Dos and Don’ts: Guidelines for Clinicians Working with Interpreters in Mental Health Settings

General Guidelines
This brief is intended to provide an outline of best practices for clinicians working with interpreters in mental health settings.

- **Interpreters** facilitate spoken or signed communication between the patient and provider. Translators work with written text.
- Interpreters are obligated to interpret everything said by the patient, provider, surrogate decision makers, and health care proxies (e.g., parents, guardians, spouses, adult children, or persons with durable power of attorney for health care).
- Interpreters facilitate the exchange of communication between the patient and provider while utilizing the first person when interpreting (e.g., “I want…” instead of “Patient says that s/he wants…”).
- Clinician and patient should speak directly to each other during the interpreted session. If the clinician or patient needs to speak to the interpreter directly, a summary of that conversation should be provided by the interpreter to the other party.

Patients with surrogate decision makers or health care proxies who are limited English proficient (LEP) should be provided with interpreting services, even if the patient is not LEP.

**DOS**

- Keep in mind that the best practice for service provision to people with limited English proficiency (LEP) is to utilize bilingual clinicians. The next best practice is to utilize a trained interpreter (in-person, telephonic, or video-conferencing).
- Use of untrained family members or friends is not recommended.
- Know how to access an interpreter (in-person, telephonic, or video-conferencing) and be familiar with the facility’s language access policies and procedures.
- Provide access to interpreters in a timely manner.**
- Inform patients that interpreter services are provided by the organization at no cost to the patient or patient’s family.**
- Recognize that the clinician leads the session, but a collaborative relationship needs to be established between the clinician and the interpreter.
- Set a brief introductory meeting (pre-session) with the interpreter, which may be by phone, and cover the following areas:
  - Clinician should:
    - share basic information about the patient (e.g., demographic information, presenting problem).
    - If time permits, share his/her level of experience with mental health interpreting and ask interpreter for this information as well.
    - clarify the type of healthcare setting and purpose of the appointment (e.g., “intake evaluation for outpatient clinic”).
    - share and discuss pertinent issues that may come up during the appointment, including technical terms or acronyms (e.g., “PTSD,” “EEG”) or medications.
    - introduce the interpreter to the patient.
    - introduce other person(s) in the room (e.g. surrogate decision makers, health care proxies, family members, providers).
- If working with novice interpreters, emphasize to the interpreter the importance of interpreting the patient’s speech or phrasing “as is”, rather than editing or organizing it to be more understandable (e.g., some psychotic patients may speak in delusional or disorganized ways, which is important for clinicians to know).
- Remember the interpreter will interpret everything the clinician and the patient say, so be aware that what is said by the clinician will be interpreted to the patient (and vice versa).
- Document the name of the interpreter in the patient’s chart (in-person, telephonic, or videoconferencing). If a relative or friend is acting as the interpreter, document the name of the person and his/her relationship to the patient.
- Although the use of untrained family or friends is not a recommended practice, a patient has the right to choose a friend or relative. However, the clinician also has the right to have a trained interpreter present during the session.
- Be aware that friends and family members are usually untrained or “ad hoc” interpreters. The provider should instruct them to interpret everything said by the patient and provider.

**DON'TS**

- Address comments to the patient while looking at the interpreter, or refer to the patient in the 3rd person. Instead, the clinician should speak directly to and look at the patient.
- Shout, speak overly slowly or too quickly, or mumble. Instead, speak in a normal tone and pace of voice and pause regularly to allow the interpreter to interpret.
- Have extensive sidebars between the patient and interpreter or clinician and interpreter in the presence of the other party. Remember, the interpreter is obligated to interpret everything that is being said by the patient or provider.
- In the case of sign language interpreting, clinicians should not use excessive hand gestures or attempt to use basic sign language as these may confuse the patient. Instead, allow the sign language interpreter to facilitate the communication.
- Use complicated medical jargon and highly idiomatic expressions that are difficult to interpret and are usually based on culturally specific associations (e.g., “do you feel blue?”).
- Ask the interpreter to persuade, convince, or demonstrate to the patient his/her support for one clinical option over another.
- Assume that, because the patient and interpreter share the same language, they also share the same cultural and ethnic background.
- Provide services in English to a patient with limited English proficiency without an interpreter. Instead, the clinician should seek appropriate interpreter services.
- Request that the patient bring his/her own interpreter to the appointment.
- Assume that, because a patient may have a limited command of English, he or she does not want or need an interpreter.

**Interpretation and Language Access Resources**

- NY State Office of Mental Health—Bureau of Cultural Competence, [http://www.omh.ny.gov/omhweb/cultural_competence](http://www.omh.ny.gov/omhweb/cultural_competence)—Provides information on how to access approved vendors for interpreter services and provides training in accessing interpretation and translation services.
- Guidelines for Use of Medical Interpreter Services, Association of American Medical Colleges, [https://www.aamc.org/students/download/70338/data/interpreterguidepdf.pdf](https://www.aamc.org/students/download/70338/data/interpreterguidepdf.pdf)—Provides guidelines and offers tips for working with an ad hoc interpreter (e.g., family, friends, or untrained staff).
- Hablamos Juntos: Language Policy and Practice in Health Care, [http://hablamosjuntos.org/default.aspx](http://hablamosjuntos.org/default.aspx)—Information and resources on developing language access programs for health care organizations providing services to Latinos.
- Limited English Proficiency (LEP); A Federal Interagency Website, [http://www.lep.gov/](http://www.lep.gov/)—Provides information on language access for federally conducted and federally assisted programs; also serves as a clearinghouse, linking to information, resources, and tools for limited English proficiency and language services resources.

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* Applicable to OMH Licensed Facilities & required by the New York State Mental Hygiene Regulation Section 527.4 and Office of Mental Retardation and Developmental Disabilities Regulation Section 633-4.
How to establish a positive triadic relationship between the clinician, interpreter and patient

Reiterate to the patient that his or her confidentiality will be preserved by both the clinician and the interpreter. This is particularly important in smaller language communities.

Make eye contact with the patient and use positive non-verbal communication (e.g., smiling when appropriate, appropriate tone of voice, use of patient’s name when appropriate) to help engage the patient in care.

Meet with the interpreter after the patient’s session has ended, in order to debrief the session as well as get the interpreter’s assessment of issues related to the patient’s cultural background or community, speech issues (e.g., organization, fluency), or any other information that may not have come up during the interpretation of the actual session but would be relevant for diagnosis or treatment.

In cases where the content of the session involves traumatic or other upsetting experiences, this “debriefing” session will also help clarify whether the interpreter is suffering from “vicarious traumatization” and could use further debriefing or access to additional resources.

References


