Applies to Program	**Applies to Program**	**Somewhat Applies to Program**	**Does not Apply to Program**
Our staff has not been adequately trained in the use of professional interpreters.[1]	7%	12%	19%	62%
Working collaboratively with a professional interpreter requires more time than is available.[1]	4%	2%	20%	74%
Telephonic interpreters are constrained in their ability to assist with key aspects of care such as treatment engagement and rapport building.[2]	5%	10%	10%	75%
The quality of communication when using telephone interpreters has not been satisfactory.[2]	4%	5%	11%	80%
Given competing demands, it is difficult to prioritize language access programs that use professional interpreters.[1]	2%	4%	6%	88%

[1]n=84
[2]n=80

Program Staff Preferences for Language Access Services

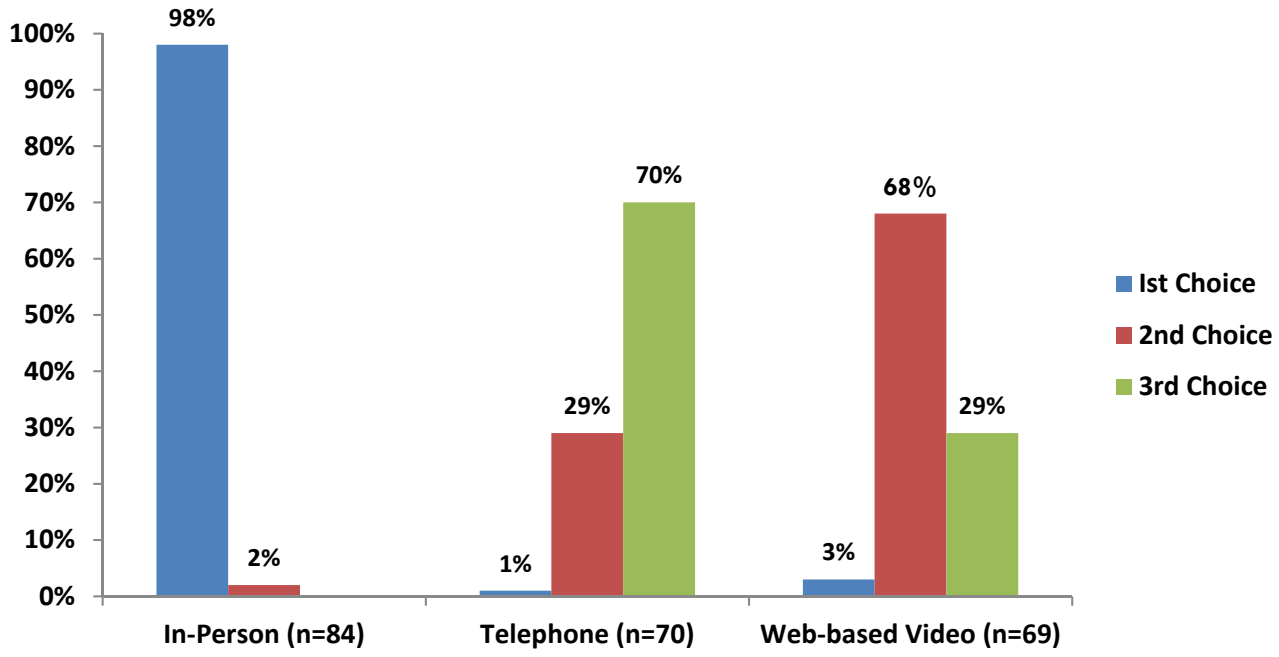
After assessing language access services at the time of data collection (2011-2012), prior to the implementation of language access initiatives, the survey also asked program representatives about their opinions and preferences regarding language access services. The preferences expressed below for innovative methods of interpretation and service delivery (including the use of video conferencing) are a reflection of the progressive culture of OMH programs.

Aim 3: What are the preferences and challenges related to format of interpretation (e.g. in-person, telephonic, or web-based) and role of the interpreter (e.g., conduit, clarifier, cultural broker, or incremental and flexible, including advocate)?

Program representatives were asked to rank three methods of interpretation in order of staff preference (first, second, third). Staff overwhelmingly identified in-person interpretation as their first choice (98%). Despite the fact that telephone is the most common method of interpretation used (and the only distance method of interpretation currently available at OMH) when in-person interpreting is not available, the majority of representatives (70%) indicated telephone interpretation as their least-preferred option (Figure 7).

Web-based video emerged as a second choice after in-person interpreting (68%), despite not being available in OMH facilities at the time of survey data collection. Web-based video was defined for program representatives as "*communicating in real time with an off-site professional interpreter through the use of standard computer networks to transmit audio and video data."* These results indicate an interest among OMH programs in increasing opportunities for web-based video interpretation.

Figure 7. Staff Preferences for Mode of Interpretation



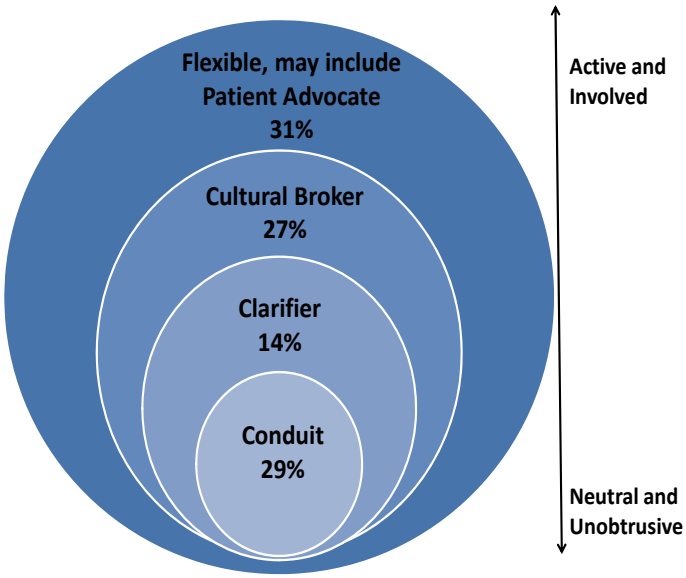
Staff Preferences for Role of Interpreter

The most common interpreter role is the role of the *conduit*. That is, the interpreter provides a complete and accurate linguistic conversion of information conveyed from one language to the other, without additions, omissions, editing, or polishing[25]. However, the National Council on Interpreting in Health Care has defined more active interpreter roles to better address language barriers that affect the care of individuals with limited English proficiency[25]. Such roles may include providing additional detail to clarify miscommunications or providing cultural brokering in order to elicit information on cultural context that may help facilitate communication[25]. Despite the availability and benefits of these roles, a systematic method of incorporating them in clinical settings has not been established. Thus, these more active roles are under-utilized in clinical encounters. Descriptions of interpreter roles as well as examples of their use can be found in Figure 8.

Program representatives were asked to indicate which of the four roles (i.e., *conduit, clarifier, cultural broker,* or *incremental and flexible* role, including advocate) they would prefer an interpreter to take. As indicated in Figure 8, the choices begin with the most neutral/ unobtrusive role of conduit and grow to allow the interpreter to take on progressively more active/ involved roles in the clinical encounter.

Figure 8. Staff Preferences for Role of Interpreter (n=117)

Conduit: The interpreter should provide a complete and accurate linguistic conversion of information conveyed from one language to another without additions, omissions, editing, or polishing.
Clarifier: The interpreter should not limit themselves to accurate linguistic conversion BUT ALSO clarify information that is being communicated by using simpler language, using metaphors or word pictures of terms that have no linguistic equivalent in the individual's language, or other strategies to enhance clarity and comprehension on both sides. For example, a Spanish-speaking individual may use the word *celaje*, which is a glimpsed image of a spirit or ghost, often associated with distress[26]. As there is no equivalent English word, the interpreter may clarify this concept to the clinician.
Cultural Broker: The interpreter should provide accurate linguistic conversion, provide clarifications and help overcome barriers to communication embedded in cultural, social class, religious, and other social differences when such differences may lead to a misunderstanding. They may provide cultural explanations and assist in exploring information that will reduce cultural barriers to understanding.
An Incremental and Flexible role, including Advocacy: The interpreter role should be determined on a case-by-case basis in order to effectively facilitate understanding between the provider and the individual served. Roles may range from the least intrusive role of conduit, to clarifier, to cultural broker, to the most active role of advocate, in which the interpreter is empowered to take actions outside of the interview as necessary to address barriers to care.



The majority of program representatives indicated that they prefer the interpreter to take a more active role than that of conduit; only 29% of representatives indicated they prefer the conduit role alone. Of all representatives, 14% and 27% indicated a preference for the roles of clarifier or cultural broker, respectively, while the most active role, which includes advocacy, was chosen as the preferred role for an interpreter by the highest proportion of participants (31%). This suggests that, despite the barriers some representatives expressed in terms of utilizing interpreters, OMH programs do recognize the utility and benefits that trained interpreters can provide, both in terms of adhering to best-practice standards and facilitating optimal communication between the provider and the individual served.

C. Recent OMH Activities

Since data collection for this report in 2011-2012, OMH has taken numerous steps to enhance the promotion and provision of appropriate Language Access Services. In accordance with various rules and regulations addressing the provision of appropriate Language Access Services to individuals served in the NYS Behavioral Health System – such as Executive Order 26 (EO26), Title VI federal laws, the National CLAS standards, The Joint Commission regulations, and OMH Cultural Linguistic Policy 502—OMH has undertaken the following steps to enhance language access in New York State:

- On behalf of OMH, the Bureau of Cultural Competence (BCC) is responsible for the implementation, facilitation, mandatory training, oversight, and compliance monitoring of Executive Order 26 (EO26), Title VI, and OMH Cultural Linguistic Policy 502.

- Each OMH facility has a Language Access Coordinator (LAC) who reports quarterly to ensure that annual training, resources, and appropriate Language Access Services are operational and provided in a timely manner to meet the diverse needs of the individuals and family members served by OMH inpatient and outpatient services.

- Each OMH facility has a contract for translation of documents, telephone interpreter services, face-to-face interpreter services, and American Sign Language interpreter services. These services are procured through the facility Business Officer annually.

- In October, 2011, OMH identified all legal and vital forms to be translated and the process for translating these forms. The forms have been translated into the **nine most common languages** spoken at OMH facilities and outpatient programs (note: the translated languages are inclusive of the six languages mandated by EO26).

- All legal and vital forms are on the internal intranet (***S:drive)*** for OMH facility access only. This is an ongoing process, as new forms may be created and/or modified. The BCC oversees translation of legal forms on behalf of OMH.

- The LAC of each OMH facility reports complaints to BCC regarding interpreter and translation services.

- OMH/ BCC have established a ***Language Access Complaint*** process and complaint form for OMH use. In addition, an investigation and mitigation process of Language Access Complaints has been established by BCC. From October, 2012, to October, 2013, only nine complaints were made on language access to the BCC, and all were resolved.

- Each OMH facility has established a ***Language Policy*** that incorporates OMH Cultural Linguistic Policy 502, The Joint Commission regulations, and EO 26 mandates addressing training, language access resources, and how to use these resources effectively and efficiently.

- Each OMH facility has established *a* ***Bi-Annual Language Access Plan***. This plan identifies the Limited English Proficiency population served at the facility and in the outpatient programs and geographic catchment that is served by the facility. The plan

also specifies the requirement for signage and posting of free interpreter and translation services, identification of professional bilingual and parenthetic staff and of current vendors used at that facility/outpatient program to provide interpreter, translation, and American Sign Language services. A training process on *Who & How to Access Language Access Services* is provided in this plan. The Facility LAC is responsible for monitoring of and compliance with the facility Language Access Plan.

- Each OMH facility will complete a 30-Item ***Language Access Checklist*** bi-annually. The checklist identifies language access components to be addressed or improved upon in the facility Language Access Plan in order to ensure compliance with LEP and Language Access Services mandates, laws, requirements, and recommendations, and recommendations under EO Order 26, Title VI, National CLAS Standards, and The Joint Commission regulations. By May, 2014, all Facilities met 28 of 30 items; the other two items do not apply to the facilities. A ***Language Access Reporting Tool*** was developed to assist facilities in reporting compliance.
- LEP individuals who come into contact with OMH will be informed of the availability of free interpreting services. While it is a culturally competent practice to allow family and friends to be involved in the recovery process, it is also not a best practice to use non-professional interpreters in clinical settings. Family inclusion is respected but both parties should consider when to access a trained and qualified interpreter. When an LEP individual is completing an application or when involved in other legal matters, the use of an independent interpreter is required.

- Upon admission, all individuals and family members are informed of their ***Language Access Rights*** to free interpreter services. Individuals are asked to identify their *Primary Language* and their *Preferred Language* upon admission.

- OMH/ BCC have implemented, facilitated, and developed webinar and video-based Train-the-Trainer activities in response to EO 26 which trains staff in how Language Access Services are provided in full compliance with EO26 mandates and requirements. Training compliance is documented annually by the LAC of each facility.

- OMH/ BCC provide a variety of training webinars and videos on Language Access Services that are posted on internet and intranet for OMH Access. Webinars include tutorials on how to select and use interpreters, and how the use of interpreters should be incorporated into clinical settings. New topics are continuously developed in conjunction with OMH needs and program requests. A list of resources, including a list of vendors providing interpreter services, is also provided. These resources can be accessed at https://www.omh.ny.gov/omhweb/cultural_competence/webinar/.

  OMH/ BCC will explore the use of video-based interpreter services in 2014. This type of interpreter service has advantages and potential cost savings. The service provides a ***real-time interpreter*** who can be accessed via computer, IPAD or iPhone.

- OMH facilities and Human Resources departments will always seek diversity in hiring OMH employees in order to meet the diverse cultural and linguistic needs of individuals living within the geographic region served by that OMH facility.

D. Conclusions and Recommendations

It should be noted that OMH's long-standing commitment to language access makes it a leader in the nation. The findings identified in this baseline study helped to inform OMH of language access needs, providing a tool to help OMH move forward in improving delivery and access to language services. In light of this commitment, the baseline status of language access in OMH services, and the new innovations that were developed and implemented since 2011, some recommendations are proposed for continuing to strengthen OMH's engagement in language access services. For each of these recommendations, information on OMH activities to implement these activities is discussed.

The NYS public mental health system serves a diverse population. In nearly one out of ten facilities, the most common language spoken by LEP individuals was not among the six most common languages in NYS, indicating a heterogeneous population base. OMH programs reported high percentages of use of bilingual clinicians and professional interpreters. However, percentages of use of family and friends as interpreters and provision of services in English to LEP individuals were still substantial at the time of data collection, particularly in programs that serve few LEP individuals and programs outside of the New York City metropolitan area. It should be noted that upstate New York saw substantial population shifts from 2000-2010, in particular by an increase in the Hispanic and Asian population, which may have resulted in an increase in the demand for language access services[27].

In trying to understand the survey results that show a higher use of services in English in areas that serve fewer LEP individuals, prior to the onset of OMH's language access initiatives, there are some factors to consider. Financial barriers do not seem to be an issue; OMH has contracted rates for translation and interpretation services, and only 2% of programs indicated that lack of ability to pay for a professional interpreter was a reason for the use of family and friends as interpreters. However, other barriers may have been in place, such as lack of experience in accessing interpreter services, lack of knowledge of how to offer interpreter services to LEP individuals, and insufficient time or competing priorities that present difficulties in accessing professional interpreters. Additionally, OMH programs reported other barriers to the use of professional interpreters at the time of data collection, including the desire for more staff training (particularly on the use of interpreters), poor communication – and limited engagement and rapport – with telephone interpreters, and time constraints. Staff reported a high preference for in-person interpretation (98% of program representatives chose this as their most-preferred method) and a high level of dissatisfaction with telephone interpretation (70% of representatives chose this as their least-preferred method). The OMH language access initiatives described in Section C were expected to have addressed – and continue to address – many of these barriers. Finally, representatives indicated an interest in the interpreter taking on a more active role in the clinical encounter than a direct conduit of information, to include clarifying communication and serving as a cultural broker or advocate.

Like all studies, this survey has some limitations. Only one staff member per program completed the survey. Although we worked with facility and program directors to identify the best representative for each program, our survey may not have captured heterogeneity in staff perspectives within programs. Furthermore, the survey does not assess the perspectives of the individuals served. This cross-sectional survey was fielded over a nearly twelve-month time period, from June, 2011 to April, 2012. Although Governor Andrew Cuomo's Executive Order 26 was issued during the data collection timeframe, we found no statistically significant differences in reports of use of bilingual clinicians, professional interpreters, family and friends, or services in English before and after the order issuance. Moreover, we could not assess the impact of the changes that OMH was implementing during this time period. Despite its limitations, this survey provides a detailed description of the state of language access at the time of data collection and

the challenges and barriers faced in the provision of interpreter services in a large, diverse public mental health setting. The survey's 95% response rate indicates a high level of program cooperation and a comprehensive picture of the NYS public mental health system. The results of this survey form a "baseline" to assess language access in the OMH system prior to the advent of the language access reforms. Our recommendations focus on continuing and expanding the work that OMH began during this period, to help OMH realize the full potential from its investment in language access. Future research should examine the impact of these changes on language access, allowing OMH to remain at the vanguard of language access within the national public mental health system.

Recommendations

The survey's findings offer a number of opportunities to improve service delivery in the OMH system.

- ***Continue language access initiatives in OMH facilities including mandated reporting.*** At the time of data collection, before new initiatives were fully implemented, 38% of programs responding indicated a perceived need for additional training in working with professional interpreters. Many program representatives also reported time constraints and the inability to prioritize access to professional interpreters. Since 2011-2012, new reporting requirements included in Governor Cuomo's EO 26 and OMH Cultural and Linguistic Competence Policy Directive 502, and the provision of a dedicated language access coordinator at each facility, may have helped to facilitate language access and emphasize the priority of language access to OMH programs. The OMH Bureau of Cultural Competence (BCC), along with the Centers of Excellence for Cultural Competence at the Nathan Kline Institute and the New York State Psychiatric Institute, have developed a template to facilitate compliance with reporting requirements, which has been pilot-tested in OMH children's facilities. Moreover, in accordance with OMH's requirements, the CLAS standards, and other regulations, LEP individuals who come into contact with OMH will be informed of the availability of free interpreting services. While it is a culturally competent practice to allow family and friends to be involved in the recovery process, it is also not a best practice to use non-professional interpreters in clinical settings. Furthermore, services should not be provided in English to non-LEP individuals. By December, 2013, OMH employees had been trained in language access, and plans were in place for training of new employees and for ongoing annual training of existing employees.

- ***Continue disseminating resources throughout the OMH system, and continue ensuring that services provided by OMH are utilized, particularly by programs serving few LEP individuals and programs outside of the NYC metropolitan area.*** At the time of data collection, the substantial rates of use of family and friends as interpreters and the provision of services in English, particularly in programs serving few LEP individuals, indicated a definite need within OMH that was intended to be addressed through the new language access initiatives. OMH should continue to prioritize the increased use of professional interpreters and bilingual clinicians, particularly in programs serving few LEP individuals and programs in the Hudson River, Central, and Western regions of the state. OMH should continue to disseminate interpretation resources available through the state-operated facilities, such as contracted agreements with professional interpretation services, as well as the benefits of using these services. The BCC provides in-person training and webinars on the use of language access services, and has provided training to all OMH staff. OMH should ensure that the additional training provided results in greater use of bilingual clinicians,

where available, and professional interpreters. The New York State Psychiatric Institute Center of Excellence for Cultural Competence (NYSPI-CECC) is developing guidelines and other training materials on working with interpreters in mental health settings, with separate materials for clinicians, administrators, and individuals served.

- ***Promote new methods for providing language access services.*** Programs indicated a desire for advances in the technology and role of interpretation. Representatives indicated frustration with telephone interpreters; although web-based video was not available for interpretation services in OMH programs at the time of this survey, the majority of program representatives indicated this as their second most-preferred method, after in-person interpretation, and ahead of the currently available telephone interpretation. There are a number of vendors offering web-based video interpretation in multiple languages; the OMH Bureau of Cultural Competence can facilitate access to these services. Additionally, program representatives indicated interest in an expanded role for interpreters, beyond a conventional conduit of information, to include clarifying communication and serving as a cultural broker and advocate. NYSPI-CECC is in the process of developing and testing a cultural brokering model that could be available for future implementation in OMH facilities.

The barriers and challenges identified by programs are not unique to OMH, but rather are faced by behavioral health providers across the country. For example, a national survey of hospitals found that only 13% met all CLAS language standards, and 19% met none of them[24]. Due to the high prevalence of diverse individuals served, OMH's commitment to language access, and the desire of programs for new technology and innovation in this area, OMH has the opportunity to continue to model improvements in language access services that could be beneficial to other government agencies across the state and nationwide. OMH can serve as a vanguard of innovation in the area of language access for individuals with serious mental illnesses.

Appendix I: Program Characteristics

Table 1 shows the descriptive characteristics of all OMH programs surveyed.

Table 1. Characteristics of OMH Programs [Mean (SD)]

	Full Sample[1] (n=135)	Programs with any LEP individuals[2] (n=90)
Age		
Children/Youth (0-17)	28.9% (44.6%)	13.8% (34.4%)
Adult (18-64)	62.1% (40.5%)	75.5% (32.3%)
Older Adult (65+)	9.0% (13.0%)	10.7% (12.7%)
Clinic Size		
Number of unduplicated individuals seen[3]	474 (1523)	606 (1829)
Individuals Born Outside US		
Percent of individuals born outside US	10.0% (14.4%)	14.1% (16.1%)
LEP Individuals Served		
Programs reporting any LEP individuals served	66.7% (47.3%)	100% (0.0%)
Distribution of Population with LEP		
0%	34.4% (47.7%)	0.0% (0.0%)
1-9.99%	45.0% (49.9%)	68.6% (46.7%)
10-19.99%	6.9% (25.4%)	10.5% (30.8%)
20-29.99%	4.6% (21.0%)	7.0% (25.6%)
30-39.99%	3.1% (17.3%)	4.7% (21.2%)
40-49.99%	1.5% (12.3%)	2.3% (15.2%)
50-59.99%	2.3% (15.0%)	3.5% (18.5%)
60-69.99%	0.0% (0.0%)	0.0% (0.0%)
70-79.99%	0.8% (8.7%)	1.2% (10.8%)
80-89.99%	0.0% (0.0%)	0.0% (0.0%)
90-100%	1.5% (12.3%)	2.3% (15.2%)
High/Low LEP		
Low LEP (<10% LEP individuals)	79.4% (40.6%)	68.6% (46.7%)
High LEP (10% or more LEP individuals)	20.6% (40.6%)	31.4% (46.7%)
Services Offered[4]		
Initial Diagnostic	82% (38%)	81% (39%)
Psychological Testing	61% (49%)	62% (49%)
Inpatient	28% (45%)	32% (47%)
Outpatient	67% (47%)	67% (47%)
Day Treatment	17% (38%)	16% (36%)
Substance Abuse Treatment	34% (48%)	42% (50%)

Forensic Services	24% (43%)	33% (47%)
Case Management	48% (50%)	53% (50%)
Psychiatric Emergency Treatment	0.7% (9%)	1% (11%)
Other[5]	19% (39%)	21% (41%)
Region of State		
NYC and Long Island	37.8% (48.7%)	43.3% (49.8%)
Hudson River	24.4% (43.1%)	26.7% (44.5%)
Central	18.5% (39.0%)	17.8% (38.5%)
Western	19.3% (39.6%)	12.2% (32.9%)

[1]n for each analysis varies slightly due to missing data
[2]n for each analysis varies slightly due to missing data
[3]Programs were asked to provide the number of unduplicated individuals their unit had seen over the past 12 months (from the time of survey completion).
[4]Programs could choose as many services as applicable; percentages not meant to sum to 100.
[5]Other services include ACT, crisis screenings/evaluations, crisis intervention, DBT, drop in centers, family therapy, healthcare monitoring, IM injections, formal assessments, assistance with ADLs, in-home services, OT, speech therapy, substance abuse support groups, telepsychiatry, outreach and engagement services, substance abuse support groups, education and vocational services, and health and wellness services.

Appendix II: Primary Caregiver Supplement

Purpose

At the time of data collection for the main survey, OMH programs that provide services to youth under the age of 18 were asked to complete a supplementary survey on the limited English proficiency needs and characteristics of the primary caregivers of individuals served under age 18. Parents or guardians of these individuals may have limited English proficiency and thus require interpreter services, even if the individuals served do not.

Methodology

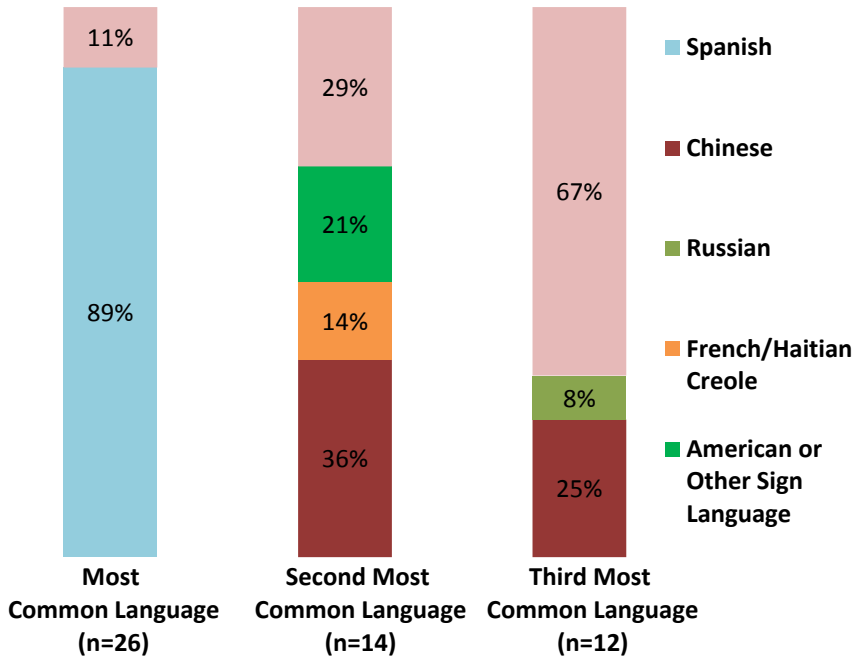
42 programs reported in the main survey that their program provides services to at least some individuals who are under 18. The supplementary primary caregiver survey was sent to those program representatives. 39 programs returned the supplementary survey, yielding a response rate of 93%.

Findings

Full results are provided in Figures 1 and 2 and Table 2. Key findings are:

- Spanish was the most common language spoken by primary caregivers (89%), although none of the programs reported Spanish as the second or third most common language.
- Chinese was the second and third most common language spoken by primary caregivers, although there was a large variety of languages other than the top 6 most common languages in NY State. (No programs reported Italian or Korean as one of their program's most common language spoken by primary caregivers; these two languages are included in Executive Order 26.)
- High rates of use of bilingual clinicians and interpreters were reported as the most common means of service provision for primary caregivers, although use of family and friends and services in English were still reported by some programs as the most common method of service provision.

Figure 1. Most Common Languages Spoken by OMH LEP Caregivers over Last Year



Other languages include: Albanian, African Dialect, Arabic, Bosnian, Japanese, Khmer (Cambodian), Kigigawa, Kurundi, Polish, Serbian, Thai, Turkish, and Vietnamese.

Figure 2. Most Common Service Delivery Method for the 1st, 2nd & 3rd Most Common Languages Spoken by LEP Primary Caregivers, over Last Year

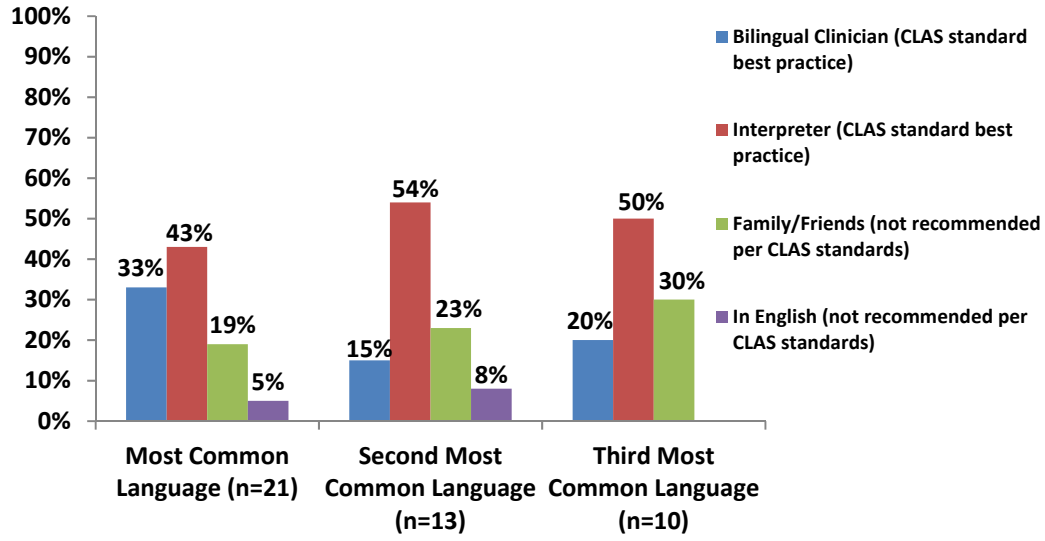


Table 2. Characteristics of Primary Caregivers of OMH Individuals Served under Age 18 [Mean (SD)]

	Full Sample[1] (n=39)	Programs with any LEP caregivers[2] (n=26)
Caregivers Born Outside US		
Caregivers born outside US	12.4% (20.1%)	17.8% (22.2%)
LEP Caregivers		
Programs reporting any LEP caregivers	68.4% (47.1%)	100% (0.0%)
Distribution of Caregiver Population with LEP		
0%	31.6% (47.1%)	0.0% (0.0%)
1-9.99%	42.1% (50.0%)	61.5% (49.6%)
10-19.99%	18.4% (39.3%)	26.9% (45.2%)
20-29.99%	5.3% (22.6%)	7.7% (27.2%)
30-39.99%	2.6% (16.2%)	3.8% (19.6%)
40-49.99%	0.0% (0.0%)	0.0% (0.0%)
50-59.99%	0.0% (0.0%)	0.0% (0.0%)
60-69.99%	0.0% (0.0%)	0.0% (0.0%)
70-79.99%	0.0% (0.0%)	0.0% (0.0%)
80-89.99%	0.0% (0.0%)	0.0% (0.0%)
90-100%	0.0% (0.0%)	0.0% (0.0%)
High/Low LEP		
Low LEP (<10% LEP caregivers)	73.7% (44.6%)	61.5% (49.6%)
High LEP (10% or more LEP caregivers)	26.3% (44.6%)	38.5% (49.6%)
Services Offered[3]		
Initial Diagnostic	82% (39%)	81% (40%)
Psychological Testing	31% (47%)	31% (47%)
Inpatient	28% (46%)	35% (49%)
Outpatient	54% (51%)	50% (51%)
Day Treatment	28% (46%)	38% (50%)
Substance Abuse Treatment	8% (27%)	0% (0%)
Forensic Services	8% (27%)	8% (27%)
Case Management	54% (51%)	54% (51%)
Psychiatric Emergency Treatment	5% (22%)	8% (27%)
Other[4]	13% (34%)	15% (37%)
Region of State		
NYC and Long Island	41.0% (49.8%)	61.5% (49.6%)
Hudson River	15.4% (36.6%)	7.7% (27.2%)
Central	25.6% (44.2%)	11.5% (32.6%)
Western	17.9% (38.9%)	19.2% (40.2%)

[1]n for each analysis varies slightly due to missing data
[2]n for each analysis varies slightly due to missing data
[3]Programs could choose as many services as applicable; percentages not meant to sum to 100.
[4]Other services include crisis screenings/evaluations, educational planning, mental health treatment planning, family therapy, medication therapy, intermediate level of care in a juvenile justice residential setting, OT, speech therapy, rehabilitation, education services, DBT, and telepsychiatry.

Appendix III. Survey Instrument

Interpreter Services Survey

Part I

When answering the following questions, please think about the past 12 months at your clinic or program. Please note that these questions refer to the patients in the clinic or program.

CLINIC OR PROGRAM CHARACTERISTICS

1. Approximately what percentage of patients at your clinic or program are: (Responses should total 100%)

Children/Youth (0-17) _____ %

Adults (18-64) _____ %

Older Adults (65 or older) _____ %

2. What type of services does your clinic or program provide? (Please check all that apply).

- ❑ Initial diagnostic interview
- ❑ Psychological testing
- ❑ Inpatient services
- ❑ Outpatient services
- ❑ Day treatment services
- ❑ Substance abuse treatment
- ❑ Forensic services
- ❑ Case management services
- ❑ Psychiatric emergency department
- ❑ Other (Please specify): _____

PATIENT BACKGROUND AND LANGUAGE NEEDS

When answering the following questions, please think about the past 12 months at your clinic or program.

3. Please think of the past 12 months at your clinic or program. In the past 12 months, approximately how many unduplicated patients were seen at your clinic or program?

_____ Patients

Note: Please provide the total number of ALL unduplicated patients seen at your clinic or program. "Unduplicated" refers to unique patients, not visits. For example, a patient who has three clinic appointments within the same week would be counted once.

4. Approximately what percentage of patients at your clinic or program were born outside the United States?

_____ **%** (Enter a number between 0 and 100. Please include Puerto Rico as "outside the US".)

5. Of those patients seen in the past 12 months, approximately <u>what percent</u> would you estimate have limited English proficiency? Limited English proficiency (LEP) refers to "individuals who do not speak English as their primary language and have a limited ability to read, speak, write, or understand English."

_____ % of patients are LEP

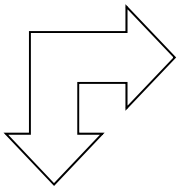
LANGUAGE ACCESS SERVICES

6. Please indicate the top 3 foreign languages spoken by your LEP population. Please write 1 to indicate the most common language, 2 for second most common language and 3 for third most common language.

___ American Sign Language/ Other Sign Language	___ Haitian Creole	___ Somali
___ Amharic	___ Hebrew	___ Spanish
___ Arabic	___ Hindi	___ Swedish
___ Armenian	___ Ilocano	___ Tagalog
___ Bengali	___ Italian	___ Taiwanese
___ Braille	___ Japanese	___ Turkish
___ Cantonese	___ Khmer (Cambodian)	___ Ukrainian
___ Farsi	___ Korean	___ Urdu
___ French	___ Lao	___ Vietnamese
___ Fujianese	___ Mandarin	___ Yiddish
___ German	___ Polish	___ Other 1 (please specify)_____
___ Greek	___ Portuguese	___ Other 2 (please specify)_____
	___ Russian	___ Other 3 (please specify)_____

7. For LEP patients who speak these three most common languages, please indicate the most common means by which services are provided.

In the chart below write the 3 most common languages on the left column and mark with an X the column that indicates the most common means by which services are provided.
Please choose only one response per language

For LEP patients who speak this language… 	**(1) Patient receives services directly from bilingual clinician or staff without the use of interpreter.**	**(2) Patient receives services with the help of family or friends acting as interpreter.**	**(3) Patient receives services with the help of a paid interpreter, not including family or friends. (Interpreters may include professional interpreters, volunteers, or clinical or non-clinical staff acting as interpreters).**	**(4) Patient receives services in English.**	**(5) Patient receives referral to another clinic/program that provides services in patient's primary language**
1. _____ Most common language					
2. _____ Second most common language					
3. _____ Third most common language					

8. What is the primary way that your program determines whether a patient requires interpreter services? Please choose only one response.

❑ Client most states his/her preference for or requests an interpreter.

❑ Therapist/staff determines that the client requires an interpreter.

❑ Each client is queried about his/her English-language proficiency and/or language preference for service

delivery.

9. Sometimes LEP patients receive services directly without interpretation, and sometimes they receive interpretation services. For the LEP patients you served in the past 12 months, what percentage of LEP patients received direct services or interpretation from the following sources? Please enter 0 if you don't use a service or if the service is not available at your program or clinic.

This section pertains to LEP patients who receive services without interpretation. Responses should total 100%.

% LEP patients receiving direct service from this source:

Bilingual clinicians (e.g., psychiatrists, psychologists, social workers, nurses who are fluent in both English and the patient's language) _____ **%**

Clinicians who do not speak patient's language without the use of interpretation _____ **%**

This section pertains to LEP patients who receive services with interpretation. Responses should total 100%.

% LEP patients receiving interpretation from this source:

Bilingual friend or family member(s) of the patient _____ **%**

Bilingual clinicians _____ **%**

(e.g., psychiatrists, psychologists, social workers, nurses

who are fluent in both English and the patient's language)

Non-clinical bilingual staff _____ **%**

(e.g., bilingual housekeeping, administrative staff)

Bilingual volunteers _____ **%**

Professional telephonic interpreters* _____ **%**

Professional in-person interpreters* _____ **%**

Other (please specify) _____ _____ **%**

**Professional interpreters are individuals who have received formal training in professional interpretation and whose primary role at the clinic or program is that of an interpreter. Formal training in professional interpretation may include workshops, continuing medical education (CME) courses, certification programs, private training programs, etc.*

10a. For LEP patients you served in the past 12 months, please indicate how patients accessed services in the following points of care. Check all that apply:

Received direct services from:

Bilingual clinicians

- ❑ Initial diagnostic assessment
- ❑ Ongoing treatment
- ❑ Case management services including discharge planning
- ❑ Please insert other option from question 2, if applicable:

_____

Received direct services from:

Clinicians who don't speak patient's languages without interpretation

- ❑ Initial diagnostic assessment
- ❑ Ongoing treatment
- ❑ Case management services including discharge planning
- ❑ Please insert other option from question 2, if applicable:

_____

Received interpretation from:

Bilingual friend or family member(s) of the patient

- ❑ Initial diagnostic assessment
- ❑ Ongoing treatment
- ❑ Case management services including discharge planning
- ❑ Please insert other option from question 2, if applicable:

_____

Bilingual clinicians

- ❑ Initial diagnostic assessment
- ❑ Ongoing treatment
- ❑ Case management services including discharge planning
- ❑ Please insert other option from question 2, if applicable:

_____

Non-clinical bilingual staff

- ❑ Initial diagnostic assessment
- ❑ Ongoing treatment
- ❑ Case management services including discharge planning
- ❑ Please insert other option from question 2, if applicable:

_____

Bilingual volunteers

- ❑ Initial diagnostic assessment
- ❑ Ongoing treatment
- ❑ Case management services including discharge planning
- ❑ Please insert other option from question 2, if applicable:

_____

Professional telephonic interpreters*

- ❑ Initial diagnostic assessment
- ❑ Ongoing treatment
- ❑ Case management services including discharge planning
- ❑ Please insert other option from question 2, if applicable:

_____

Professional in-person interpreters*

- ❑ Initial diagnostic assessment
- ❑ Ongoing treatment
- ❑ Case management services including discharge planning
- ❑ Please insert other from question 2, if applicable:
  _____

Other

- ❑ Initial diagnostic assessment
- ❑ Ongoing treatment
- ❑ Case management services including discharge planning
- ❑ Please insert other from question 2, if applicable:
  _____

10b. For LEP patients served at your clinic or program in the past months, how did LEP patients access services of information at the front desk or reception area? Please check all that apply.

Patients received services or information:

In their own language directly from:

- ❑ Bilingual clinicians
- ❑ Non-clinical bilingual staff
- ❑ Bilingual volunteers

In English from:

- ❑ Clinicians who do not speak their language
- ❑ Non-clinical staff who do not speak their language

Through interpretation conducted by:

- ❑ Bilingual family members or friends of patient
- ❑ Bilingual clinicians
- ❑ Non-clinical bilingual staff
- ❑ Bilingual volunteers

❑ Professional telephonic interpreters

❑ Professional in-person interpreters

❑ Other (please specify) _____

A variety of factors influence a clinic or program's decisions regarding how best to meet the language needs of their patients.

REASONS FOR USE

11. Thinking about your clinic or program, which of the following factors contributed to the decision to use professional interpreters in the past 12 months? (Check all that apply)

❑ Not applicable

❑ We do not have staff who speak the specific language needed.

❑ The treatment situation is very delicate, requiring a high level of professionalism.

❑ We have staff who speak the language, but the high number of LEP (limited English proficiency) patients

exceeds our ability to meet the demand.

❑ We have staff who speak the language, but they are not trained in interpretation.

❑ We have staff who speak the language, but they are not knowledgeable about the cross-cultural issues (e.g.,

symptom expression, cultural beliefs about medication, stigma).

❑ Funds were available for this use.

❑ In order to meet legal requirements regarding language access.

❑ Other (please specify):
_____

12. Thinking about your clinic or program, which of the following factors contributed to the decision to use non-clinical bilingual staff (e.g., administrative, housekeeping staff) and volunteers who have not received formal training in interpretation as interpreters in the past 12 months? (Check all that apply)

❑ Not applicable

❑ Need for interpretation is so rare that we can meet this need with existing staff.

❑ Limited funds to pay for professional interpreters.

❑ Limited availability of bilingual clinicians.

❑ Lag time to obtain a professional interpreter is too long.

❑ Available professional interpreters have little training/experience in mental health settings.

❑ Available professional interpreters have little cultural knowledge or experience.

❑ Staff and/or patients do not like using telephone interpreting services.

❑ Other (please specify):

_____

13. Thinking about your clinic or program, which of the following factors have contributed to the decision to use bilingual family or friends of the patient as interpreters in the past 12 months? (Check all that apply)

❑ Not applicable

❑ Patients prefer that family or friends serve as interpreters above all other options.

❑ Patient has a strong preference for the characteristics of the interpreter (e.g., gender, age, nationality), which

may not be available from a professional interpreter service.

❑ Because it is a small community, patients have concerns about violations of confidentiality with an unknown

interpreter.

❑ Staff belief that doing so would help gain patients' trust and/or reduce patient fears or concerns.

❑ Staff belief that doing do would help to engage the family in treatment.

❑ There are limited funds to pay for professional interpreters.

❑ There is limited availability of bilingual staff.

❑ The lag time to obtain a professional interpreter is too long.

❑ Available professional interpreters have little training/experience in mental health settings.

❑ Available professional interpreters have little cultural knowledge or experience.

❑ Staff and/or patients do not like using telephone interpreting services.

❑ Other (please specify):

_____

In this next section, we are interested in your clinic or program's experiences of working with interpreters and their impact on service provision, as well as barriers to effective staff-interpreter relationships. We are also interested in staff and client preferences regarding interpreter roles, functions, and mode of access.

EVALUATION OF SERVICE USE

14. Please think of your clinic or program's experiences working with IN-PERSON PROFESSIONAL INTERPRETERS (e.g., face-to-face) in the past 12 months. By professional interpreters, we mean individuals who have received formal training in interpretation and whose primary role is that of an interpreter, in this case through face-to-face interactions. Please rate the degree to which in-person professional interpreters have helped or hindered services in the following areas:

Diagnosis/Assessment

- ❑ Significantly helped
- ❑ Helped
- ❑ Neither helped nor hindered
- ❑ Hindered
- ❑ Significantly hindered
- ❑ Not applicable

Patient engagement in treatment

- ❑ Significantly helped
- ❑ Helped
- ❑ Neither helped nor hindered
- ❑ Hindered
- ❑ Significantly hindered
- ❑ Not applicable

Staff understanding of social, cultural, or religious aspects of care

- ❑ Significantly helped
- ❑ Helped
- ❑ Neither helped nor hindered
- ❑ Hindered
- ❑ Significantly hindered
- ❑ Not applicable

Preservation of patient confidentiality

- ❑ Significantly helped
- ❑ Helped
- ❑ Neither helped nor hindered
- ❑ Hindered
- ❑ Significantly hindered
- ❑ Not applicable

15. Please think of your clinic or program's experiences working with PROFESSIONAL TELEPHONIC INTERPRETERS in the past 12 months. Please rate the degree to which professional telephonic interpreters have helped or hindered services in the following areas:

Diagnosis/Assessment

- ❑ Significantly helped
- ❑ Helped
- ❑ Neither helped nor hindered
- ❑ Hindered
- ❑ Significantly hindered
- ❑ Not applicable

Patient engagement in treatment

- ❑ Significantly helped
- ❑ Helped
- ❑ Neither helped nor hindered
- ❑ Hindered
- ❑ Significantly hindered
- ❑ Not applicable

Staff understanding of social, cultural, or religious aspects of care

- ❑ Significantly helped
- ❑ Helped
- ❑ Neither helped nor hindered
- ❑ Hindered
- ❑ Significantly hindered
- ❑ Not applicable

Preservation of patient confidentiality

- ❑ Significantly helped
- ❑ Helped
- ❑ Neither helped nor hindered
- ❑ Hindered
- ❑ Significantly hindered
- ❑ Not applicable

16. There are a number of challenges that can make it difficult to implement language access services using professional interpreters. Please indicate the degree to which the following statements apply to your clinic or program.

Our staff has not been adequately trained in the use of professional interpreters.

- ❑ Strongly applies
- ❑ Applies
- ❑ Applies somewhat
- ❑ Not applicable

Question 16 continues onto the next page

Working collaboratively with a professional interpreter requires more time than is available.

- ❑ Strongly applies
- ❑ Applies
- ❑ Applies somewhat
- ❑ Not applicable

Given competing demands, it is difficult to prioritize language access programs that use professional interpreters.

- ❑ Strongly applies
- ❑ Applies
- ❑ Applies somewhat
- ❑ Not applicable

Please note: The following questions refer only to the use of <u>TELEPHONE</u> interpreters.

The quality of communication when using telephone interpreters has not been satisfactory.

- ❑ Strongly applies
- ❑ Applies
- ❑ Applies somewhat
- ❑ Not applicable

Telephonic interpreters are constrained in their ability to assist with key aspects of patient care such as treatment engagement and rapport building.

- ❑ Strongly applies
- ❑ Applies
- ❑ Applies somewhat
- ❑ Not applicable

Another obstacle to the use of telephone interpretation (SPECIFY):

_____

- ❑ Strongly applies
- ❑ Applies
- ❑ Applies somewhat
- ❑ Not applicable

EVALUATION OF SERVICE USE

In this next section, we are interested in your clinic or program's experiences of working with interpreters and their impact on service provision, as well as barriers to effective staff-interpreter relationships. We are also interested in staff and client preferences regarding interpreter roles, functions, and mode of access. Please answer the following questions whether or not your clinic or program works with interpreters.

17. Clinics and programs have different preferences regarding the roles and functions of professional interpreters. Some prefer that the interpreter remains a neutral and unobtrusive presence, whereas others prefer a more active and flexible role in the clinic. In general, what is the most appropriate role for an interpreter in your clinic or program? Please choose only one response.

❑ **Conduit:** *The interpreter should provide a complete and accurate linguistic conversion of information conveyed from one language to another without additions, omissions, editing or polishing.*

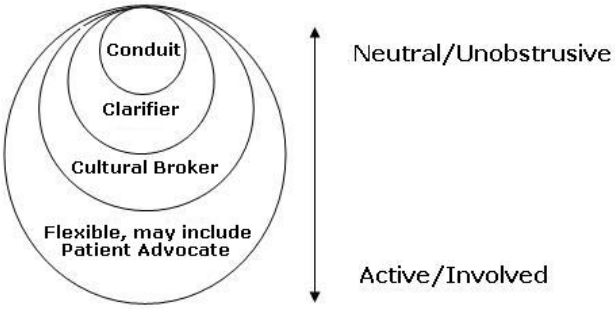
❑ **Clarifier:** *The interpreter should not limit themselves to accurate linguistic conversion BUT ALSO clarify information that is being communicated by using simpler language, using metaphors or word pictures of terms that have no linguistic equivalent in the patient's language, or other strategies to enhance clarity and comprehension on both sides.*

❑ **Cultural Broker:** *The interpreter should provide accurate linguistic conversion, provide clarifications and help overcome barriers to communication embedded in cultural, social class, religious, and other social differences when such differences may lead to a misunderstanding. They may provide cultural explanations and assist in exploring information that will reduce cultural barriers to understanding.*

❑ **An Incremental and Flexible role, including Advocacy:** *The interpreter role should be determined on a case-by-case basis in order to effectively facilitate patient-provider understanding. Roles may range from the least intrusive role of conduit, to clarifier, to cultural*

broker, to the most active role of patient advocate, in which the interpreter is empowered to take actions outside of the interview as necessary to address barriers to care.

18. Assuming that interpreters have the training and experience to assume various roles (i.e., conduit, cultural broker, etc.) who should determine the tasks, functions, and roles that the interpreter should assume in a given situation? <u>Please choose only one response.</u>



- ❑ Interpreter has complete discretion.
- ❑ Interpreter has more discretion than clinician.
- ❑ Interpreter and clinician have equal input.
- ❑ Interpreter has less discretion than clinician
- ❑ Clinician has total authority.

19. In your opinion, what is your clinical staff's preference for the format of interpretation?

Please rank so 1=highest preference, 2=middle preference, and 3=lowest preference.

_____ Telephone

_____ In-person (Professional)

_____ Videoconferencing*

*Videoconferencing involves communicating in real time with an off-site professional interpreter through the use of standard computer networks to transmit audio and video data.

20. In your opinion, what is your patient population's preference for the format of interpretation?

Please rank so 1=highest preference, 2=middle preference, and 3=lowest preference.

_____ Telephone

_____ In-person (Professional)

_____ Videoconferencing

21. In recent years, videoconferencing has emerged as a new approach to interpretation. Videoconferencing involves communicating in real time with an off-site professional interpreter through the use of standard computer networks to transmit audio and video data.

If your agency had access to videoconferencing, how receptive would your clinical staff be to working with a professional interpreter using a videoconferencing format?

- ❑ Very receptive
- ❑ Receptive
- ❑ Somewhat receptive
- ❑ Not receptive at all

22. Which of the following issues would be advantages of utilizing videoconferencing as a format for professional interpretation? (Check all that apply)

- ❑ It could be faster than accessing an in-person professional interpreter, particularly for languages that are less commonly spoken.
- ❑ Unlike telephonic interpretation, the patient, clinician, and interpreter can see each other, which could better facilitate patient engagement and rapport-building.
- ❑ Unlike telephonic interpretation, the patient, clinician, and interpreter can see each other, which could help improve communication.
- ❑ None of the above

23. Which of the following issues would be barriers to utilizing videoconferencing as a format for professional interpretation? (Check all that apply)

- ❑ Lack of equipment (e.g., computers, webcams)
- ❑ Lack of access to the Internet
- ❑ Lack of information technology (IT) support
- ❑ Administration does not allow use of videoconferencing or related technologies
- ❑ Cost of the service
- ❑ Concerns about confidentiality/security of video data
- ❑ Consumer mistrust/discomfort with technology
- ❑ Staff mistrust/discomfort with technology
- ❑ Staff preference for another mode of interpretation (please specify)

  _____
- ❑ None of the above

Part II

INTERPRETER SERVICES SURVEY--PRIMARY CAREGIVER SUPPLEMENT

(for child/adolescent patients only-disregard if your program does not serve child/adolescent patients)

*For the remaining questions, please think about the **primary caregivers** (usually parents or legal guardians) with whom you interact most often to coordinate care for each child or adolescent patient. When answering the following questions, please think about the past 12 months at your clinic or program*

CLINIC OR PROGRAM CHARACTERISTICS

1. What types of services does your clinic or program provide that include the patient's *primary caregiver(s)*? (Please check all that apply).

- ❑ Initial diagnostic interview
- ❑ Psychological testing
- ❑ Inpatient services
- ❑ Outpatient services
- ❑ Day treatment services
- ❑ Substance abuse treatment
- ❑ Forensic services
- ❑ Case management services
- ❑ Psychiatric emergency department
- ❑ Other → **please include this service in question #8a**

(Please specify): _____

CAREGIVER BACKGROUND AND LANGUAGE NEEDS

2. Of those child/adolescent patients seen in the past 12 months at your clinic or program, approximately what percentage had a *primary caregiver* who was born outside the United States (including Puerto Rico)?

Please enter a number between 0 and 100. _____%

3. Of those child/adolescent patients seen in the past 12 months, approximately what percent had a *primary caregiver* who has limited English proficiency? Limited English proficiency refers to "individuals who do not speak English as their primary language and have a limited ability to read, write, speak, or understand English."

Please enter a number between 0 and 100. _____%

4. Please indicate the top 3 foreign languages spoken by the LEP *primary caregivers* of your patients. Write 1, 2, or 3 next to the top 3 foreign languages:

___ American Sign Language/ Other Sign Language	___ Haitian Creole	___ Somali
___ Amharic	___ Hebrew	___ Spanish
___ Arabic	___ Hindi	___ Swedish
___ Armenian	___ Ilocano	___ Tagalog
___ Bengali	___ Italian	___ Taiwanese
___ Braille	___ Japanese	___ Turkish
___ Cantonese	___ Khmer (Cambodian)	___ Ukrainian
___ Farsi	___ Korean	___ Urdu
___ French	___ Lao	___ Vietnamese
___ Fujianese	___ Mandarin	___ Yiddish
___ German	___ Polish	___ Other 1 (please specify)
___ Greek	___ Portuguese	___ Other 2 (please specify)
	___ Russian	___ Other 3 (please specify)

5a. For LEP *primary caregivers* who speak the most common foreign language listed above, please indicate the most common means by which services are provided: (Check one)

❑ Primary caregiver receives services directly from bilingual clinician or staff without the use of an interpreter.

❑ Primary caregiver receives services with the help of family or friends acting as interpreter.

❑ Primary caregiver receives services with the help of a paid or volunteer interpreter, not including family or friends.(Interpreters may include professional interpreters, volunteers, or clinical or non-clinical staff acting as interpreters).

❑ Primary caregiver receives services in English.

❑ Primary caregiver receives referral to another clinic/program that provides services in primary caregiver's primary language.

5b. For LEP *primary caregivers* who speak the second most common foreign language listed above, please indicate the most common means by which services are provided: (Check one)

❑ Primary caregiver receives services directly from bilingual clinician or staff without the use of interpreter.

❑ Primary caregiver receives services with the help of family or friends acting as interpreter.

❑ Primary caregiver receives services with the help of a paid or volunteer interpreter, not including family or friends. (Interpreters may include professional interpreters, volunteers, or clinical or non-clinical staff acting as interpreters).

❑ Primary caregiver receives services in English.

❑ Primary caregiver receives referral to another clinic/program that provides services in primary caregiver's primary language.

5c. For LEP *primary caregivers* who speak the third most common foreign language listed above, please indicate the most common means by which services are provided: (Check one)

❑ Primary caregiver receives services directly from bilingual clinician or staff without the use of interpreter.

❑ Primary caregiver receives services with the help of family or friends acting as interpreters.

❑ Primary caregiver receives services with the help of a paid or volunteer interpreter, not including family or friends. (Interpreters may include professional interpreters, volunteers, or non-clinical staff acting as interpreters).

❑ Primary caregiver receives services in English.

❑ Primary caregiver receives referral to another clinic/program that provides services in primary caregiver's primary Language.

LANGUAGE ACCESS SERVICES

6. What us the primary way that your program determines whether a *primary caregiver* requires interpreter services? Please choose one.

❑ Caregiver must state his/her preference for or request an interpreter.

❑ Therapist/staff determines that the caregiver requires an interpreter.

❑ Each caregiver is queried about his/her English-language proficiency and/or language preference for service delivery.

7. Sometimes LEP caregivers interact with the provider directly without interpretation, and sometimes they receive interpretation services to facilitate their interaction with the provider. For the child/adolescent patients you served in the past 12 months, what percentage had LEP primary caregivers who received direct services or interpretation from the following sources? Please enter 0 if you don't use a service or if the service is not available at your program or clinic.

This section pertains to LEP caregivers who receive services without interpretation. Responses should total 100%.

Received Direct Services From:

Bilingual clinicians (e.g. psychiatrists, psychologists, social workers, nurses who are fluent in both English and the caregiver's language)

Please enter a number between 0 and 100. _____%

Clinicians who do not speak the primary caregiver's language without the use of interpretation

Please enter a number between 0 and 100. _____%

This section pertains to LEP caregivers who receive services with interpretation. Responses should total 100%.

Received Interpretation From:

Bilingual friend or family member(s) of the primary caregiver

Please enter a number between 0 and 100. _____%

Bilingual clinicians (e.g. psychiatrists, psychologists, social workers, nurses who are fluent in both English and the caregiver's language)

Please enter a number between 0 and 100. _____%

Non-clinical bilingual staff (e.g. bilingual housekeeping, administrative staff)

Please enter a number between 0 and 100. _____%

Bilingual volunteers

Please enter a number between 0 and 100. _____%

Professional telephonic interpreters*

Please enter a number between 0 and 100. _____%

Professional in-person interpreters*

Please enter a number between 0 and 100. _____%

Other (please specify)

Please enter a number between 0 and 100. _____%

**Professional interpreters are individuals who have received formal training in professional interpretation and whose primary role at the clinic or program is that of an interpreter. Formal training in professional interpretation may include workshops, continuing medical education (CME) courses, certification programs, private training programs, etc.*

8a. For child/adolescent patients you served in the past 12 months with LEP primary caregivers, please indicate how *caregivers* accessed services in the following points of care. Check all that apply.

	Received direct services from:		Received interpretation from:						
	Bilingual clinicians	**Clinicians who don't speak caregiver's language without interpretation**	**Bilingual friend or family member(s) of the caregiver**	**Bilingual clinicians**	**Non-clinical bilingual staff**	**Bilingual volunteers**	**Professional telephonic interpreters ***	**Professional in-person interpreters ***	**Other**
Initial diagnostic Assessment	❑	❑	❑	❑	❑	❑	❑	❑	❑
Ongoing treatment	❑	❑	❑	❑	❑	❑	❑	❑	❑
Case management services, including discharge planning	❑	❑	❑	❑	❑	❑	❑	❑	❑
Other, from question #2	❑	❑	❑	❑	❑	❑	❑	❑	❑

**Professional interpreters are individuals who have received formal training in professional interpretation and whose primary role at the clinic or program is that of an interpreter. Formal training in professional interpretation may include workshops, continuing medical education (CME) courses, certification programs, private training programs, etc.*

8b. For child/adolescent patients served at your clinic or program in the past 12 months with LEP *primary caregivers,* how did the LEP caregivers access services or information at the front desk or reception area? Please check all that apply.

***Primary caregivers* received services or information:**

In their own language directly from:

- ❑ Bilingual clinicians
- ❑ Non-clinical bilingual staff
- ❑ Bilingual volunteers

In English from:

- ❑ Clinicians who do not speak their language
- ❑ Non-clinical staff who do not speak their language

Through interpretation conducted by:

- ❑ Bilingual family members or friends of caregiver
- ❑ Bilingual clinicians
- ❑ Non-clinical bilingual staff
- ❑ Bilingual volunteers
- ❑ Professional telephonic interpreters
- ❑ Professional in-person interpreters
- ❑ Other (please specify) _____

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