Limited English Proficiency as a Barrier to Health & Social Services

Prepared for:

Office For Civil Rights
Department of Health & Human Services

Prepared by:

Macro International, Inc.

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ABSTRACT

This report examines the issue of barriers to health and social services created by Limited English Proficiency. Because of its immigrant roots, the United States has always had a substantial population that, at least for some period of time, possessed limited understanding of English. During its early development, clashes were common concerning language. Although English eventually became the dominant language, it has never been designated as the nation's official language.

The Office for Civil Rights in the Department of Health and Human Services oversees the connection between delivery of services by recipients of DHHS funds and free access to those services by the population. The major question they seek always to answer with regard to services funded by the Department is: "are the services freely available to all sectors of the population, without regard to race, creed, color, or national origin?"

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CHAPTER 1: INTRODUCTION

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This report outlines the range of current practices regarding the provision of language appropriate services to persons with Limited English Proficiency. Information is reported from site visits and interviews in three major urban areas: Seattle, Boston and Los Angeles. The interviews yielded information concerning legislative and executive branch interventions, private and public sector initiatives and responses to the tide of immigrants and refugees in need of services and the relative costs and benefits derived from operation of alternative models of delivering care when language is a barrier to effective communication.

1. Problem Statement

Physician: "*M., would you ask her if she is allergic to any medications?*"
Aide (in Navajo): "*Does the white man's medicine make you want to vomit?*"
Patient (in Navajo): "*No.*"
Physician: "*Did you ask her if the white man's medicine makes her vomit?*"
Aide: "*Yes.*"
Physician: "*That's not quite what I need to know, I have to know about allergies and medications.*"
Aide: "*Well, I don't know about those things . . . what's allergy mean anyway? If you know so much Navajo, why don't you ask her?*"[1]

Communications between doctor and patient are fraught with difficulty, often because of the great disparity in knowledge about medicine. Physicians sometimes ask a leading question that the patient does not understand; patients respond with what they think the doctor wants to know. If effective communication is difficult when both parties speak the same language, those difficulties become magnified enormously when they speak different languages. Because communication between physician and patient is critical to the outcome of a medical encounter, it

1 Robert W. Putsch, M.D., *Cross-cultural Communication: The Special Case of Interpreters in Health Care*, JAMA, Dec. 20 1985-Vol 254, No. 23.

is vital that the process be brought within normal language boundaries for this type of interaction. Increasingly, within America, this process has become complicated by language differences. When language becomes a barrier, who is responsible for bridging the barrier?

One of the primary functions of the Office for Civil Rights (OCR) within the U.S. Department of Health & Human Services (DHHS) is oversight of the programs administered by the Department with reference to the laws established to guarantee the civil rights of all citizens. At issue always is the extent to which institutions or individuals who receive Department funds follow civil rights laws in their use of those funds. For at least the past 25 years, a major issue has been the rights of citizens and recent immigrants with Limited English Proficiency (LEP) to receive the same type and quality of services available to the population at large. Title VI of the U.S. Civil Rights Act of 1964 states:

"No person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."[2]

What is it that constitutes effective compliance with these laws as it concerns services to LEP population groups? Does language constitute a barrier to services as effective as a policy that denies access to service by, for example, a specific racial group? At issue are the respective responsibilities of the service providers and the consumers of their services with regard to language. This basic question has prompted calls for a specific regulation that would define the basic responsibilities of service providers. Largely, these calls for regulation argue that responsibility for language appropriate services rests with the service provider and not with the consumer of those services. The main issue that would be addressed by such a regulation is of relatively recent origin in this country.[3]

Although non-English speaking immigrants in the United States have always faced a language barrier, it is only in the past 25 years, beginning with the waves of immigrants from Southeast Asia following the Vietnam War that we have had to address the issue of large numbers of LEP persons who needed immediate access to the nation's health and social services. The paragraphs below discuss the changing environment in which providers of health and social services find themselves in contemporary America. That environment poses special problems to the services sector, in which

2 42 U.S.C. § 2000d.

3 The involvement during the past 15 years of legal and advocacy organizations, such as the Mexican American Legal Defense Fund (MALDEF), the National Health Law Center, the Congressional Hispanic Caucus, Japanese American Citizen's League, National Council of La Raza, and the Asian and Pacific Islander Legal Center, has prompted OCR to explore regulatory alternatives.

speak two languages. Instead, the population consists of people who speak English and people who speak Spanish. In such cities, we may be witnessing the growth of segregated systems of health and social services, in which market forces are beginning to drive the development of bilingual provider systems aimed, in the case of Los Angeles, at Hispanic communities. In this approach, providers recruit professionals who are bilingual, thereby finessing the entire issue of interpreters. Even in areas such as Los Angeles, in which Spanish is a major language group, dozens of other languages exist whose members will not be served by such bilingual systems. The basic problem remains and continues to grow with immigrants arriving from all parts of the globe associated with the continuing balkanization of former nations and empires.

3. LEP in the Context of Health & Social Services

The dramatic shift in demographics coupled with the emergence of a multilingual society have significant implications for the provision of health and social services throughout the United States. Nearly all service delivery systems are likely to be affected, although some more profoundly than others. In a 1983 article, Muecke asserts "... *Some 90 percent of* [recent refugees from Southeast Asia] *are under 45 years of age. Consequently, their first contacts with our health care system are usually through obstetrics, pediatrics, and emergency rooms.*"[5] A 1985 study of Mexican immigrant utilization of U.S. health services in San Diego found that, "... *In general Mexican immigrants appear to have rates of health service utilization below those of the general U.S. population.... Compared to the general U.S. population, Mexican immigrants, particularly the undocumented, utilize hospitals and clinics as a source of care to a much greater degree, relying less upon private doctors.*"[6] A recent study of 83 public and private teaching hospitals, conducted by the National Public Health and Hospital Institute, reported that, "*Overall, more than 11 percent of patients ... required interpreter services. One-third of the responding institutions reported that on average, 27% of their patients required interpreter services.*"[7] A recent national survey of minority health care conducted by Louis Harris and Associates found that language barriers in health care present problems for 21 percent of Americans. Within this LEP population, 26 percent of Hispanic adults

5 M.A. Muecke, *Caring for Southeast Asian Refugee Patients in the USA.* American Journal of Public Health. April 1993, Vol. 73, No.4. p.431.

6 L.R. Chavez, W.A. Cornelius, O.W. Jones, *Mexican Immigrants and the Utilization of U.S. Health Services: The Case of San Diego.* Social Science Medicine. Vol. 21, No. 1. p.101.

7 D. Andrulis, C. Ginsberg, V. Martin, C. McGregor, Y. Shaw-Taylor, *Interpretation and Translation Services in Health Care: A Survey of US Public and Private Teaching Hospitals.* A National Public Health and Hospital Institute Report, March 1995. p.viii.

and 22 percent of Asian American adults require the use of an interpreter in health care services.[8]

With respect to the provision of health and social services, what are the consequences associated with the inability to communicate for the LEP individual? for the provider? for society as a whole? The implications for the LEP individual are perhaps most obvious. But the consequences for providers and society are considerable and should not be dismissed. In a recent issue of the Journal of the American Medical Association, Woloshin, Bickett and others, physicians themselves, state, "... *when finding an interpreter is difficult or means long delays, physicians or patients may attempt to communicate by using inadequate language skills.*"[9] The following example illustrates the ramifications of failed communication during a service encounter for the LEP individual, the provider, and society. A Russian refugee, distressed at having a sore throat he could not shake, complained of "urgina" to staff at social services agency in New York City. They referred him to a local hospital for care and were quite surprised some weeks later when he received a bill in excess of $5,000 for hospital services. A call to the hospital revealed that a well-meaning emergency room physician had misunderstood the refugee's condition as "angina" and had ordered a series of tests for a heart problem. In this example, failed communication resulted in inappropriate treatment for the LEP patient and incurred excessive, unnecessary costs to the refugee or his insurer. Even when the LEP client is able to access the service system, the language barrier can result easily in a misdiagnosis, or the provision of inappropriate or inadequate services. The inability to communicate in English may also result in the denial of needed services for which the LEP individual is eligible and entitled. The case of the Russian refugee also illustrates the problems faced by providers. In the example, the doctor could not accurately take a medical history and was thus unable to fulfill his professional responsibilities. The inability to communicate with LEP clients poses ethical, professional, and legal dilemmas for the provider. For the Russian patient, failed communication led to a battery of expensive medical tests that were completely unnecessary. These costs are eventually passed on to society in the form of rising health care costs. Additionally, society has a vested interest in ensuring that all individuals who are infected with a communicable disease are diagnosed and receive proper treatment.

4. Factors that Affect Language Access in Different Service Areas

As mentioned earlier, the huge numbers of immigrants and refugees entering the U.S. have had a major impact on local service systems. There are many factors involved in service delivery to the LEP

8 Louis Harris and Associates, Inc. "News Release," The Commonwealth Fund National Comparative Survey of Minority Health Care, March 20, 1995.

9 S. Woloshin, N. Bickell, L. Schwartz, F. Gany, and G. Welch, *Language Barriers in Medicine in the United States,* JAMA, March 1, 1996, Vol. 273, No.9.

population that must be considered in planning and providing appropriate services. The status of LEP individuals—whether immigrant, refugee, undocumented alien, or foreign visitor—must be considered by professionals. Although stereotyping should be avoided, there are certain issues associated with each status that would affect language access. Some LEP individuals are highly educated and are aware of interpreter and translator services, while other LEP patients may be illiterate in their native language and lack an awareness of the service systems available to them. Cultural factors can be equally important in examining behaviors that will affect health access. Many cultures promote use of alternative medicine and have difficulty accepting treatment or advice from physicians trained in Western medicine. Some cultures provide limited medical services to their populations, while others offer a broad range of services. The culture from which the LEP individual originates will often determine how aggressive LEP persons are in seeking appropriate treatment. Educational and cultural differences lead some LEP clients to demand language services and others to accept the status quo with complacency and obedience.

The degree to which any particular ethnic or racial group is able to assimilate into the larger society is also a determining factor in providing language services. First generation refugees and immigrants pose the greater burden on society in terms of language assistance services, while second generation citizens usually become proficient in the English language. In many cases, second and third generation family members speak only English, or have a very limited knowledge of their native language.

The level of English acquired by refugees and immigrants can greatly affect socioeconomic status, which, in turn, affects their insurability. There are few opportunities in the job market for individuals who have difficulty speaking English, and often those jobs lack insurance and other benefits.

The sense of community among different LEP groups can also affect the overall access. Often, when large nu mbers of LEP individuals exist in a community, there are enough community members available to serve as interpreters. There, the issue is not whether interpreter services are available in the community, but the quality of interpretation provided by members of the community. Without screening, training, and monitoring of community interpreters, serious concerns exist about the effectiveness of the communication provided to LEP clients.

The numbers of LEP individuals living within an area can also affect service delivery, as the study team discovered in Los Angeles. Yet, even more significant than sheer numbers, is the effect that state and local politics and local philosophies can have on the service delivery system. Whether a commitment is given to adequate language services ultimately depends on the decisions made by those governing and providing services in state and local communities.

5. Summary of OCR study

The Office for Civil Rights has been involved in the LEP controversy for over 15 years. The central office in Washington has been pressed to issue strong regulations that would define the responsibilities of providers in providing language appropriate services. Regional

OCR offices have had to work with both public and private provider communities and with the many activist organizations that have sprung up locally to press for more effective and equal treatment of persons with limited proficiency in the English language.

A. The Role of OCR in LEP

The Office for Civil Rights is a central actor in any issue that involves basic rights of Americans. The Office is charged with the responsibility and the authority to examine compliance with civil rights laws and regulations, although the Department of Justice is the lead agency involved in enforcing Title VI. OCR has been considering the need to regulate this area for some time. In 1979, a set of proposed regulations were promulgated for public comment by OCR within the then Department of Health, Education and Welfare (DHEW).[10] OCR's role, though, goes beyond the issuance of regulations. Its regional offices receive complaints and work with providers and with state and local government agencies to reduce barriers where they appear to exist. Often, negotiated settlements of disputes or agreements can resolve complaints well before the disputes move into the courts. In some cases, OCR regional offices have induced an entire geographic region to shift to a new approach, based on their work with providers and public agencies.

This negotiated approach has many advantages, but also at least one disadvantage. It clearly reduces cost and produces results beneficial to individual claimants. The State of Washington is an instructive illustration of how much progress can be made, in part due to the efforts of the OCR regional office. In Washington, however, the substantial progress made in providing language-appropriate services must be attributed at least as much to state officials who agreed with the basic premise and with providers who took steps to develop appropriate systems that produced the intended results, rather than surface steps that might have satisfied minimum legal requirements without producing any real change.

On the other hand, a negotiated approach eliminates the possibility of producing landmark precedents that can be used in regions lacking the enthusiasm of areas like Washington. Cases like *Lau v. Nichols*[11] have been useful traditionally in establishing legal rights in a way that minimize the need for subsequent individual law suits. Unfortunately, the *Lau* decision applies only to educational services and no clear court test is available in health care, although there is considerable support in both education and social services, according to a recent study completed by the National Health Law Program.[12]

10 Office for Civil Rights, Office of the Secretary, Health Education, and Welfare. Draft Proposed Rules for Part 80—Nondiscrimination Under Programs Receiving Federal Assistance Through the Department of Health, Education, and Welfare: Effectuation of Title VI of the Civil Rights Act of 1964, June 4, 1979.

11 414 U.S. 563 (1974).

12 Yolanda Vera and Jane Perkins, *"No Hablo Ingles"—Ensuring Linguistically*

The central issue facing OCR is what can be done when neither providers nor state or local governments are willing to move aggressively to provide language services for LEP persons? One option clearly, is to develop and issue a regulation that defines in unambiguous terms the responsibilities of providers that receive Federal funding. Other options include the development and promulgation of policy guidance to regional offices (both OCR and other Federal administrative offices such as the Health Care Financing Administrat ion). Before deciding whether to move more aggressively in one direction or another, the Office for Civil Rights decided to collect information about what was happening in different parts of the country. OCR requested Macro International, Inc. to study this issue and to report back on its findings.

B. What questions does the Macro study attempt to answer?

Macro International, Inc. was commissioned to conduct an exploratory study examining two basic issues:

- What models were being used by providers of health and social services to deliver language appropriate services to LEP persons?
- What were the relative costs and benefits of using these alternative service delivery modes?

Macro was asked to study these questions by visiting several major metropolitan areas and by collecting data from health and social service providers.[13] The study design is discussed below. Lists of the individuals and institutions consulted during the study can be found in the Appendix G.

C. Macro Study Design

The basic issue to be examined through the study was the extent to which persons with limited grasp of the English language gain or fail to gain access to health and social services as a consequence of the availability of cost-effective language services. The intent of the study was to determine the extent to which service providers adapted their outreach and service protocols to meet the needs of clients who seek access to the services. It was assumed that alternative approaches had been adopted by various service providers and that, through the study, it would be possible to define and compare the relative costs and benefits of these alternative approaches in different types of services and involving different language groups.

The fundamental design of the study included a literature review, interviews with a sample of service providers (including providers of language services), advocacy groups, and policy individuals and organizations. Several sources of literature were examined during the study:

Appropriate Health Care. National Health Law Program. p. 26, 1995. In Press.

13 The study design proposed by the Government suggested two cities; Macro eventually selected and visited three cities.

- On-Line information services—DIALOG, MEDLARS, ERIC, ASPE's PIC, and other on-line sources were searched for potentially productive literature.

- Interviews with key officials and stakeholders were used to obtain additional literature sources.

- Advocacy groups and policy analysis organizations that are included in the study were asked for reference works.

A current list of studies/articles that have been obtained and are included in the review is attached. The final bibliography is attached as Appendix D.

An initial round of interviews was conducted in Washington, DC to obtain a beginning base of information, from which the study team completed the project design, including the selection of language groups and cities to be included. The final list of people interviewed during the study is attached.

The study design also included provision for collecting data in three geographic areas, not including Washington, D.C.:

- Seattle, Washington — On the basis of limited interviews with policy individuals in Washington, Seattle was recommended as a city that might be viewed as a model for dealing effectively with the problems encountered when persons with limited English proficiency attempt to gain access to the health and social service system.

- Boston and surrounding area — the Boston and the Worcester area of Massachusetts were suggested also as a region in which substantial information could be obtained on alternative approaches to providing language services intended to improve access to health and social services.

- Los Angeles, California — Los Angeles was selected on the basis of its wide range of language groups and the very substantial number of service providers.

At the outset of the study, it was unclear whether specific languages posed unique problems not experienced by other language groups. The study design assumed that potentially substantial differences might exist in terms of access to care depending on the relative size of the population group within a geographic region. That is language groups with large numbers of members in an area (Spanish in Los Angeles, for example) might pose different problems and might even give rise to different solutions than low population-density language groups. Initially, the study was aimed at two Asian languages—Chinese and Vietnamese—two European languages —Russian and Polish were early candidates—and Spanish. As the study progressed, specific languages merged, with no single language assuming greater importance, except for Spanish in Los Angeles. In that case, providers exhibited a fundamentally different approach—bilingual staff providers in contrast to the interpreter model observed in the other cities. The concentration of Spanish in Los Angeles had created a sufficiently large market that

health providers were competing on the basis of their language competence.

The site visits provided first-hand insights into the problems and the methods being used by various types o f providers. During the site visits, different types of services, both health and social were included, but the great concentration of discussions centered about health services. The problems seemed larger and the solutions more comprehensive in the health sector.

CHAPTER 2: FINDINGS

1. Summary

The study findings are organized into nine sections. Section 2 discusses the extent to which there is a legislative framework that governs the need to provide language-appropriate services to LEP persons. This section draws heavily on a study completed by Yolanda Vera and Jane Perkins of the National Law Health Program and the study team is indebted to them for permitting use of their draft study report. Section 3 examines the catalytic agents that appear to affect the development and use of language services. The report then goes on to define the alternative models the study team found as a result of examining the literature and conducting site visits to three major metropolitan areas. The models are reviewed and their costs and relative benefits are discussed. Other sections then discuss ways to integrate language into a service provider's daily operations so as to provide the most effective basic services possible. The systems aspect can disable effective language services, even when institutions have reasonable language resources. Language systems are generally linked to a decision by top management to assume primary responsibility for effecting language-appropriate services. Other organizations may provide services, but consider those services as an "extra" or special service, believing that basic language services are the responsibility of their consumers. In multi-lingual environments, a system is needed to assure that language services are connected effectively and efficiently to the clients who need such services. Only in strictly bilingual environments, in which only two languages are required (often English and Spanish) and in which the provider staff are all or mostly all fluent in both languages, can the provider deliver the basic services (e.g., health care) without recourse to a managed language system.

2. Legislative Framework Governing Services to LEP Populations

A. Federal Legislative Initiatives

Although OCR has been invested in this issue over a 15-year time period, other Federal and state agencies have supported service delivery to the LEP population through regulatory or programmatic initiatives. The study team was able to identify several programs visited that were recipients of Federal, state or local funding; or were initiated in response to state regulations. This section describes how various Federal and state agencies have participated in shaping the service delivery system. A more detailed discussion on Federal programs is provided in Appendix H.

The Federal Department of Health and Human Services is organized into several different components, each focusing on specialty areas of service, research and policy. Although Title VI would appear to affect all services provided within and for DHHS, health and social services historically have been managed separately. As a result, policies concerning services for LEP populations have not been developed for the entire Department, but rather for separate agencies. Separation of health and social services is not unique to the Federal government, however, for most states have been structured in a similar fashion. Many DHHS efforts have promoted services to support increased health access to minority populations, but it is only recently, within the past few years, that efforts to remove or address

cultural and linguistic barriers have been initiated.

This section examines legislation within DHHS, beginning with agencies located in the Public Health Service (PHS). Removal of language and cultural barriers from health care has been a stated goal within PHS and, although all of its agencies share responsibility for this goal, the Office of Minority Health has been designated as the leader within PHS in spearheading a movement towards changing an existing system.

1. Minority Health Improvement Act of 1990

Section 1707 of the Public Health Service Act (otherwise known as the "Minority Health Improvement Act of 1990") expands the scope of the Office of Minority Health's efforts to target the LEP population by the following activities: (1) establishment of an advisory committee that would provide advice, assistance, and oversight; (2) interagency agreements with other agencies to support work in research, demonstrations, and evaluations to test innovative models of delivering services, (3) contracts with health care providers to develop or increase providers' capacity to provide bilingual or interpreter services, (4) establishment of the Center for Linguistic and Cultural Competence in Health Care, and (5) establishment of individual offices of minority health within agencies of the Public Health Service.

2. The Hill Burton Act (Hospital Survey and Construction Act of 1946)

The Hill Burton Act spurred development and construction of many public and non-profit community hospitals, health centers, and nursing homes. A "community service" stipulation was attached to all grant funds, which required providers to serve all persons living in the service area without discriminating. Along with Title VI, OCR Regional offices have been able to use Hill Burton as a source of guidance in seeking to enforce civil rights complaints against facilities. OCR has consistently interpreted "community service" to require that Hill-Burton hospitals serve LEP patients.[1]

3. The Refugee Act of 1980

Since 1975, the Office of Refugee Resettlement (ORR) has been the major funding agent of services to refugees newly entering the country. The Refugee Act of 1980 (section 413(a) of the Immigration and Naturalization Act) grants comprehensive authority to ORR for the domestic resettlement program. ORR is responsible for carrying out those activities that provide for effective resettlement of refugees and for assisting refugees to achieve self-sufficiency. Their primary focus is to integrate refugees into the service system, prepare them for job readiness, and promote full-time employment. As such, various programs that are funded by ORR, and through ORR, that involve the provision of language services to new refugees are designed specifically to meet this goal.

1 Vera, p.10-12

B. State Level Legislative Efforts

As will be discussed in the next section on catalytic agents, state and local laws or policies have served to propel the issue of language services for the LEP into a larger arena and have acted as a catalyst to promote service delivery. According to the National Public Health and Hospital Institute Survey, 12 out of 27 states responding had statutes or regulations that related to the provision of interpreter services.[2] All three of the states visited by the study team had regulations around interpreter services.

Table 1 on the following page summarizes information on state legislation.[3] Many of the State laws around language services have thresholds included guidance for when a service must be offered. Other laws are written in language too vague to be enforced. The authors of the NPHHI study conclude that only California, Maryland, New York and Vermont have laws that specifically mandate that hospitals must provide interpreter services.[4]

In examining state law, it must be noted that phrases such as "as soon as possible," and "if available," provide large loopholes for providers who prefer not to accept the responsibility for interpreter services. In such cases, compliance enforcement could become costly and difficult.

3. Catalytic Agents That Spur Language Appropriate Services

What causes some providers to adopt a proactive approach to serving LEP clients while others remain unaware of the problem or exhibit a reluctance to adapt their service systems to ensure language access? In the absence of Title VI regulations related to LEP clients, how do providers perceive and act upon their obligation to serve the LEP population?

With some notable exceptions, few providers appear to have voluntarily initiated language services or adapted their service strategies to ensure language access. Small, community-based clinics located in neighborhoods with sizable LEP populations or with a mandate to serve specific ethnic groups seem most likely to voluntarily adopt language appropriate service strategies. Larger facilities typically began developing and implementing language services in response to pressure from the regional OCR offices and legal services organizations, or state laws and departmental regulations. As illustrated in the following sections, some catalysts have the potential to bring about change

2 Ginsberg, C., V. Martin, D. Andrulis, Y. Shaw-Taylor, and C. McGregor. Interpretation and translation services in health care: A survey of US public and private teaching hospitals, p.7-9

3 Much of the information for this table was obtained through these secondary sources: Ginsberg, et. al.; Woloshin, et. al.; and Y. Vera and J. Perkins. The study team is indebted to the timely release of these studies and regulatory reviews.

4 Ibid, p.12.

Arizona	Title 9 of the Arizona Administrative Code establishes that written materials for the Arizona Health Care Cost Containment System be translated into a second language when that language exceeds 5% or 200 members.
California	Enacted in 1991, Section 1259 of the California Health and Safety Code (or Senate Bill 1840) requires acute care hospitals to (1) adopt and review annually existing policies around providing language assistance services, (2) develop and post notices for about procedures for obtaining interpreter services and filing complaints, (3) prepare and maintain lists of interpreters and bilingual employees who can translate body party, symptoms, and other medical information, (4) review all standardized written material for decisions around translation, and (5) identify and record primary language of all patients on hospital documents.
Colorado	Part 9 (Patient Rights) of the Colorado Code of Regulations 6 CCR 1011-1 states that patients have the right to receive informed consent for all treatment in a communication understood by the patient.
Florida	Florida's Patient's Bill of Rights and Responsibilities strongly recommends that health providers provide patients who do not speak English with an interpreter when receiving medical services, if the providers have individuals "readily" available who can interpret.
Hawaii	Foreign language interpreter services are required for mental health patients only. Programs operated by the Department of Health must have bilingual resources, the use of family or friends as first-choice interpreter is encouraged.
Illinois	The Illinois Health Facilities Language Assistance Services Act (210 ILCS 87/10) recommends that arrangements be made to provide interpreters or bilingual professional staff for patients experiencing language and communication barriers to ensure "adequate and speedy communication." Other aspects of this legislation are similar to the California Code 1259.
Maryland	Maryland's Code of Regulations states that each hospital is required to have staff or volunteer interpreters available or on call for deal and non-English speaking patients and families, who do not otherwise have available interpreters.
Massachusetts	The Massachusetts's Department of Public Health, through its Office of Refugee and Immigrant Health, attaches conditions around interpreter services to applications for facilities seeking expansions. All hospitals are required to obtain a determination of need certificate from DPH before undertaking major expansions or purchases of expensive equipment. DPH assesses, monitors, and provides policy guidance around interpreter services.

Table 1 State Legislative Initiatives Covering Limited English Proficiency

New Jersey	New Jersey's Health Care Facilities Planning Act (Section 26:2H-12.8) states that hospitals shall "reasonably respond to requests for interpreters if 10% of the service area population speaking that language.
New York	New York State's Section 405.7, Official Compilation of Codes, Rules and Regulations, refers to Patient's Rights pertaining to interpreter services in the following manner. Hospitals shall (1) manage a resource of skilled interpreters," and (2) provide translations of significant hospital forms, instructions and information. These services shall be regularly available for non-English speaking groups of more than 1% of the total hospital service area population, as calculated by the U.S. census data. This regulation also states that skilled interpreters are required to be available within 20 minutes for outpatient requests and within 10 minutes for emergency department requests.
Ohio	Ohio's Administrative Code 5122-1428 within the Department of Mental Health, states that psychiatric hospitals shall ensure that patients, families, and significant others who are non-English speaking shall have access to interpreters at no charge. In addition, all diagnostic testing services for such patients should be provided by qualified and experienced interpreter.
Pennsylvania	Pennsylvania's Hospital Association Licensure Regulations for General and Special Hospitals, Title 28 Pa. Code Part IV Subpart A pertains to Patient's Rights, and states that where possible, patients who do not speak English should have access to an interpreter. In addition, Title 55 Pa. Code states that voluntary informed consent for sterilization procedures should only be accepted if the individual was offered an interpreter.
Vermont	Vermont's Patient's Bill of Rights states that any patient who does not understand the "predominant language of the community" has a right to an interpreter if a language barrier exists and continues to be a problem for the patient's understanding of the care and treatment provided.
Washington	In 1993, the Governor passed an Executive Order creating a Department of Interpreter Services within the Department of Social and Health Services (DSHS). Administrative Policy 7.07 states that all persons, regardless of their ability to communicate in English, have equal access to services and programs administered by DSHS. Such access is to be provided by bilingual staff or by qualified interpreters. DSHS requires all hospitals to provide interpreters who pass a certification test and sign a confidentiality agreement. State Medicaid will reimburse providers for outpatient use of qualified interpreters.

Table 1 State Legislative Initiatives Covering Limited English Proficiency

across an entire service system while others may only impact the internal policies of an individual provider. The relative effectiveness or ineffectiveness of these "catalysts" to bring about change, are best viewed in the context of the political and social climate of the community in which the provider is located. A host of factors can mitigate or intensify the impact of various catalysts on the service system. For example, existing racial and ethnic tensions, the introduction of policy initiatives that are unrelated to language access, but affect LEP populations, or the presence of a charismatic personality in a position of authority can have a potentially significant effect on promoting or obstructing the initiation of language services.

A. OCR and Legal Services Organizations.

In Seattle and Boston, OCR and legal services have had a notable impact on the development of language services in the health and social service arena. In both of these cities, legal services organizations worked in partnership with OCR to exert pressure on providers to initiate interpreter programs. Seattle and the surrounding area have been engaged in development of language services as an adjunct to care since approximately 1980. Much of the progress can be attributed to pressure from the region's Offices of Civil Rights, accompanied by the added pressure of a local legal services organization, heralded by some as the "conscience" of the system . In response to such pressures, the region organized a relatively complete language service network that allows health *and* social services to obtain interpreters for a very wide set of languages and dialects—at least 50 and perhaps many more. In the Boston/Worcester area, OCR and legal services have been the driving force behind the introduction of language services in the social services arena. OCR's impact on hospital policies and the health care system is less evident. The OCR Regional Office successfully negotiated a voluntary agreement with the Massachusetts Department of Public Welfare (DPW) requiring them to develop detailed plans for serving LEP clients. The negotiation came about due to legal services' threat to pursue a class action suit against DPW. Potentially, this agreement will result in state-wide changes in the DPW system that will make DPW services more accessible to LEP clients. OCR also negotiated a voluntary agreement with a hospital in Maine. This agreement will improve language services within the Maine hospital but will have little impact on the health service system more broadly.

In contrast to Seattle and the greater Boston area, pressure from the OCR or legal services agencies has not been the driving force behind the development of language services in Los Angeles County. OCR and legal services have had more of an influence in Northern California service areas. Mention of OCR or legal services as critical players in the debate surrounding language access was noticeably absent during the study team's discussions with Los Angeles County providers. Legal advocacy on behalf of LEP clients in Los Angeles County has focused on individual employment discrimination cases and "English only" rules in the workplace. Legal advocates are currently directing their attention and resources toward the repeal of Proposition 187, a California initiative aimed at prohibiting individuals who are residing

in the U.S. illegally from obtaining government services.

B. State Laws and Departmental Regulations.

The study team identified examples of state laws or departmental policies explicitly directing providers to implement language services. It is not known how many states have adopted this approach. An article by the National Health Law Program identifies California, Florida, Hawaii, Illinois, Louisiana, Minnesota, New Jersey, Ohio, and Pennsylvania as states that have enacted statutes addressing linguistic minorities within health care settings.[5] In addition to these states, the study by the National Public Health and Hospital Institute identifies Arizona, Colorado, Maryland, New York and Vermont as states that have laws or regulations around language services.[6] The laws and policies identified by the study team during the Los Angeles site visit had the effect of galvanizing providers to compile lists of bilingual employees or design an interpreter program on paper. It was not clear that these laws and policies were particularly effective in forcing providers to develop and implement integrated interpreter programs that ensured language access. However, they did seem to represent a first step in establishing provider responsibility for ensuring communication with an LEP client.

In the State of Washington, Governor Lowry in 1993 issued an Executive Order that establishes clear expectations for state agencies and institutions of higher education. The Order sets expectations for improving employment, customer services, community relations and contracting opportunities for ethnic minorities, persons with disabilities, women, and gays and lesbians. The state also created a positive incentive approach by agreeing to pay for interpreter services for social services and non-inpatient medical services.[7]

The Massachusetts Department of Public Health (DPH) has adapted its internal policies regulating hospital expansion to effectively force hospitals to establish a minimum level of interpreter services. All hospitals in Massachusetts are required to obtain a determination of need certificate from DPH before undertaking major expansions or purchase of expensive equipment. Beginning in 1987, the Office of Refugee and Immigrant Health, within DPH, attached a provision to the certification process, requiring hospitals to provide interpreter services as a condition of approval. As a result, 26 hospitals initiated interpreter programs. While this policy has succeeded in forcing hospitals to develop interpreter programs on paper, there is widespread concern that their true ability to serve LEP patients remains grossly inadequate.

5 Vera.

6 Andrulis p.9-10.

7 Their assumption is that inpatient interpreter services are reimbursed by third-party payers.

In Los Angeles, a state law related to the provision of language services has had a direct impact on the development of language services in area hospitals. California state law (section 1259 of the Health and Safety Code), enacted in 1991, requires acute care hospitals to establish a policy for *"providing language assistance services to patients with language or communication barriers"*. The intent of the statute is to *"ensure that patients with limited English proficiency and those who are deaf are not denied access to basic health care services."* The law requires acute care hospitals to take specific actions to ensure that their services are language accessible to LEP groups comprising a minimum of 5 percent of the population in the geographical service area. All of the hospital representatives interviewed for this study were keenly aware of the state's legal requirements regarding interpreter services. The law appears to have been effective in galvanizing hospitals to assess t heir internal language resources, but has had less impact in forcing hospital administrators to develop systems for deploying those resources. Depending on how individual providers perceived their responsibility for compliance, actions taken to respond to this law vary from a fully integrated system to simply a list of bilingual employees and an action plan for implementing further work towards compliance. Providers and advocates also indicated that there was minimal enforcement provided around Section 1259.

C. Market Forces

Another factor influencing the development of language services in Los Angeles, is the increased competition for patients among HMOs, hospitals, and other health care providers as they attempt to offset rising health care costs. In Los Angeles, fierce competition for new patient "markets" has resulted in HMOs and other health care providers taking a second look at LEP groups who historically have not been part of their target client populations. Marketing efforts have focused on the dominant LEP language groups: Spanish in Los Angeles, and Chinese in the San Francisco Bay area. For these language groups, increased competition may result in better access and linguistically appropriate care. However, there is reason to be skeptical concerning whether bilingual/bicultural marketing strategies will translate into more broadly available language-accessible health services. It is important to note that smaller, though still sizable, language groups have not yet become the focus of marketing efforts.

D. Medi-Cal Managed Care Initiative.

California's Medi-Cal Managed Care Initiative has the potential to have a significant impact on the development of language services although its effects are only beginning to surface. The State of California plans to shift all Medi-Cal recipients into a managed care health plan by 1996. State-wide there are approximately 2.5 million Medi-Cal recipients, roughly one million of whom reside in Los Angeles county. California's Department of Health Services (DHS) plans to contract with commercial HMOs to serve 30-40% of the Medi-Cal population. The remainder will be served through a new entity called the Local Initiative Health Authority which is currently being established in each county and that will function like a non-profit HMO made up of a network of "traditional providers".[8]

DHS has established cultural and linguistic requirements for the Medi-Cal managed care program. The requirements are fairly detailed and include several provisions of special interest to OCR including:

- interpretation of the provider's responsibility to serve LEP patients under Title VI of the Civil Rights Act of 1964;
- required 24-hour access to interpreter services for all members;
- provision of linguistic services to LEP population groups residing in the proposed service area who meet a numeric threshold; and
- required assessment of linguistic capability of interpreters or bilingual employed and contracted staff.

DHS released the first request for applications, which included these provisions, and was directed at commercial HMOs in September 1994. There is intense interest among HMOs to enter the Medi-Cal market, particularly in Los Angeles county where nearly 40 percent of the state Medi-Cal population resides. The study team observed that many HMOs are already attempting to incorporate some level of Spanish language capability into their service systems as part of their effort to market to Medi-Cal recipients. For example, one HMO described outreach activities aimed at the Medi-Cal population which included hosting school health fairs in predominately Spanish-speaking communities. Bilingual/Spanish staff from the HMO also invite residents to attend an open house, held at the community clinic, where the HMO plan is described in both Spanish and English. Currently, 26 commercial HMOs are approved to accept Medi-Cal clients.

Traditional providers are also watching the developments closely to see whether DHS will monitor and enforce provisions related to linguistic requirements. It was not clear at the time of the study team's visit whether the Local Initiative Health Authority will be held to the same linguistic and cultural requirements as the commercial HMOs although it seems likely that it will be.

E. Malpractice

The study team hypothesized that the potential threat of a malpractice suit, resulting from failed communication, might serve as a catalyst to initiating interpreter services among some health care facilities. An attempt was made to ascertain whether health providers perceived the inability to communicate with LEP patients or the potential for miscommunication with LEP patients as a potential malpractice risk. The study team uncovered little evidence to suggest that language-related malpractice cases have been successfully filed against provid ers . Legal advocates maintain that those LEP clients most likely to receive inappropriate or inadequate care due to their inability to communicate with the health provider are least likely to pursue legal action as a means of recourse. Even

8 Telephone interview with Mr. Castalo de la Rocha, Local Initiative Health Authority for Los Angeles County, January 5, 1995.

when LEP patients do come forward, the financial responsibility associated with obtaining legal services is a huge burden for most plaintiffs, and legal advocates surmised that the ideal counsel would be a large firm desiring to try such a case pro bono.

F. Assumption of Responsibility

The key to unlocking the door to effective language-appropriate services appears to be an assumption by providers of primary responsibility for assuring language access to their services. In some communities, providers announce that it is not their responsibility, whereas in others, such as Seattle[9] and Boston, providers largely accept the responsibility.

4. Models of Language Services

Providers have adopted a variety of approaches to bridge the language gap and facilitate communication with LEP clients. This report does not attempt to evaluate the relative effectiveness of one method in comparison with another. In fact, few providers relied on one method to meet all their interpretation and communication needs. Most providers use a combination of methods in order to expand their coverage, reduce response time and adjust the standard of interpretation to best meet the needs of the situation. It was observed that a specific method may be more or less appropriate given the circumstances of a particular service setting. To some extent, the methods adopted by the provider are related to the type of service being provided, but mainly the methods are selected out of economic considerations, or as the "default" option, because no other options are available.

The size of the LEP language group was also a determinant of the method adopted. On a systems level the study team observed two phenomena: (1) in Los Angeles the dominance of the Spanish language resulted in the development of a bilingual (Spanish/English) service system with an emphasis on the bilingual provider model; (2) in Boston and Seattle where several major language groups exist, providers adopted a more comprehensive approach to serving all language groups regardless of size. On the program level, dominant languages are more likely to be served by bilingual staff or staff interpreters; frequent but smaller language groups by contract interpreters, and infrequently encountered languages by the AT&T language line.

As discussed in a subsequent chapter of this report, the actual method adopted by the provider may be less important than whether or not a provider has a system in place to assure that the LEP individual will be linked with the appropriate language resource at all key contact points in the service encounter, and ensure a standard level of quality in interpretation. The various methods of communication observed by the study team are described below along with a summary of their respective strengths and limitations.

9 Appendix E contains a discussion of the strategy used in Seattle during the early 1980s to get health care providers—mainly hospitals—to assume primary responsibility for language-appropriate services. The paper, by Sherry Riddick, RN, MPH, was presented at a language conference in Los Angeles in 1991.

- Bilingual-Bicultural Provider
- Bilingual Provider
- Volunteer Staff Interpreters
- Paid Staff Interpreters
- Volunteer Community Interpreters
- Contract Interpreters
- AT&T Language Line
- Language Bank
- Family and Friends

A. Bilingual-Bicultural Service Providers

In this model, services are provided directly by professionals who speak the primary language of the LEP client. Staff members are recruited and hired to reflect the basic ethnic composition of the LEP client population. This model was most frequently encountered in community-based service settings in which a limited number of language groups were being served, the size of the facility was relatively small, or the guiding mission of the facility was to serve a defined community or ethnic group. Throughout the Los Angeles area, the study team observed a heavy reliance on the bilingual/bicultural provider model as opposed to interpreter services. This phenomenon may be explained, in part, by the multi-ethnic character of Los Angeles. In 1990, 37.8 percent of Los Angeles residents were Hispanic, 10.2 percent Asian, 10.6 percent Black, and 40.8 percent White.[10] Over 340,000 Spanish-speaking persons were reported as "linguistically isolated" in the area during the 1990 census. These statistics illustrate that while Los Angeles' ethnic diversity presents a challenge to providers who face the need to develop service systems that can respond to perhaps forty language groups, there are also potentially greater bilingual resources available in Los Angeles than in many other cities. In contrast, the bilingual/bicultural model was encountered infrequently in Boston and Seattle. This may be due to a philosophical preference for interpreter services or to the fact that neither city contains a large enough pool of bilingual/bicultural professionals to meet the service needs of the existing LEP population.

Main Strengths

This approach provides the maximum opportunity to communicate effectively with the client, since both culture and language are accommodated. Numerous examples are given of service providers who do not understand the cultural significance of what they are being told, or, perhaps as importantly, do not understand the cultural importance of what they are attempting to communicate to their clients. In one case cited by Linda Haffner, Director of Interpreter Services at Stanford University Medical Center,[11] an 18-year old Mexican patient was hav-

10 As hley Dunn, *In California, the Numbers Add Up to Anxiety*, NEW YORK TIMES, October 30, 1994, E3.

ing regular birth contractions, but was dilated only 4 cm. She was becoming exhausted, and the medical staff wanted to give her an epidural block, but the patient had refused. The patient had misunderstood the difference between an epidural block and a spinal block and was fearful that she might become paralyzed. She had associated spinal blocks with severe complications, plus her husband kept reminding her that, without real pain, she would not be a "real mother," a common belief among Mexican patients. Here misunderstanding about the nature of the procedure had combined with cultural beliefs to jeopardize the delivery. After a competent explanation, the woman and her husband agreed to the procedure and the delivery process proceeded normally. In this case, the interpreter filled the role of cultural understanding. Had the physician or the nurse been of the same culture, the procedure could have proceeded satisfactorily and more quickly. In many mental health settings, LEP patients speaking directly with their provider rather than through an interpreter, is the preferred model.

Another strength of the bilingual/bicultural provider model, which may be obvious, is cost effectiveness. The Association of Asian Pacific Community Health Organizations (AAPCHO) conducted a study of language access in seven health centers across the country serving the Asian and Pacific Islander population. One of its findings, supported by preliminary process data collected on site, indicates that interpreter encounters for physicians tend to be only slightly longer in length, while those for nurse practitioners and physician assistants are much longer. Cost savings could be substantially realized in the bilingual/bicultural model, especially when providers maximize staffing arrangements. AAPCHO authors note, however, that the hidden costs and activities involved in recruiting bilingual/bicultural professional staff can offset some of these savings.[12]

Main Limitations

This model becomes increasingly impractical as the size of the facility (and client population) increases and the number of languages climbs above three or four. Fairly quickly, economics dictates that providers adopt an interpreter model. If all communications between service providers and service recipients could be provided by people who were not only bilingual but culturally knowledgeable, the chances for consistently safe and effective communication would be almost always assured. However, most service providers whom we contacted during our site visits will virtually never be able to satisfy this standard. In both the Seattle and the Boston areas, many languages are encountered, with any single facility

11 Linda Haffner, *Cross-cultural Medicine A Decade Later, Translation is Not Enough: Interpreting in a Medical Setting*, West J Med 1992 Sep: 157:255-259.

12 Association of Asian Pacific Community Health Organizations. The Language Access Project, Draft Final Report. Development of Models and Standards for Bilingual/Bicultural Services for Asian and Pacific Islander Americans, October 1993, p.84.

likely to encounter 20 or more different languages or dialects. The chances of being able to staff a large facility—a hospital for example—with physicians and nurses who satisfy the cultural and language requirements of their patient population approaches zero. Service providers that serve a limited number of languages can employ this approach, so long as their clients remain limited to a few languages.

B. Bilingual Service Providers

Only slightly more common than employing staff who are both ethnically and linguistically akin to their clients is a model in which staff are fluent in the language of their clients but not necessarily from the same ethnic background. In this model, staff are recruited with language competence as one of a number of skill requirements. All or most client encounters are engaged by staff members who speak the language of the clients. It is different in that regard from mixed models in which some staff members speak a client language and are used at varying times as staff interpreters. In a truly bilingual model, staff physicians and nurses, social workers, counselors, etc., would be employed who speak the dominant language of the client group. In at least one such model in a rural area in Georgia, staff physicians were provided language training until they became sufficiently proficient that they could conduct routine patient contacts in the client's language (Spanish).

Main Strengths

This model has similar strengths to the bilingual-bicultural model, but language is the key element. It implies that staff can be hired who are not from the cultural group being served, but that they must be fluent in the language.

Main Limitations

This model suffers from the same problem as the bicultural model, but it opens the possibility of added problems, unless strict language competence standards are employed. In several discussions with staff interpreters, for example, we were told that their facility tried to avoid using physicians who had studied the language of their patient (generally Spanish) in high school or college, because their level of language competence was often flawed and introduced the possibility of miscommunication with all of the attendant possible complications.

C. Volunteer Staff Interpreters

In this model, staff members who speak a language other than English are asked to serve periodically as interpreters in addition to their normal job duties. The concept of the "volunteer" interpreter is somewhat muddied by the fact that in some cases bilingual individuals receive additional compensation for their language skills. In many cases, bilingual staff assume interpreting duties without supplementary financial compensation. This model typically is adopted by institutions that are in an early stage of providing language services—perhaps the first stage after the institution realizes that a language barrier is affecting its ability to provide competent services. In some variants on this model, institutions formally incorporate interpreting into an employee's job description, while in others interpreting becomes an added burden without supplementary compensation, or recognition. Janitors, receptionists, technicians, and other clerical workers have all been used by institutions for this purpose.

In many cases, such staff carry beepers which are used to summon them to emergency situations. Institutions that employ this model typically treat language services as an "extra" service rather than as a normal part of their service system. Such treatment suggests that the administrators and managers within such an institution do not believe that they are obligated to serve Limited English Proficiency persons.

Main Strengths

The main benefit of this model is that it allows organizations to capitalize on their existing internal resources—the bilingual capabilities of their staff. A secondary benefit is increased voluntarism within the institution. Many hospitals began more structured interpreter services programs through efforts within departments of volunteer services, and hospital administrators point with pride to the work of their volunteers. When this model is institutionalized as a professional service, it can be an efficient method for ensuring communication with LEP clients.

The study team encountered one hospital-based program where this model had been adopted successfully to augment the interpreter program which included full-time staff interpreters for dominant languages. "Volunteer" staff interpreters were used to accommodate less commonly encountered languages or to fill in the gaps for more common languages. In this situation, the "volunteer" staff model was effective because "volunteer" staff were required to complete the same screening and training process as paid professional interpreters (thus assuring a standard level of quality of interpretation throughout the institution). Additionally, the hospital established a system where the supervisors of the "volunteer" staff interpreters had to approve staff acceptance of interpreter requests. This reduced the potential for conflict over competing job priorities as bilingual staff struggled to balance interpreter requests with the demands of their daily work.

Bilingual staff participating in the hospital's interpreter program were initially recruited during a hospital-wide effort initiated by the President and CEO of the hospital, demonstrating commitment at the highest level of management. In this model, volunteer staff interpreters received entertainment, gift, and food incentives for each encounter. Although this method of compensation was clearly working in this situation, other intrinsic incen tives were visible. Staff who interpreted on an ad hoc basis would frequently provide positive feedback on th e value of the experience and often thanked the interpreter services staff for sending them on such assignmen ts.

Main Limitations

Frequently, this model is adopted by institutions in a cavalier manner. Bilingual staff are asked typically to self-declare their bilingual capabilities and little or no follow-up is done to assess their linguistic skill level. In addition, staff often receive little or no training on how to serve as interpreters. Untrained interpreters pre-

sent unknown risks to the service, since they may not understand their role, or how to perform the duties of an interpreter. This problem is especially difficult in medical settings, wherein knowledge of medical terms and procedures is vital in communicating with the client and the medical team. Untrained interpreters often collapse several questions, or several responses into a smaller number, without realizing that they may be hiding important information inadvertently. The limitation of using staff interpreters is most acute potentially in institutions that do not recognize language services as part of their formal responsibilities to their clients and their community. Such institutions typically do not exercise the same type of control and care as institutions that have integrated language services into their service protocols. There is also a hidden cost involved in diverting staff resources to interpreting. As will be discussed in a later section, the hidden costs include the cost of lost work time when staff are taken away from their primary job duties to fill interpreter requests as well as the compensation paid to the "volunteer" staff interpreter during the time served as an interpreter. The hourly rate of most health care professionals (e.g., nurses, physicians, and medical technicians) is most likely higher than what the institution would pay for the hourly services of an interpreter.

D. Paid Interpreter Staff

In this model, the institution hires staff interpreters, i.e., staff whose primary or sole duty is interpreting in one or more languages other than English. Many of these individuals are employed full-time at the institution and receive the same benefits as all other staff employees. Generally, institutions that adopt this model recognize a legal responsibility to provide services in the language of their clients. In most cases, the hiring process and requirements for staff interpreters are similar to those used to hire nurses, medical technicians, or other professional staff. Generally too, hiring full or part-time staff interpreters reflects an economic decision that staff interpreters are more cost-effective than contract interpreters. Designated interpreters are usually hired when the volume of patients speaking a particular language is considered too great to be accommodated by either "voluntary" staff interpreters or part-time contract interpreters. This model has been adopted widely in Seattle and to a lesser degree in Boston. The study team observed a general reluctance on the part of many providers in the Los Angeles area to hire full or part-time staff whose sole responsibility was interpreting. The concept of a professional medical interpreter who possesses a specific set of skills, in addition to bilingual capability was not observed to have been adopted widely in the Los Angeles area.

Main Strengths

The central strength of the staff interpreter model is that scheduling is facilitated and quality control is easier to manage, since the staff competence level is a known quantity. In addition, staff interpreters become increasingly proficient over time in working with other staff professionals, e.g., staff physicians or nurses. It is possible to form professional teams of people, each of whom knows his/her duties well and knows the appropriate role to play in assuring that a competent service is provided the client. This concept of a team, with provider (physician), patient, and interpreter defined as the

"team," is seen as important because of the need to work together to facilitate communication. According to Dr. Eric Hardt, a physician at Boston City Hospital and author of a training program guide for physicians working with interpreters, the ideal medical encounter is one in which the interpreter and physician are partners and communicate effectively, incorporating cultural beliefs and explanations into the session. Problems could arise in situations where the interpreter acts as the interviewer or when the physician merely regards the interpreter as a tool. A professional triadic relationship promotes respect between the physician/provider and the interpreter, ensures confidentiality between the interpreter and the patient, and ultimately fosters bonding between the physician and patient, resulting in effective communication and appropriate health care.[13]

Main Limitations

The main limitation of this model is a limitation inherent in all of the models described throughout this section. In the absence of a system for screening and training there is no quality control that assures a standard leve l of interpreter competence.

E. Volunteer Community Interpreters

In many large cities across the country, bilingual residents in a community, often associated with a voluntary agency working with refugee resettlement, or a member of a hospital's volunteer service group agree to serve as interpreters. They may accompany the patient from the community or may be supplied by the provider. Although both cases rely on voluntarism to provide a needed service to LEP patients, in one instance, the health provider assumes responsibility for providing and engaging the service, and in the other, the patient or agency working on the patient's behalf assumes that burden. Volunteers who work within a formal hospital program are accountable to the hospital and, thus, enter into a relationship that is similar to that of employer and employee. Hospitals provide supervision and scheduling of assignments. Many teaching hospitals regularly recruit residents and students from the university community as volunteer interpreters, who may be eligible to participate in an internship through the interpreter services program.

Main Strengths

The major strength of a volunteer model is that it engages the resources of a community in a joint effort to provide a needed service that might not otherwise be provided. A hospital might be able to tap the resources of its general volunteer pool to identify bilingual individuals who could serve as volunteer interpreters. In this instance, the model could work effectively if the following professional standards were applied.

- *Formal personnel approaches*: volunteers need to "hired" and should be subject to being "fired."

13 Eric J. Hardt, M.D., Discussion Leader's Guide for the Bilingual Medical Interview I and the Bilingual Medical Interview II: the Geriatric Interview, Boston Area Health Education Center. 1991..

- *Job descriptions:* volunteers need to have and to understand their job duties and responsibilities.

- *Qualification standards*: volunteers need to pass the same type of qualifying standards as paid interpreters.

- *Training*: volunteers need to be trained in the essentials of the service they are providing.

- *Availability*: volunteers need to be available throughout the same range of operating service hours as the main service.

- *Management:* volunteers need to be managed just like paid staff. They need direction and they need quality feedback.

The strengths of the other type of volunteer model are that the provider assumes no responsibility and no cost for provision of services, and thus, services to LEP clients provided in this manner are always "free." But, as will be discussed below in the limitations section, providers using this model will usually get what they pay for in terms of service, expertise, and availability.

Main Limitations

Frequently, the volunteer model is adopted in situations where the service provider has not acknowledged its obligation to provide a language service. The provider maintains that it cannot (or will not) afford to pay for ancillary interpreter services. When this occurs, the burden of providing interpreter services is shifted to a voluntary agency or to the LEP client.

When the volunteer program is organized within the institution (usually a hospital) the volunteer services program may fail to meet the needs of the organization for whom they work, because the organization itself fails to organize and manage the volunteers properly. Organizations often assume that volunteers will organize themselves, when they would never make such an assumption about paid staff. Volunteers are simply unpaid staff and must be managed accordingly. A volunteer interpreter model could be as effective as a paid interpreter model if the volunteer program is established according to professional standards.

Some services are difficult to organize precisely because the highest quality resources are engaged in the activity as a way of earning a living. Thus, the needed expertise may not be available in the region and it would be necessary to rely on less qualified people to provide the service. The issues then raised are: a) have the managers in charge recognized that they may not be obtaining the same level of quality; and b) is the quality they are getting adequate to their needs?

The major limitation to using community volunteers is the inadequate level of services they are able to provide to physicians and other health care professionals. When a community interpreter runs out of time, he or she may simply leave, and the LEP client is stranded. When a community interpreter does not understand medical terminology or procedures, there is no mechanism for the physician to know this and mistakes can be made out of pride or ignorance that would not otherwise be tolerated in a medical setting. When a community interpreter advocates

too strongly for a patient, there is usually no supervising influence involved to curtail advice or monitor performance. In many cases where physicians are obliged to use this model, they are not fully com fortable with the triadic relationship established, but profess that they want to treat LEP patients and some co mmunication is better than none.

F. Contract Interpreters

In this model, bilingual individuals are hired by the service provider on a contractual basis to provide interpretation. Usually, these individuals do not work at any single institution on a full-time basis. Although they may be fully employed as an interpreter working for several different facilities. It is generally assumed that these individuals have specialized skills and training to serve as "qualified" interpreters although this not always the case. Contract interpreters are typically paid an hourly wage and do not receive benefits. A provider may contract directly with the interpreter or may work through a language bank or language service that provides an interpreter on demand for a fee. In most cases, contract interpreters are not used for emergency situations, unless previously arranged with the provider. Contract situations generally involve scheduled appointments.

Main Strengths

Use of contract interpreters is a cost-effective approach to supplementing the basic language capability of the institution. It can be useful as a way of initiating language services, before much is known about relative demand, or as a way of supplementing an existing capability. For accounting purposes, use of contract interpreters allows for collection of clear cost data for administrators seeking to justify expansion of existing services.

When contract interpreters are managed and dispatched through a language bank or service, the locus of responsibility for recruiting and maintenance of quality control is shifted to the language bank. The institution does not have to become involved in issues of competency or standards as long as staff have confidence that the language bank is operated according to professional standards.

Main limitations

One of the main limitations of the contract interpreter model is availability. Contract interpreters typically are individual entrepreneurs whose main livelihood revolves around language services. Thus, the ready availability of any single interpreter is always in doubt. As interpreters become better known, their availability may become increasingly difficult, short of engaging them in some form of "retainer" agreement. In addition, if the institution contracts directly with interpreters this places an added workload on the host institution. Quality control, scheduling, and cost management are now work elements that must be managed internally. Some providers have sought to alleviate the availability problem of their contract interpreters by working with other providers and combining resources. The study team observed that in Seattle and Boston, when many providers are located within a community, a pool of contract interpreters can exist for the shared benefit of several different providers.

G. Language Bank Services

Language "banks" are collective approaches to obtaining the services of interpreters without hiring them as staff. Typically, a language bank is operated in one of two forms: (1) an organization has its own set of services and decides to integrate language services into its service portfolio; or (2) a language service organization is formed whose main/only business is to provide language services to various clients. In Seattle, for example, the Hospital Interpreter Program is operated as one service of an existing organization, whereas in Massachusetts the language bank, operated by an Area Health Education Center (AHEC) was formed originally to serve the local medical center, but expanded services to include the entire medical community.

Language banks can be organized into specialty areas—medical interpreting, social services interpreting, legal interpreting—or as a central service with people trained in multiple arenas. As the employer and dispatcher of interpreters, language banks operate similar to any type of temporary services company. They assume the responsibility for recruiting, screening, testing, training, hiring and paying the interpreters. In addition, most language banks conduct community needs assessments to determine future language needs and market their services to the community. Billing for interpreter services generally includes similar overhead costs to those for other temporary services companies, although most interpreters generally do not receive extensive benefits from language bank employment.

Main Strengths

Language banks are highly useful in covering a wide set of languages, precisely because the institutions using the service need not use any particular language provider any more hours per year than its clients require. Even the language service itself need not hire full-time interpreters. Indeed, it is unnecessary for any interpreters to be hired full time, or even part time, unless the language service determines that such a staffing arrangem ent would be more cost effective. Mainly such language banks enter into contracts with both interpreters and with institutions that require interpreter services, acting as the broker for the language service.

Main Limitations

Language services provided through such language banks may be more expensive for institutions in some parts of the country than either staff interpreters, or hiring contract interpreters directly. Use of the language bank as an intermediary introduces another element outside the control of the service institutions (hospitals, for example). In one case, for example, several institutions decided to drop the Hospital Interpreter Program as their language service, because they believed it to be both too expensive and less responsive to their needs than they believed necessary to maintain an effective health care delivery service.

H. AT&T Language Line

The AT&T Language Line is a service provided under contract by AT&T. Service providers enter into a contract and then use and pay for the service on an individual call basis, being charged by the minute. The service offers to provide interpreting services in 140 languages in

virtually instantaneous response to a request. To obtain access, service providers must first enter into a contractual agreement with AT&T, although services can be provided even without a contract. Subsequently, interpreters are accessed by calling the Language Line and requesting a specific language. AT&T provides a "touch" pamphlet to users to assist in identifying the language being spoken. Clients are asked to scan the pamphlet which contains material in different languages to identify their language of choice. Once the language is identified, the Language Line can be engaged and an interpreting session initiated.

Service providers report generally that they rely on the Language Line for their backup system, when they cannot otherwise accommodate a client language, and for "call-backs," to LEP clients to verify appointments or to provide some simple information to clients. No service provider consulted by the study team used this system exclusively.

Main Strengths

The AT&T Language Line provides a needed service for service providers that cannot always be expected to have the language service available on staff or through a contract service. Given the large number of languages and dialects in many major metropolitan areas (in excess of 100) Language Line or some equivalent seems vital to the continued ability of providers to deliver quality services to an increasingly wide ethnic/cultural population base. The service's rapid response and ability to offer such a wide language range are its main strengths. In one case, a provider places portable telephones on carts throughout the hospital so that AT&T can be called easily from anywhere in the facility without worrying about the availability of telephone jacks.

Main Limitations

Language Line has two major limitations: cost, and the inherent limitations of the telephone as a method of communication. Although the service is considered reasonable in cost for short encounters, say a few minutes, its hourly rate would be between three and four times the normal hourly rate for high quality interpreting services. AT&T charges by the minute and varies its rates by type of language and by time of day. Four language "tiers" are used, with Spanish being Tier 1, and languages such as Farsi, Urdu, and Tagalog being grouped in Tier 4. Peak hours (5 a.m. to 5 p.m.) are the least expensive. Rates vary from $2.20/minute to $4.50/minute. Most of the study respondents maintain that they have used the Language Line and that generally they are satisfied with AT&T's responsiveness.

Aside from cost, many providers cite limitations around the AT&T system pertaining to its lack of cultural appropriateness and sensitivity. Although most providers appeared to be satisfied with the quality of the service, some tend to prefer using community volunteers or friends and family, citing that many LEP clients simply are not comfortable with phone interpretation.

I. Family and Friends

In some instances, family and friends are still regularly relied on to serve as interpreters. This practice is most often seen in situations where providers believe they are not obligated to accommodate the language needs of their clients. In some cases, patients may elect to use a family

member; in other instances, the patient may not be aware that he or she is entitled to an interpreter or that an interpreter program exists. The use of children as interpreters seems less common, although it still occurs. One coordinator of interpreter services in Boston indicated that, before she was hired, a 12-year-old girl, who had been diagnosed with a malignant brain tumor, was asked to relay the news to her parents by serving as an interpreter for the physician. This type of inappropriate use of minors would never occur in institutions that employ effective language response systems.

Main Strengths

The only strength of using friends or relatives is the potential comfort brought to the client through reliance o n someone they know well to intervene for them in a potentially frightening encounter with a system they do not understand. Most providers did not endorse this method although they acknowledged that it is used. Th ere was a difference of opinion among providers as to whether or not patients should be allowed to use a family member when a "qualified" interpreter was available. Some facilities had policies explicitly prohibiting the use of family and friends while others would offer the services of an interpreter but allow the patient to use a family member if he or she desired.

Main Limitations

Several important limitations exist. First, use of family members or friends presents potentially dangerous communication breakdowns, when an untrained individual fails to understand the message being communicated. Also the potential for a breach of confidentiality is high. Patients may be reluctant to reveal information of a personal nature that might be vital to an effective diagnosis, for fear of revealing such information to family or friends. A case is cited of a 50-year old peasant woman from Mexico who had visited the hospital several times, with vague symptoms being reported each time. The physician began to believe that she was not truly ill. When the woman was finally questioned through a competent interpreter, she admitted that she had been afraid to discuss her real symptoms—a fistula in her rectum—because her (35-year old) son had been interpreting for her and she was ashamed to admit her condition in front of him.[14] The dynamics between individuals who have a personal relationship often distorts the content of the communication. Overall, providers were adamant that minors should not be used as interpreters under any circumstances. Nevertheless, there were reports that this practice continues.

5. Cost of Language Services

The cost of providing cost-effective language appropriate services depends substantially on the model selected and on how costs are counted. Many providers do not track such costs, because they use one of the models involving in-house staff who function in other capacities and do not compensate for the language service. Some providers were reluctant to reveal cost data to the study team. Many providers ignore the issue of effectiveness, assuming perhaps that anyone who

14 Haffner, *Cross-Cultural Medicine*.

is apparently bilingual[15] is competent to serve as an interpreter. The data outlined below combines information supplied by different providers and is based almost exclusively on Seattle and Boston site visits, supplemented by data from the National Public Health & Hospital Institute report.

A. Cost Analysis of Alternative Models

There are three main cost components in providing language appropriate services: (1) direct interpreter costs; (2) overhead and benefits; and (3) interpreter management costs. All models can be examined by including and aggregating the costs associated with each component.

Direct Interpreter Costs

Certified interpreters are paid between $10 and $25 per hour[16], depending on geographic region and employment status of the interpreter. In Seattle, the rate varies between $20 and $25, whereas in Massachusetts, interpreters earn between $10 and $20. The total cost of delivering a full language service depends heavily on how the system is organized, i.e., how much of the service is available through full-time paid staff vs. contract interpreters, who manages the logistics of the language service, whether paid or volunteer staff are used, and whether provider staff are themselves bilingual.

The National Public Health and Hospital Institute survey of public and private teaching hospitals estimates that full-time staff interpreters earn an average salary of $29, 618, with a median salary of $27,020. The range of salaries is large, with hourly rates ranging from $10 per hour to $32 per hour.

AT&T Language Line costs range from $2.20 per minute to $4.50 per minute, depending on the language spoken and the time of day. Although expensive on a cost per hour basis, it has the advantage of charges by the minute. A ten minute requirement might cost between $22 and $45 by AT&T, whereas it might cost as much as $70 for a contract interpreter service (@ $35/hour) where they need to pay for a one-hour minimum, plus transportation time and cost. As the encounter time rises, the cost advantage shifts rapidly in favor of other methods.

Overhead & Benefits

Employing a full-time staff member increases the total cost to the extent of benefits and overhead. Benefits often increase salaries by 25-30% and overhead rates can add another 50% to 75%, which could bring the total cost of an internal staff interpreter to $35-$40 per hour.

In discussions with providers in the state of Washington, $35 per hour was a figure quoted frequently as the total cost for interpreter services. The State of Washington has agreed to compensate providers at the rate o f $37 per hour for certified interpreters.

15 Providers who allow employees to self-declare language status often fail to verify competence.

16 Rates as low as $8 per hour are reported in Philadelphia.

	Direct Costs per Hour	Overhead & Benefits	Total Costs per Hour
Management Contract[1]	Included	Included	$35 — $40
Direct Contract[2]	$10 — $25	NA	$10 — $25
Staff Interpreters	$10 — $25	50% — 75%	$15 — $45
Volunteer Interpreters	-0-	-0-	-0-
AT&T	Included	Included	$132 — $270

Table 2: Direct Interpreter Costs

1. Under a managed contract with a language bank, all costs are included within the negotiated rate.
2. Direct Contracts imply a system in which the provider hires interpreters under contract as individuals, rather than using a language bank.

In estimating and comparing direct interpreter costs, providers must also consider the need to pay for transpo rtation, travel time and guaranteed minimums for contract interpreters, and fringe benefits, overhead and potential down time for in-house staff interpreters.[17] Similarly, when considering the use of volunteers, providers still need to include the costs for interpreter management discussed below. No interpreter approach is cost-free, although some providers tend to hide or ignore some of the costs. For example, providers that use volunteer staff interpreters often assume that their approach carries no cost, whereas they should be including the cost associated with the time spent on interpreting instead of normal staff work tasks. Some programs require volunteer staff interpreters to complete their normal work, in addition to their interpreting tasks, presumtively shifting the cost of interpreting from the provider to the provider staff, creating a possible morale problem. Thus, estimating the cost of using staff in a "volunteer" capacity cannot be estimated without specifying how the staff time will be made up while they are interpreting.

"Volunteer Interpreters" are assigned a zero direct cost, which is appropriate, given that volunteers receive no direct compensation. Table 2 illustrates the average HOURLY costs associated with alternative models.

Interpreter Management Costs

A complete interpreter management system would need to include the following set of services:

- *Recruitment and Development*: locating and negotiating with individual interpreters, including assessment of language skills, and development and presentation of required training for interpreters and provider staff.

17 Some interpreters report that they are required to pay for parking fees, which could be $5-$7 for an encounter, whereas other providers cover such travel expenses.

- *Logistics:* scheduling interpreters and assuring their availability.

- *Quality Control*: oversight and feedback to assure that provider staff and patients are satisfied with interpreters.

- *Cost Management*: collection and analysis of total cost of language service to assure that the system is operating efficiently.

This management function would need to be present, regardless of the model used, although under a managed contract system, using a language bank, the language bank managers assume these duties. It is difficult to estimate the management costs associated with effective services, but many of the language services in Seattle provider institutions employed one or more staff persons to manage the entire language service function. Thus, one FTE staff person might be associated with management in a system in which 5 to 10 FTE interpreters are involved. For lower levels of language services, part-time staff would be used to provide this management. The total cost associated with alternative models then might be as shown in Table 3 below.

In calculating costs, it is also necessary to recognize that many providers employ more than one method, depending on the language needed. For example, many providers in Seattle used contracts with a central language bank, individual contracts with outside private interpreters, full-time staff interpreters, and AT&T Language Line. The issue faced by providers in Seattle was how a provider could accommodate most effectively the needs of its clients at the least cost. Almost invariably, the answer to that question involved more than one method. It is important that, whatever method is to be used, all costs are included. It would be necessary to account for the following functions:

- Direct salary of interpreter

- Fringe benefits & overhead

- Interpreter Management

- Equivalent contact hours — will contract interpreters be paid for travel time and cost, as well as a

	Direct Costs per Hour	Overhead & Benefits	Management Costs per Hour	Total Costs per Hour
Managed Contract	Included	Included	Included	$25 — $40
Direct Contract	$10 — $25	NA	$2.50	$12.50 — $27.50
Staff Interpreters	$10 — $25	50% — 75%	$2.50	$12.50 — $47.50
Volunteer Interpreters	-0-	-0-	$2.50	$2.50

Table 3 Total interpreter Service Costs

minimum one hour charge? Will interpreters be paid for missed appointments?

- Are there cost differentials attributed to interpreting requirements after normal business hours?

- Who will pay for costs associated with insuring interpreters against any liabilities?[18]

- Who will pay for the costs of training, or certification through standardized tests?

- Expenses for travel, parking, etc.

Hypothetical Example:

If we hypothesize a hospital in which 5,000 encounters are experienced for which language is an issue in succ essful delivery of the service, we can calculate the range of costs associated with alternative methods. Assum e encounters average 69 minutes in length, but with a range of 10 minutes to four hours. Contract interpreters are paid for a minimum of one hour, plus transportation time and costs. Further, each contract interpreter is paid when appointments fail to show or cancel at the last minute. Under such a scenario, a 45 minute encounter would require that contract interpreters would be paid for one full hour, whereas in-house staff would be used only for the 45 minute encounter. Volunteer interpreters, whether they are on staff or are brought in would work for one to two hours. In-house bilingual professional staff create no additional direct costs. AT&T Language Line has a high direct cost, but charges are incurred only for the amount of time they are on-line. AT&T also would not require a management staff to oversee the scheduling and management of interpreters.

It should be noted that the cost assumptions used in the model could vary substantially, depending on local cost parameters and how interpreter language services are managed within an institution. In most respects, more careful management would yield increased direct costs because of the need to assign staff to contract management, scheduling and quality control.

Table 4 illustrates a hypothetical illustration of a language requirement facing a provider. In the example, 5,000 "language encounters" covering four languages would require approximately 6,000 interpreter contact hours, but with a wide range of 10 minutes to over two hours. If we assume that providers have available to them a wide range of language models, it is possible to calculate potential costs, using the following definitions:

1. A "Managed Contract" is a contract for interpreter services between a provider, e.g., a hospital, and a language bank or service such as Seattle's Hospital Interpretation Service. Under this type of arrangement, the language service assumes responsibility for recruiting, qualifying, and scheduling specific inter-

18 Many interpreters are required to carry "errors and omissions" liability insurance that can run between $300 and $700 per year.

	Number and Duration of Interpreter Encounters				
	Spanish	Vietnamese	Russian	Farsi	Total
0-15	40	130	40	75	285
16-30	110	195	55	175	535
31-45	100	175	50	125	450
46-60	275	350	175	350	1,150
60-120	725	675	75	475	1,950
120+	150	225	55	200	630
Total Encounters	1,400	1,750	450	1,400	5,000
Encounter Hours	1,680	2,100	540	1,680	6,000

Table 4 Encounter Hours in Hypothetical Example

preters, whereas the provider is responsible for determining when an interpreter is needed and for notifying the language service of its needs.

2. "Contract Interpreters" are interpreters who are hired under contract directly by the provider, instead of through a language service. In this case, the direct cost per hour is less than for managed contracts, but there would be a higher management overhead to account for the added work required of the provider in recruiting and managing the interpreters.

3. Staff interpreters could easily carry the same or even a higher cost per hour than contract interpreters because of the benefits and overhead associated with full time employees. Staff interpreters are assumed to earn $20/hour, inflated by a factor of 1.75 to account for overhead and fringe benefits, with interpreter management adding approximately 10% to the total cost. Staff interpreters provide a fixed capacity, however, so that their effective unit cost would decrease as they become busier.

4. Volunteer interpreters have no direct costs associated with their use, but they would still carry a management cost. Volunteers are sometimes less responsive to management needs. Thus, the management time might actually be considerably higher.

5. AT&T Language Line is clearly the most expensive way to obtain language services and no institutions used this approach for other than a last option, or for providing services such as "call-backs" which are limited in duration and would be difficult to manage using contract interpreters. The great advantage of AT&T is its wide range of languages and the fact that its charges are only for the actual minutes used to interpret. Because most programs that the study team encountered used a range of language approaches, the

total cost of their service would vary according to the proportions of each method. As the demand for individual languages increases, for example, many institutions switch from contracts to in-house staff interpreters.

How would a provider staff a language requirement such as is illustrated in Table 4? First, the provider would need to break the requirement into languages, because of the unlikely ability to find interpreters who speak, for example, both Spanish and Russian, or Russian and Farsi. The staffing decision then becomes a series of questions about each language. How do we staff the Spanish requirement? How do we staff the Russian requirement, etc.?

The Spanish requirement would require slightly less than one FTE interpreter[19], and providers could use any of the staffing models discussed above. Using the cost data illustrated earlier in Table 3, a provider might encounter the costs outlined in Table 5 for the 1,680 hours of Spanish language interpreting. The expected cost range is shown, except for AT&T which has specific unit costs associated with various language groups.

In this illustration, using contract interpreters who are managed by the provider might be the least expensive alternative, except for use of an all-volunteer interpreter approach. In that case, there are no costs associated with the interpreting function; all costs accrue because of the need to manage the volunteer workforce. The c ost range is so relatively large, however, that the most cost-effective solution would depend entirely on the re lative availability of interpreters through the various methods and the salary rates that can be negotiated. Bec ause of guaranteed minimum hours, the contract interpreters actually use more hours than the encounters sug gest would be necessary. A 15-minute encounter, for example, would be charged for the full hour for contract interpreters, whereas in-house staff or AT&T would use just the time required for the encounters. In the case of

	Direct Cost	Interpreter Management	Total Cost
Managed Contract	Included	Included	$63,000
Direct Contract	$26,500 — $66,250	$4,200	$30,700 — $70,450
Staff	$33,600 — $84,000	$4,200	$37,800 — $88,200
Volunteer	-0-	$4,200	$4,200
AT&T	$221,760	Included	$221,760

Table 2 Cost Comparison for Providing 1,680 Hours of Spanish Interpretation

19 A full-time interpreter would provide approximately 1920 hours of work.

in-house staff, they would be free to go onto other interpreting or to other tasks.

In-house staff costs increase in large steps, since staff are hired generally either full-time or half-time to avoid the need to pay benefits. Once staff are hired, however, they provide a certain fixed capacity, in which cost no longer rises until the next step increase is required because of exceeding the half-time or full-time capacity (with 1,920 hours generally viewed as full-time).

The AT&T service appears to be so expensive that no one would use them, except that many providers do. Why is that? AT&T has certain fixed advantages: (1) they are available almost instantly; (2) they impose no added management costs; and (3) the service is terminated at the end of the encounter. Therefore, the marginal cost of a five-minute AT&T encounter might be $2.20 x 5 = $11. The same encounter using a contract interpreter could be as high as $35-$40. For some types of encounters, then, or for certain circumstances, AT&T becomes the most cost-effective provider. Also, AT&T may be the default option when a provider encounters a language or a combination of language and timeliness-need (emergency room response) that can be filled in no other way.

The analysis could be extended to the other languages, but the point would remain the same. The choice of method depends on the number of encounters, the relative ease of finding interpreters for the language, the need for rapid response, and the relative salary levels commanded within an area by interpreters.

Virtually no providers visited by the study team relied exclusively on one method. The exceptions were those few providers that relied on a bilingual-bicultural staffing approach, in which all staff members spoke the languages of their clients. As was noted earlier, however, this type of approach has limited utility in most service settings in which dozens of languages are faced by the provider.

B. Other Cost Issues

Providers use many methods beyond the few discussed above. Many providers have attempted to meet their responsibilities by using existing staff who have language capabilities. Sometimes, the staff are treated as "volunteers", with no added pay, while other providers pay some kind of salary differential[20]. One large HMO paid a salary differential to its 2,500 Spanish-speaking staff (who are spread across a large number of hospitals and other health care facilities owned by the HMO chain) that approximated one million dollars per year. Differential approaches used include the following ("volunteers" implies that staff have other duties beyond interpreting):

- Volunteer staffing with no pay differential;

20 The survey of public and private teaching hospitals completed by the National Public Health and Hospital Institute reports that 16.9% of the hospitals surveyed reported payments of $1.00/hour pay differentials, monthly bonuses of $40 to $100, paid overtime, or other benefits.

- Volunteer staffing with a non-financial reward (e.g., tickets to theme parks);

- Volunteer staffing with financial differential, where interpreting subtracts from time available to other duties; and

- Volunteer staffing with financial differential, where interpreting is additive to existing duties.

Many providers seem unaware of cost shifting that can disguise the actual cost of interpreter services. For example, in several of the salary differential methods, use of existing staff as interpreters is often treated as a "cost-free" approach to interpreting. In fact, the cost of interpreting has been shifted to the department that employs the volunteer staff interpreter, although without any accountability. Similarly, sometimes when a salary differential is added for interpreting services, the cost may be borne by the department in which the employee works, or to the general overhead of the institution. These "hidden" costs not only disguise the actual cost of interpreter services, but also tend to be accompanied by policies that ignore the need for quality control of the function. When cost becomes a clearly identifiable component of the institution, then accountability for performance becomes important.

C. The Potential Costs of Inadequate Services

There are other "hidden costs" that can become very expensive to an institution. These are costs that could be avoided through use of effective language services. These costs are associated with the consequences of providing inadequate services.

What is an inadequate language service? It would be a service in which encounters between provider and cli ent include miscommunication caused by inadequate understanding of the respective languages being spoke n. It would include also miscommunication caused by inadequate or missing translations when they are need ed. For example, a posted notice in English carrying an instruction is useless to a client who speaks only Fars i. Mainly, miscommunications occur through spoken forms. A physician misunderstands what a patient is saying and orders unnecessary tests, or, worse, a physician fails to order tests because of a miscommunication and the patient's condition worsens.

Patients, we are told, have died as a result of a breakdown in language communication, although virtually no specific examples were cited by people interviewed for this study. If state or local agencies fail to translate documents sent to their clients informing them of a change in their status, the clients may or may not understand the change. The costs of such miscommunication are hidden currently. Does such miscommunication, when it results in injury, equal malpractice? Few cases exist to test this issue. When inquiring of providers, especially health care providers, the study team was informed that malpractice is not a driving force and, therefore, is not now recognized as a cost of inadequate language services.

There is some, albeit scant, evidence that real costs are being driven by miscommunication, mainly in the form of unnecessary medical tests ordered because of a misunderstanding on the part of the provider. Because such costs can be hid-

den easily in the complex medical accounting systems that support claims processing, it is perhaps not surprising that they do not surface as a major element that might drive a more serious consideration of language as a vital provider service.

6. Systems & Coordination

A. Integrating Language into the Service System

The degree to which language services are fully integrated into the service delivery system is a key factor in determining the extent to which LEP clients and providers are able to communicate effectively. In many instances, a language resource may be available (in the form of a bilingual staff member, or contract interpreter); however, access to services and effective communication cannot be assured unless there is a systematic method for linking the LEP client to the language resource at critical contact points during the service encounter, and ensuring quality standards of interpretation. With several notable exceptions, the study team observed that many facilities had internal language resources available but lacked the coordinated system to deploy those resources in an effective and efficient manner. In the absence of a coordinated system, the burden of facilitating communication is shifted from the provider to the LEP client. By default the client must determine which language resources may be available, as well as how and when to access them. This increases the potential for miscommunication or no communication between the LEP client and the provider, and typically results in inefficiencies for the organization.

1. Critical Contact Points in the Service Encounter

Figure 1 illustrates the critical contact points during a service encounter when language services may be required to facilitate communication. This diagram illustrates three important points. First, the LEP client is likely to require interpretation at different phases of the service encounter. Second, the LEP client may need to communicate with a different provider or staff member at each of the different phases. (For example, the LEP client must be able to communicate with a receptionist in order to schedule an appointment, or to a nurse to express discomfort or pain during an inpatient stay in a hospital). Lastly, failure of communication at any one of these points can potentially jeopardize the LEP client's ability to access the service, or compromise his or her ability to receive the appropriate service. The absence of a system to manage communication as the LEP client moves from one phase of the service encounter to the next increases the likelihood that a failure in communication will occur.

2. Components of an Integrated Language Service

The study team observed that facilities without a systematic approach to language appropriate services often treated language services as a non-essential ancillary service. In contrast, facilities that openly acknowledged their obligation to serve LEP clients were more likely to have an integrated system in place. The most highly integrated systems were found in Seattle and in one hospital in Los Angeles. Generally, top administrators in these organizations had internalized their responsibilities to facilitate communication with LEP clients.

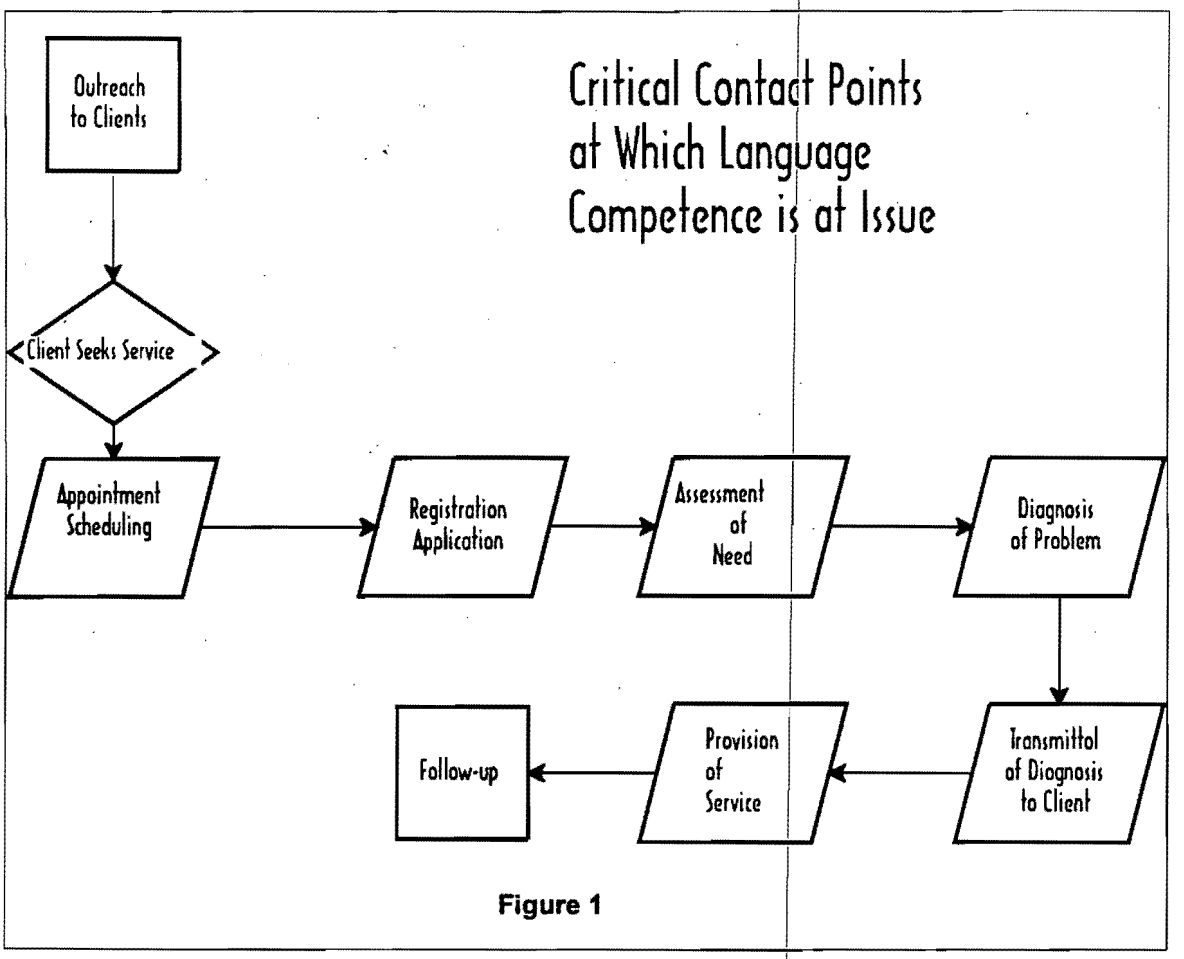

Figure 1 Critical Contact Points

Typically, fully integrated language services incorporate the following features:

- *Identifies LEP patients at all possible entry points into the service system.* Some of the hospitals visited by the study team had a procedure for identifying LEP patients during outpatient registration but not during inpatient registration. Consequently, the LEP patient's ability to access language services depended on whether he or she entered the system as an inpatient or an outpatient.

- *Links LEP clients with an appropriate language resource at all critical contact points in the service encounter.* As described in the preceding section, a breakdown in communication may occur at any number of points during a service encounter. One hospital, visited by the study team, had interpreters available for the initial consultation with the physician. However, when the patient was hospitalized there was no system in place to alert the nurses that the patient could not communicate in English. Moreover, the nurses had received no education on how or when to utilize the in-house interpreters, so this resource, while available, was untapped and a

breakdown in communication occurred unnecessarily (the problem was resolved after a needs assessment was completed and training provided to the nursing staff). The facilities which had the most highly integrated language programs: (1) had developed centralized systems for arranging interpreter encounters; (2) employed full time interpreter coordinators on staff; and (3) provided a central number to call to request interpreter services.

- *Guarantees that language services are available, without unreasonable delay during normal service hours.* Language services should be available during regular operating hours. If the facility is a hospital, this means that language services should be available 24 hours a day. Many hospitals rely on a combination of interpreter models to expand language coverage. For example, a hospital may employ in-house interpreters to handle the majority of language requests during daytime hours and rely on the AT&T language line to ensure coverage at night. Another hospital maintained two portable speaker phones on rolling carts which were designated for AT&T language line interpreter encounters. The portability of these phones ensured that interpretation in any language could be provided in any place throughout the hospital regardless of whether there was a phone jack in the room. Without a system in place to identify alternative language resources and a protocol for deploying those resources, the potential for a communication breakdown or delay is increased. The study team found that many hospitals maintain lists of staff who speak a language other than English. These individuals are asked to interpret on an *ad hoc* basis, although problems with such an approach can occur when these bilingual volunteer staff are off-duty or unavailable to serve as interpreters and no back-up system is in place.

- *Maximizes the number of languages that can be interpreted without unreasonable delay, no matter how infrequently the provider encounters the specific language.* An integrated system, enables the provider to identify alternative language resources, (both internally and in the community) which can be deployed on an as-needed basis to increase the number of languages that can be covered. This does not mean that a provider should employ an interpreter for every language that the facility is likely to encounter. Generally, providers rely on staff interpreters or bilingual staff to accommodate LEP clients who speak the dominant language in the service area. Less commonly encountered languages can be accommodated through the AT&T language line, participation in a community language bank, hiring contract interpreters for temporary assignments, or enlisting the services of a volunteer interpreter through a formal arrangement.

- *Ensures uniform standards of quality in the interpreter encounter.* There is currently an active

debate surrounding the issue of standards for interpretation in the health and social service setting. This study does not attempt to define a standard of competency for interpretation. However, at a minimum, providers should apply the same standard to all individuals who engage in interpretation within their facility. Frequently, individuals whose job title designates them as an interpreter are required to pass an assessment exam while bilingual staff in the same facility who serve as interpreters on an *ad hoc* basis are not so required. This inconsistency compromises the quality of interpretation within the organization.

- *Monitors language service activity levels and associated costs.* Only a few facilities collected data on the number of requests for interpreter services and the number of associated interpreter encounters. Without this information, it is impossible for any program to efficiently allocate and manage language resources in a cost-effective manner. For example, if a facility receives a few infrequent requests for interpretation in Korean, it may be cost effective to rely on a bilingual staff member or a contract interpreter to fill occasional requests. As the volume of requests for Korean language increases, it may prove more cost-effective to hire a full-time staff interpreter.

B. Community Coordination: Sharing Resources

While coordination within an organization can determine how the LEP client can gain access to services and continue to receive appropriate services, the level of coordination external to the organization or community coordination often sets the tone for progress made within a city or town. The study team observed that large facilities, such as hospitals and medical centers, tended to have developed systems of coordination. Smaller providers, such as clinics, health department programs, and private physicians professed an interest in serving LEP clients, but because of a lack of resources could not even consider hiring interpreter staff. Smaller provid ers tended to opt to provide language services in the form of bilingual, usually bicultural, staff, if they provid ed the services at all. Large providers, even those with highly rated interpreter services programs, admitted to difficulties in offering 24-hour coverage and locating interpreters for obscure languages.

In some areas, it was observed that providers and advocates worked together to devise solutions to language problems in different provider facilities. In Boston, interpreter services coordinators at several hospitals are collaborating on a shared pool of contract interpreters, a uniform way to screen and train, and a system to monitor performance. In Boston, Worcester, and Seattle, training programs for medical interpreters are sponsored by local colleges and universities. The courses are designed by hospital professionals who work closely with interpreters, physicians, and educators to capture the needs of the local community. It was also observed that the services provided

by language banks are not in demand immediately upon implementation, but as providers draw comfort in using the service, business increases. After only three years in business, the language bank in Worcester grew from serving three health care providers to well over 25.

The extent of community collaboration around language access services depends on a number of factors: caring, motivated and charismatic advocates; the local political climate, support from top management within the medical community; academic and educational commitment to training programs; the degree of existing turf issues for patients; the active involvement of legal services; and an interest in the greater community. Many advocates and providers encountered by the study team freely admitted little knowledge of what other providers were doing, even those that were located within their own cities. It is interesting to note that in the Boson area, there were several different groups that had formed to advocate for language services for the LEP, and key individuals in some groups had not even met their counterparts in others.

The process of establishing community coordination is easier to describe than to implement. While some of the features described in the first part of this section could be modified to fit the needs of a community, the most difficult aspect of community coordination can be bringing all the appropriate providers, advocates, and interested parties together to discuss ways to change a system. Individuals from many different organizations may need to air problems with the current system, defend past actions, lament a lack of resources, and express their "wish lists" before real action can be planned and implement. Those behaviors should be anticipated and viewed as a healthy introduction to systems change. The fact that people who come from different backgrounds can meet together around a common goal—providing language services to the LEP residents in a community—demonstrates some level of commitment to the issue.

Community collaboration has empowered advocates and providers to devise programs that not only meet the needs of the LEP citizens, but also enrich the community environment, strengthen the local economy, increase cultural diversity, and foster harmonious relationships. In Los Angeles, sadly the site of much racial and ethnic tension, one provider relayed angst over the role that the media has played in inciting different groups to rail against one other. Instead of writing about the positive, collaborative activities that are occurring, journalists often choose to focus on strife and mayhem, feeding into the broad societal anger and unrest that characterizes much of urban America. In all three cities visited, community collaboration has been a catalyst for language services, but in differing degrees.

7. Quality Assurance

Too often, the complexity of effective communication is underestimated. As noted throughout this report, a host of factors other than language, (i.e., culture, educational level, familiarity with the service setting, degree of acculturation) can have a potentially significant impact on an individual's ability to communicate or understand a particular message. Nevertheless, providers and LEP clients often mistakenly assume that because a person is fluent in a language other than

English, he or she is qualified or prepared to serve as an interpreter in a health or social service setting. Similarly, providers and LEP clients assume that a person who is a self-declared bilingual is sufficiently fluent in English and the second language to communicate effectively in any situation. This is not always true. Interpretation in the health and social service setting may require knowledge of technical terms, professional jargon, or an ability to communicate sensitive information (i.e., a diagnosis of terminal cancer, or the conditions under which a child may be removed from the home due to allegations of child abuse and neglect). Although medicine is not the only field in which communication is problematic, imperfect communication in the medical arena can lead to morbidity, or even inadvertent and premature death.

This report does not attempt to define quality standards for interpreters or prescribe a set of essential skills that all interpreters working in a health or social service setting should possess. However, the question arises as to what steps a provider can take to demonstrate a good faith effort to ensure effective communication thro ughout the organization? A quality assurance system that includes a mechanism for screening, training, and monitoring, along with a policy that outlines the professional responsibilities of an interpreter, is one such ste p to assure a minimum standard of effective communication.

A. Assessment of Interpreter Skills

There is a growing awareness of the importance of assessing the linguistic skills of individuals who serve as interpreters. The provider should be confident that the individual responsible for facilitating communication is sufficiently fluent in English and the second language to meet the interpretation needs of both the LEP client and the provider. Despite this awareness, providers still rely heavily on self-declared bilingual individuals, whose skills have not been assessed, and who have received little or no training to serve as interpreters. A 1992 study of fifteen Chicago area hospitals and health associations found that it was:

"*Common practice in area hospitals . . . to maintain a list of all employees who speak a language other than English. These employees may range in job duties from janitor to doctor. Their qualifications are only that they are able to speak Vietnamese, Polish, Urdu, or Russian ...*" These "*. . .volunteers are not tested for their foreign language proficiency, their knowledge of medical concepts, technology or terminology.*" [21]

The Macro study team also observed this phenomenon during the site visits to Boston and Los Angeles and surmise that the practice is not uncommon throughout the United States. In addition, most community volunteer interpreters who accompany patients are similarly unqualified for the job of medical interpreter.

21 W. Siegal, *Immigrants at Risk: Language and Cultural Barriers Experienced by Multi-Ethnic Patients in a Sample of Chicago Hospitals and Health Associations.* Paper prepared for the Chicago Institute on Urban Poverty Travelers & Immigrants Aid. April 1992. p. 5.

For the purposes of this study, a distinction is made between a skills assessment and certification of interpreters. A *skills assessment* can be conducted by an organization based on its own internal definition of the critical skills required for effective interpretation within the organizational setting. *Certification*, implies that there is a uniform set of skills that all professionals working in the field have accepted as the required minimum standard of competency. Certification exams are usually conducted by an impartial body outside of the provider organization.

There is an emerging debate over what "critical" skills an interpreter should possess. At a minimum most study respondents agreed that an interpreter should demonstrate oral fluency in both English and the second language and, for those working in a medical setting, some knowledge of basic medical terms and body parts. The ability to translate written materials was seen as a specialized skill. While facilities acknowledged that they needed translations of particular documents, providers did not generally believe it to be essential that all interpreters possess this skill. There was considerable debate over how to measure oral fluency and little agreement over what constituted "basic medical terms and body parts." One particularly innovative hospital-based interpreter program conducted a survey of physicians and health professionals to develop a list of "key medical terms." This list was incorporated into the hospital's handbook for interpreters. All interpreters were expected to understand and explain the key medical terms in English and the other language.

The study team found that the debate surrounding competency of interpreters was particularly strong in the Boston/Worcester area and virtually non-existent in Los Angeles. Many of the Boston programs had begun developing internal standards of competency and accompanying skills assessment exams. Some of these assessment exams had been developed independently. Others sought input from a variety of sources including community colleges, agencies involved in certifying court interpreters, private language companies such as Berlitz, and the U.S. Department of State's Foreign Service language program. Often the assessment exams were not applied uniformly to all individuals involved in interpreting within the organization. For example, in several hospitals, an individual whose job title designated her as an interpreter was required to pass a skills assessment exam while bilingual staff who served informally as interpreters on an *ad hoc* basis were not. Such inconsistencies compromise the quality of interpretation within an organization. Only one hospital applied its internal assessment exam uniformly to all individuals involved in interpreting regardless of their job title. This hospital required all bilingual staff who expressed an interest in "volunteering" as interpreters to pass the same screening test as paid staff interpreters. Paid interpreters and "volunteer" staff interpreters were also required to attend the same standard orientation and training session.

B. Certification of Interpreters

Certification implies a uniform set of skills that all professionals working in the field have accepted as the required minimum standard of competency. These standards are usually developed and sanc-

tioned by professionals working in the field and are tied to both a system of training and professional licensing. In many professio ns it is illegal to work as a professional in the field without being certified or licensed. For example, lawyers, ac countants, and physicians must all pass a standard professional exam before they are able to practice in their respective fields. Certification generally results in an increase in the remuneration paid to the certified profes sional, since there is an assumption that certification guarantees a standard level of quality or competency. For example, certified interpreters working in the Federal courts are paid $250 per day while non-certified interpreters are paid an average of $120 per day.

There is an active debate surrounding certification of medical interpreters, as well as certification of interpreters working in the social service setting. The debate is due, in part, to the fact that the profession of medical interpretation is still evolving. The debate focuses on several issues. Should those working in the field of medical interpretation develop their own standards and certification process or should they follow the models established by court or conference interpreters? Who should be responsible for establishing competency standards for medical interpreters? Should the standards be developed at the state, local, or national level? What skills should the standards cover? Who should be responsible for administering and bearing the cost of the actual certification process?

A brief overview of the competency standards and certification processes for court interpreters and interpreters for the deaf illustrates the complex array of issues faced by those concerned with interpretation in the health and social service settings.

Interpreters for the Deaf. Standards of competency and certification for interpreters for the deaf are handled by The Registry of Interpreters for the Deaf, Inc. (RID). RID is a national association that certifies all sign language interpreters and transliterators who pass a standardized evaluation test. RID offers eighteen different professional certifications indicating varying degrees of skill and proficiency levels. Written and performance exams are administered by RID representatives at various testing sites around the country throughout the year. RID continuously revises and updates the various evaluation tests.

Federal Court Interpreters. Competency standards for interpreters working in the Federal courts were established by law under the Federal Court Interpreter's Act of 1978 (amended in 1988). The Federal Administrative Office of the U.S. Courts is responsible for oversight of the certification process. The certification exams are administered by the University of Arizona once every two years. Certification is offered in Spanish, Haitian Creole and Navajo. The exam includes both a written and oral component and is revised each time it is offered. The federal certification exam has a very low pass rate (estimated between 4 and 6 percent). Many individuals interviewed for this study expressed the view that the standards adopted by the Federal courts are unreasonably rigorous.

State Court Interpreters. Each state is responsible for establishing its own competency standards for court interpreters.

However, most states do not have any uniform standards in place. California, Washington, and New Jersey are among the few that have developed viable testing programs to certify court interpreters. Each state has developed language specific exams to meet its own needs. For example, New Jersey certifies Spanish, Portuguese, and Haitian Creole while Washington certifies many Asian languages including Vietnamese, Cambodian, and Cantonese. Currently, the National Center for State Courts, a nonprofit policy group, is exploring the possibility of helping states develop cooperative agreements that would enable them to share exams and avoid re-development of existing assessment tools.

A few states are getting involved in developing certification exams for interpreters working in the health or social service sector. The state of Washington has developed a standardized test that covers language skills and knowledge of the social services (some label it as knowledge of state bureaucratic jargon). Washington state is also developing a test for medical interpreters which is being hotly debated. The state of California offers certification for medical interpreters. Interestingly, in the Los Angeles area, it appeared that few interpreters working in the medical field had been certified by the state. In general, only a few providers were aware that the state operated a certification program. Those who knew about its existence expressed the view that the exam was prohibitively expensive and did not measure the appropriate skills.

In Washington, California, and Massachusetts, the study team encountered examples of professionals, working in the field of medical interpreting, who are banding together in an effort to develop standards of competency that eventually could serve as the basis for developing a certification exam. Most of these professionals are currently employed as medical interpreters, coordinators of hospital-based interpreter programs, or are affiliated with local universities and community colleges. In June of 1994, representatives of these fledgling groups and newly formed associations met in Seattle, Washington to exchange information and share ideas about their efforts to develop competency standards for medical interpreters.

C. Training

Training can be an important component of an effective interpreter program. Traditionally, interpretation has been viewed as a "specialized" service provided for the benefit of the LEP individual. However, particularly in th e medical setting, there is a growing recognition that the interpreter serves two clients—the LEP individual and the provider. In a medical and social service setting, the job of the interpreter is to facilitate two-way communication between the two clients. Consequently, training is essential for both the interpreter and the professional working with the interpreter. Training for the interpreter may focus on skills development, defining the role of the interpreter in the service encounter, or specialized knowledge the interpreter must have to work effectively in the particular service setting. Training for the professional focuses on learning how to work with an interpreter to facilitate communication with the LEP patient or client. While most respondents expressed the view that training was critical, training for interpreters working in the medical

and social service settings is still not widely available and training for providers who work with interpreters is virtually non-existent. Most individuals who serve as interpreters in health care facilities and social service agencies do so with little or no formal training.

The study team visited or collected information about several hospitals and community colleges that were developing training courses for medical interpreters. The duration and content of these courses varied widely. Community college courses usually provide 20 to 40 hours of instruction. Hospital-based programs usually consist of an initial 8 to 16 hour orientation or informal ongoing seminars on a monthly basis. The content of the training varies as well. Some courses place a heavy emphasis on teaching medical terminology while others focus on communication issues, such as defining the role of the interpreter, medical ethics, legal responsibilities, or cross-cultural issues in health care.

One hospital in Boston has developed an innovative training program aimed at physicians and health care professionals who work with interpreters. The hospital has produced several training videos that help physicians understand the role of the interpreter and provide guidelines for establishing an effective team approach to communication with the interpreter. A few residency programs offer optional training for medical students on how to work with an interpreter. As part of a general publication on improving patient adherence to tuberculosis, aimed at public health professionals, the Centers for Disease Control developed a set of guidelines for working with interpreters.[22]

Training can be instrumental in helping to define the role of the interpreter in the communication encounter. A 1993 article in Patient Care, describes how the "*. . . cross-cultural medical interview represents a sharing of control between [the health professional] and the interpreter, who holds a position of considerable power as both a channel of information and a broker of cultures.*"[23] Effective communication is best facilitated when the provider, interpreter, and patient work as a team to ask and answer questions and impart the necessary information. The team approach can work effectively only if each participant clearly understands his or her role and responsibilities during the communication encounter. In Los Angeles, study respondents explained that bilingual staff are frequently asked to assume different, often conflicting roles within the organization. For example, a bilingual community health worker may serve as a patient advocate in one situation and an interpreter for a monolingual doctor in another. In the first situation the community health worker is expected to advise and counsel the LEP patient. However, the same bi-

22 U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention. *Improving Patient Adherence to Tuberculosis Treatment.* Revised 1994, p. 6.

23 D. Buchwald, P.V. Caralis, F. Gany, E.J. Hardt, E.J., M.A. Muecke, R.W. Putsch, *The Medical Interview Across Cultures.* Patient Care. April 5, 1993, p.143.

lingual employee is expected to act in an objective manner when serving as an interpreter.

D. Monitoring and Feedback

A system for monitoring and feedback allows the provider to adapt and adjust interpreter services to reflect the communication needs of the organization in an efficient manner, thus improving the overall quality of services. Few programs visited by the study team systematically collected data on interpreter requests and services , and fewer still offered any mechanism to assess provider or client satisfaction with interpreter services. Hospitals in the Seattle area collected data on interpreter requests, encounters, and costs. This data was used for program planning purposes and served as the basis for receiving reimbursement from the State for contract interpreter services. One HMO used its general customer complaint line to monitor problems associated with language access for LEP clients. The HMO used a standard form to categorize customer complaints. A new category related to language barriers was added to the form. Another HMO planned to add questions related to language barriers and interpreter services to its annual member satisfaction survey.

E. Policies and Protocols for Interpreters

A policy or protocol that provides professional guidelines for the interpreter is another mechanism that can b e used to help ensure quality standards. Confidentiality of patient/client information is a highly sensitive mat ter with legal implications, particularly in the medical setting. Additionally, providers and interpreters may have differing philosophies on the role of the interpreter in the service encounter. Competing or conflicting philosophies on interpretation can easily lead to miscommunication.

A policy can help clarify the professional responsibilities of the interpreter and reduce the potential for miscommunication or a breach of confidentiality. The study team found several examples of policies and professional guidelines that were developed by individual providers or professional associations.

- In 1979, The Registry of Interpreters for the Deaf, Inc. (RID) published a code of ethics for sign interpreters. The code covers confidentiality, the role of the interpreter, and guidelines for faithfully conveying the content and spirit of communication. RID has also developed a set of professional guidelines for working with sign interpreters in medical and mental health settings.

- In 1988, the Refugee Assistance Program at the University of Minnesota, developed a proposed code of ethics for interpreters in mental health under contract to the National Institute of Mental Health. This document includes comprehensive professional guidelines for interpreters that could be adapted easily to medical and social service settings.[24]

24 L. Benhamida, *Proposed Code of Ethics for Interpreters in Mental Health for*

- The American Speech, Hearing, and Language Association (ASHLA), a national, association for speech pathologists, audiologists and other speech and language professionals, is in the process of developing guidelines for working with interpreters. These guidelines will cover issues related to client confidentiality, the role of the interpreter, and conducting a speech and language assessment for the LEP client.

The study team also found a few examples of policies that had been developed by individual providers. One hospital in Los Angeles had developed an interpreter handbook. The handbook included information on rules regarding patient confidentiality and a statement of the hospital's philosophy on interpretation. Another Los Angeles hospital had developed policies around interpreter services for Spanish-speaking patients only. The Department of Public Health in Massachusetts provided guidelines for medical interpreting services to hospital facilities with which it worked, but the guidelines were purposely kept simple. One hospital in Boston developed its own policies and guidelines for the benefit of staff, interpreters, and patients and families, explaining appropriate issues surrounding interpreting, as well as tips, procedures, and modes of interpreting.

8. Translations of Key Materials

According to Bruce Downing, a nationally known expert in the field of medical and mental health interpreting, translation is defined as "*the conversion of a static source language message into written form in the target language.*"[25] It is the written form of communication, whereas interpretation is the verbal or oral form. In many situations, interpreters are also asked to translate hospital and other forms for LEP clients. Although this action may be merited by the circumstance, such a request of an interpreter may imply a lack of knowledge about translation. Written communication is usually produced in a thoughtful manner, using research when necessary, rewriting and editing until the final product is suitable for distribution. Translation of written materials should occur in the same way. The original text (or the source language) should be translated into the target language by using a process called *back translation*. This process allows the translation to be checked for quality assurance. The three steps involved in back translation are: (1) translation of the source language text into the target language, (2) translation of the target language text back into English or the source language by another individual besides the translator, and (3) comparison of the original and the back translation .

Refugees and Others. Prepared by the Refugee Assistance Program-Mental Health: Technical Assistance Center at the University of Minnesota under contract #278-85-0024 CH with the National Institute of Mental Health, 1988.

25 B. Downing, *Professional Interpretation: Insuring Access for Refugee and Immigrant Patients*. University of Minnesota, 1992.

If there is a great amount of different between the two versions, the result may be a translation of poor quality and not useful to professionals.[26]

The study team observed that difficulties among providers in translating all appropriate forms, even in those languages that were commonly requested. One clinic in Los Angeles serving several different Asian clients produced under various contracts a broad range of pamphlets and other translated documents in approximatel y six different languages. In other parts of the country, it would appear that providers have limited access to t ranslated materials and are faced with the choice of translating on their own time or spending staff time resear ching sources. Some providers used outside contract translators and were willing to spend resources on tran slating forms in three or four key languages.

The guidelines around what kinds of material should be translated are clear. According to Benhamida, this would include "... *any written texts that would normally be given to English-speaking patients, such as patient education, discharge instructions, directions for using equipment, information about medication, informed consent forms, insurance/billing information, and public health materials.*"[27]

Translating of hospital signs should also be part of the translation process. In a hospital in the Boston area, interpreter services are described on small cards that are printed in over a dozen different languages. A hospital in Los Angeles located within a Hispanic community displays signs in Spanish alongside all English signs.

9. Population Thresholds in the Context of Language Services

Prominent in past debates on potential regulatory approaches to this subject is the question of language thresholds, i.e., percentages of the total population in a region that speak a specific language, above which a provider would need to assure language appropriate services. A threshold of five percent was mentioned and debated in several past proposed regulations. Much of the debate centered about the appropriate percentage to be used as a "trigger." What the study team found in practice—at least as defined in the three major metropolitan areas visited—was that a language threshold was not an issue and might actually prove to be counterproductive. In Seattle, Boston, and Los Angeles, the central issue was responsibility for assuring effective communication. In both Seattle and Boston, that question has been answered largely through the assumption of responsibility by providers. Providers do not ask them-

26 L. Benhamida, *Language Planning in Mental Health for Refugees and Others: Obtaining Quality Translations.* Prepared by the Refugee Assistance Program-Mental Health: Technical Assistance Center at the University of Minnesota under contract #278-85-0024 CH with the National Institute of Mental Health, 1988.

27 Ibid.

selves whether a patient attempting to get treatment at a hospital speaks a language representing more then five percent of the region's population. The providers assume they must find a way to communicate. That there is a way—AT&T provides the ultimate fallback— makes it possible. In Los Angeles, providers are struggling with that question and different providers have arrived at different answers. There is no single policy, as there is in Seattle.

If a regulation were now to be issued with a threshold defined, two things might begin to happen. First, providers would no longer assume automatic responsibility for effective communication; second, providers might then have to begin diverting valuable resources collecting data on languages spoken by their region's population. This latter task could be done by anyone, but several regulations assumed that providers would need to collect the data. This data is not currently available and different methods are used to reach some conclusions on the question. Warrant rolls are used by the Washington State government to determine how many languages are spoken by recipients of state services.

A number of providers and members of the interpreter community stated their strong belief that, however useful a regulation might be in forcing an improvement in services, there is not enough known about how to provide this service to write a detailed regulation. Setting language thresholds is one of the subjects that they believe should not be included.

10. Enforcement and Oversight

Without vigilant enforcement and oversight, laws and regulations prescribing the provision of language services are only minimally effective in ensuring LEP client access to and receipt of appropriate services. The study team observed that laws or policies directing facilities to accommodate the language needs of LEP clients were often a critical first step in forcing providers to acknowledge some level of responsibility for serving the LEP population. However, in many instances providers responded to the law or regulation by taking the minimum action necessary to demonstrate compliance. Instead of adapting the existing service system to meet the language needs of LEP clients, or developing an innovative approach to language services, providers often focused on conforming to the letter of the law. The study team observed that "paper compliance" with the law did not always result in language access to and receipt of appropriate services for LEP clients. Several study respondents expressed the view that without vigilant enforcement, regulations and laws were inherently limited in their ability to significantly improve services for LEP clients.

CHAPTER 3: CONCLUSIONS

1. Key Study Questions

The OCR study asked Macro to answer two questions:

a) *What models are being used by providers of health and social services to deliver language-appropriate services to LEP persons?*

The study team identified nine different language service "models" including:

- bilingual/bicultural providers
- bilingual providers
- volunteer bilingual staff interpreters
- paid staff interpreters
- volunteer community interpreters
- contract interpreters
- AT&T language line
- language bank
- family and friends

Few providers relied on one model to meet all their interpretation and communication needs. Most providers that accepted responsibility for effective communications with their clients used a combination of methods to expand coverage, reduce response time, and tailor the standard of interpretation to the specifics of the service encounter. Given the complexity of communication in the health and social service setting, no single approach or model was found to be inherently superior to another. The exception was the use of family or friends which presents the greatest potential for a dangerous breakdown in communication and poses an ethical dilemma when minors are involved in interpretation. Although the use of family and friends occurs, providers interviewed for this study generally felt the practice should be discouraged. Virtual unanimity exists that minors should not be used.

To some extent, the models adopted by the providers are related to the type of service being delivered, but mainly the methods are selected out of economic considerations, or as the "default" option, because no other options are available. In terms of facilitating communication, the actual model used is less important than whether the provider has a system in place to link the LEP individual with an appropriate language resource and ensure a standard level of quality of interpretation throughout the service encounter. The provider's willingness to accept responsibility for accommodating the language needs of LEP clients was a key determinant of effective communication.

b) What are the relative costs and benefits of using these alternative service delivery modes?

The cost of delivering language-appropriate services varies substantially, depending on the rates negotiated with interpreters and the extent to which providers believe in the necessity to manage their language services. Hospital providers with large LEP populations are incurring costs in excess of $300,000 per year and some providers report costs in excess of $1,000,000[1]. In some areas, the State of Washington, for example, the state is willing to reimburse providers of

health and social services up to $37 per hour for non-inpatient certified interpreter services. The willingness of the state to become so engaged suggests that both the government in that state and most of the providers have accepted responsibility for assuring effective communications.

The cost of interpreter services is so highly variable that no one model appears to offer significant cost advantages across the full range of languages or service needs. Much depends on how many hours of interpreting are needed and on how relatively easy it is to recruit people who are competent in the languages. The advantage lies with those providers who are able to adopt efficient management and recruit and retain effective interpreters. Staff interpreters, while potentially more expensive because of benefits and overhead, may offer greater relative advantage in effectiveness because of increased competence over time and improved ability to work effectively with other staff professionals.

Some providers might gain an apparent cost advantage over other providers by being unwilling to accept responsibility for effective communication. Thus, when one provider forces clients to bring their own interpreters and another supplies that service, the former gains a slight cost edge. That edge could be costly in an increasingly competitive environment, if clients elect to avoid providers that cannot accommodate their language needs.

In some regions, for example Los Angeles, providers have begun to compete partly on their ability to provide a bilingual capability.

Cost comparisons made by providers do not always include a full accounting of cost. Some providers include only direct costs associated with staff in comparison with a fully-loaded cost associated with a language service. Valid cost comparisons require that all costs–direct as well as indirect–be included in the comparisons.

The benefits of alternative approaches, like the costs, depend on the effectiveness of provider management. Any of the methods, including use of volunteers, could be effective if they are managed appropriately.[2] That management includes the following systemic elements:

- Trains both interpreters and provider staff in the essentials of effective interpreting.
- Identifies LEP patients at all possible entry points into the service system.
- Links LEP clients with an appropriate language resource at all critical contact points in the service encounter.
- Guarantees that language services are available, without unreason-

1 Reported by one large HMO with multiple hospitals and clinics.

2 This statement does not apply to use of family or friends in which control over quality of communication and ethical issues is problematic.

able delay during normal service hours.

- Maximizes the number of languages that can be interpreted with*out unreasonable delay no matter how infrequently the provider encounters the specific language.*

- *E*nsures uniform standards of quality in the interpreter encounter.

- Monitors language service activity levels and associated costs.

Interpreting structures and services that ignore key elements would be less effective than those that include all of the elements. The most likely element to be missing is training. Most providers and oversight institutions are focusing on testing and certification, which appears to miss a vital element–training–that needs to be present in any high quality system.

2. Is a Regulation Necessary?

Many providers of language services as well as government institutions such as regional Office of Civil Rights look forward to a regulation that would clarify and simplify their jobs. The study team concludes that a regulation would be helpful in those regions wherein no progress is being made, but that other non-regulatory approaches might be more cost-effective initially.

a. OCR's main task is to convince health and social service providers that:

- Title VI language referring to "national origin" includes language, and that "equal access" applies to ALL services receiving Federal funding, including those in the health and social service sectors (i.e. hospitals, clinics, health centers, social service agencies).

- Providers are responsible for assuring effective communication with their clients, because they are the only ones that can assure communication quality. Leaving the interpreting task to their clients is tantamount to delegating to the client the responsibility for the quality of communication between provider and client. Mistakes or poor quality can result in added costs and harm to clients. Most clients are ill-equipped to assure effective communication.

b. A regulation is probably not possible or even useful at this stage:

- Local systems are still developing and too many open questions remain about how best to assure effective communication.

- No single approach is likely to emerge as best and regulations might drive out local innovations.

- Regulations could be counterproductive–a regulation, for example that specified a language "threshold", above which service institutions would have to provide interpreters, might reduce the responsibility now assumed by providers in some regions.

Based on the available evidence gathered in this study, it seems clear that the health and social service providers across the country approach this subject of language access very differently. While flexibility

still seems highly useful, a most important next stage of development might be aimed at reaching some type type of consensus among providers and state governments regarding levels of accommodation expected of providers in attempting to serve a multi-lingual population.

APPENDIX A: SEATTLE, WASHINGTON

The basic model used in Seattle health care providers is as follows:

- Patients enter the system either through emergency services or regular admitting processes. The admissions forms contain a mandatory field for language, in which the patient is asked whether they require interpreter services. If patients have difficulty responding, or signal that they need such a service, the record is flagged. Patients who cannot speak any English are shown a multi-lingual card (AT&T has developed a point card) and asked to point to their language. Once the language is identified, the admissions process can be completed. At this stage, any of several systems are used to complete the record—in-house staff, AT&T, or contract interpreters.

- Once the patient record is flagged, each time that patient calls for an appointment the service 's computer system generates an automatic request to Interpreter Services for an interpreter.[2] Interpreter Services then contacts its list of in-house or contract providers and schedules an appointment for the interpreter. Where an interpreter cannot be matched regardless of the effort made, the appointment is rescheduled. In unusual circumstances, AT&T Language Line may be used.

- The interpreter generally signs in and out on a standard form, indicating the patient's name and the service provided. Interpreters are limited generally to between three and four hours, after which they need some compelling reason for remaining with the patient. It is not unusual for providers to request that the interpreter remain with the patient for lengthy stays (a hospital delivery, for example) but such practices are discouraged because of cost. Interpreters are paid for their full stay, even if appointments are delayed or patients fail to show.

- Interpreters often follow the patient to the pharmacy to assure that prescriptions are obtained and the patient understands the instructions for taking the medication. One interpreters claims she uses a "rule of three." She repeats instructions three times to assure that the patient understands.

2. In-House Model

A number of providers have begun to adopt a full or partial in-house interpreting model. In the case of the Asian Counseling and Referral Service a bilingual-bicultural service delivery model is used, in which interpreters are

2 This computerize d system was seen in several providers, but we do not know whether it represents a wide-spread model. Some providers, for example do not have an Interpreter Services Unit, but might have a part-time person responsible for this activity.

Case Study: Seattle, Washington

A. Summary

The Seattle area in particular and Washington state in general appear to have adopted a broad philosophy of service delivery that encompasses the population of persons with Limited English Proficiency. The area has been engaged in development of language services as an adjunct to care since approximately 1980. Much of the progress can be attributed to pressure from the Region's Office of Civil Rights, accompanied by the added pressure of Evergreen Legal Services, heralded by some as the "conscience" of the system. In response to the threat of lawsuits by OCR, the region has organized a relatively complete language service network that now allows health and social service providers to obtain interpreters for a very wide set of languages and dialects—at least 50 and perhaps many more. The number changes each year with the arrival of new refugees. Bosnian has been added recently to the language set in use and being served by Seattle's interpreter community. With AT&T Language Line, at least 100 languages and dialects can be accommodated. In the last two years, the state Department of Social and Health Services (DSHS) has begun to pay for interpreter services when used to provide non-inpatient health services (out-patient, emergency room, and day surgery) to clients of DSHS. This provision of state financing has made a substantial difference in the expenses incurred by health providers, although one finance director in a prominent Seattle medical center claims that he has yet to receive his first payment for language services from the state.

The state has become active in many parts of the language service structure. The state now:

- pays for language services
- has developed and administers a statewide test to certify interpreters—the test does not yet cover explicitly medical interpretation, but that component is being added. Passage of the test is required to be eligible to receive state reimbursement.
- is proposing to develop a "brokering" system in which the state would contract with a "broker" who would in turn manage the interpreter services function for state services that require language services (both health and social services would be covered).

B. System Costs

Interpreter services vary substantially in cost, depending on the model used. Costs can vary even within individual provider systems, depending on the particular method used to obtain language services. Costs vary as follows:

- individual interpreters under contract to providers usually receive fees approximating $20 per hour. The fees are often supplemented by mileage or other expenses. Generally a minimum one-hour fee is charged by interpreters.
- Interpreter agencies charge fees ranging from $30 — $40 per hour. The fees are higher to cover the costs associated with managing the business, profits, and overhead.

- The Hospital Interpretation Service (non-profit service operated by the Central Seattle Community Health Centers — a consortium of sec. 330-funded CHCs) charges between $35 — $40 per hour.

- Direct staff interpreters are used by a number of health care providers (e.g., Pacific Medical Center) and are claimed to be the least expensive and most effective solution since staff are more readily available and can perform a variety of tasks. The claim of least cost needs to be verified, because full time staff receive benefits not paid to contract interpreters. Generally staff interpreters are used when the volume of interpreting business is high enough to warrant the added overhead and benefits costs.

- AT&T Language Line costs providers $2.75 per minute, after payment of certain initial charges. While expensive, AT&T charges only for time actually used, whereas interpreters charge typically by the hour.

- Relatives and friends are used although infrequently and only at the express request of the patient/client. Clearly such approaches bear a zero cost to the provider, although they may result in hidden added costs by prolonging an interview, or by failing to produce an adequate communication between patient and provider. Use of relatives is generally discouraged.

Total costs to the health sector are substantial. Two health care providers estimate their total costs for one year to be between $300,000 and $400,000. The costs are climbing rapidly as Seattle's LEP population continues to grow. One hospital estimates that its costs have climbed from $65,000 to over $300,000 in four years. There are no readily available system-wide costs, although Seattle-area health care providers almost certainly exceed $5,000,000 and statewide costs could be as high as $10,000,000.

C. Models Used in Seattle

During the site visit to Seattle, a number of language models were encountered in service providers. Probably because of the aggressive stance adopted by the Regional Office of Civil Rights, service providers appeared to have accepted the basic principle that language should not be a barrier to services. While all health care providers in Seattle were not visited, all of the providers that participated expressed the same view—services had to be provided regardless of language. Language services include both spoken and signed languages. We encountered one provider who, with the help of interpreters, was able to examine a woman who could neither hear nor see.

Curiously perhaps, the issue of population size that appears to dominate much of the commentary regarding potential regulations, was never raised by any of the providers with whom we spoke. The providers appeared to understand that it was their responsibility to provide appropriate interpreter services whenever a patient/client presented themselves for service, whether that patient belonged to a large minority (Asian and Pacific Is-

lander) or a tiny minority as is the case now with Bosnians and Somalis in Seattle. The issue of population size seems connected with support systems, rather than with basic services. For example, the state has developed a test to certify interpreters, but it covers only the seven most frequently encountered languages.

The state uses its "warrant roles"[1] to establish the languages likely to be encountered. Thus, the entire issue of interpreter competence, as demonstrated by state tests, is limited to major language groups. The state similarly is translating documents used to communicate with its clients. We were told that over 2,000 documents had been translated, but only the major languages will be involved.

In Seattle, we visited providers who deal routinely with 40-50 languages. Languages and dialects present throughout the state may exceed 100. With such large numbers, providers often have to search throughout the community to find interpreters who can function in that capacity. At some stage, whatever the provider intent, standards give way to practical realities. Providers claim that they often go to community associations and advertise in the newspapers in a search for interpreters.

Models encountered during the site visit include:

- Interpreters hired under contract, either as individuals or as part of an interpreting service agency.
- Staff interpreters
- AT&T Language Line

1. Contract Interpreters

The Washington state experience with interpreter services dates to 1980. A class-action complaint was filed in 1979, alleging non-compliance with Civil Rights laws on the part of health service providers. The Office of Civil Rights intervened and essentially threatened legal action if steps were not taken to assure access to care for persons with limited English proficiency. During that period Seattle had seen its population of Vietnamese and other Indo-Chinese refugees climb rapidly. In response, the Indo-Chinese Language service was created, which turned eventually into the Hospital Interpretation Program (HIP), now operated by the Central Seattle Community Health Centers. The Seattle Area Hospital Council was formed by the region's hospitals to act as a non-profit broker for the hospitals in arranging for language services through HIP.

This service provided the bulk of language services for much of the 1980's, although a number of providers opted for a different approach—the bilingual-bicultural staff approach. As the demand for language interpreters escalated, private language services began to form to partly serve the demand. In addition to these for-profit agencies, individual interpreters operate as language service providers who contract with health and social service providers.

1 "Warrant roles" define the list of people who receive checks from the state.

The basic model used in Seattle health care providers is as follows:

- Patients enter the system either through emergency services or regular admitting processes. The admissions forms contain a mandatory field for language, in which the patient is asked whether they require interpreter services. If patients have difficulty responding, or signal that they need such a service, the record is flagged. Patients who cannot speak any English are shown a multi-lingual card (AT&T has developed a point card) and asked to point to their language. Once the language is identified, the admissions process can be completed. At this stage, any of several systems are used to complete the record—in-house staff, AT&T, or contract interpreters.

- Once the patient record is flagged, each time that patient calls for an appointment the service 's computer system generates an automatic request to Interpreter Services for an interpreter.[2] Interpreter Services then contacts its list of in-house or contract providers and schedules an appointment for the interpreter. Where an interpreter cannot be matched regardless of the effort made, the appointment is rescheduled. In unusual circumstances, AT&T Language Line may be used.

- The interpreter generally signs in and out on a standard form, indicating the patient's name and the service provided. Interpreters are limited generally to between three and four hours, after which they need some compelling reason for remaining with the patient. It is not unusual for providers to request that the interpreter remain with the patient for lengthy stays (a hospital delivery, for example) but such practices are discouraged because of cost. Interpreters are paid for their full stay, even if appointments are delayed or patients fail to show.

- Interpreters often follow the patient to the pharmacy to assure that prescriptions are obtained and the patient understands the instructions for taking the medication. One interpreters claims she uses a "rule of three." She repeats instructions three times to assure that the patient understands.

2. In-House Model

A number of providers have begun to adopt a full or partial in-house interpreting model. In the case of the Asian Counseling and Referral Service a bilingual-bicultural service delivery model is used, in which interpreters are

2 This computerize d system was seen in several providers, but we do not know whether it represents a wide-spread model. Some providers, for example do not have an Interpreter Services Unit, but might have a part-time person responsible for this activity.

not used at all. Instead, service providers who are themselves bilingual (or multilingual) are employed.

The in-house model does not differ dramatically from the contract model in terms of its execution. Clients must still be identified as to language and appropriate staff scheduled to meet the needs of the client. Cost is used as the central argument for the staff interpreter model[3], with a number of institutions opting for in-house staff when the demand for individual languages begins to exceed on a regular basis the cost of contract services. The Pacific Medical Center, for example, brought on a Russian interpreter and is considering hiring a second in response to a growing demand. Russian is one of the fastest growing language demands in the area.

The bilingual-bicultural staffing model is clearly the most difficult to organize and operate and seems appropriate in limited circumstances. For direct health care providers as large as the Pacific Medical Center, Group Health Cooperative of Puget Sound, or Children's Hospital, an interpreter model seems the only plausible course. The Asian Counseling and Referral Service provides a set of mental health and social services that can be accommodated with a bilingual staff. Even here, however, they admit that the model is more expensive to operate because of the added staff development time. In their case, they would add that, for them an interpreter model would simply not work as well.

3. AT&T Language Line & Other Backups

Surprisingly, in this region wherein language services are relatively well-developed and widely adopted as part of the practice, AT&T is still used as a backup service. Although we encountered no services for which AT&T is the sole or dominant language service, it is employed commonly when a language is encountered that cannot be covered any other way, or where there is an immediate need and no other way to respond. The language must be identified first, but the response is relatively rapid and satisfactory in the opinion of those who have used the service.[4] No other formal backup systems were identified, although providers do rely on in-house staff who

3 The Asian Counseling & Referral Service would disagree on this point. They use a bicultural service delivery model, because they do not believe that an interpreter model would provide the type of service required by their clients. They advocate their model as more costly initially, but ultimately as more cost-effective.

4 One worry expressed by providers is that the state "Brokering" system, if it goes into practice, will complicate the delivery of this limited but necessary AT&T service. Presently, they contract directly with AT&T and bill the state where appropriate. Under the "Brokering" system, the state's broker would have the contract with AT&T and the service provider—a hospital for example—would have to contact the broker and the broker would then contact AT&T. They worry that this approach will slow down the provision of services.

are not formal interpreters and on relatives when necessary. Approaches regarded widely as inappropriate are:

- use of minor children, where the need to obtain personal information might be compromised, or where the child could be placed in a conflicted situation.

- use of staff whose language skills are clearly inadequate (interpreters cite the occasional instance of a physician who wants to use his/her school language skills, despite their inadequacy.

C. TRAINING & CERTIFICATION

Washington is evolving rapidly toward a system with its own standards, albeit with large gaps in that system . The state has developed a standardized test that covers language skills and knowledge of the social services (some label it as knowledge of state bureaucratic jargon). The state is developing a test for medical interpreters, recognized as badly needed since the current test fails almost completely to test for skills/knowledge in medicine. The current test is hotly disputed, with many believing that it is simply a bad test. Pass rates are substantially higher than the federal court interpreter test (4%) with pass rates varying by language from 25-80%.

What is largely missing from the current system is a standardized training system that would focus on both interpreters and providers—currently the entire system focuses on the competence of interpreters. Seattle interpreters can take a 14 hour course—*The Art of Interpreting*—and there are a few local colleges that provide training. There is nothing that could be construed as a standardized training program, however, and it is acknowledged as a serious weak point in the system. Testing without training is considered inadequate as a response to the need. Some services provide informal training. For example, the Pacific Medical Center operates a monthly Interpreters Forum that provides an opportunity to discuss subjects of common interest to area interpreters.

Also missing from this picture is any training to providers. There is considerable discussion of the need, but almost no substantive response. Part of the need is basic—the "do's and don'ts" of using interpreters in varying medical settings, for example. This type of training could perhaps be accommodated through development of a standardized video (whether physicians would watch the video is another issue) or a standardized continuing education course. There remain broader issues, however. Culturally competent services may well require more than linguistic accuracy. Providers may have to be able to understand something of the culture of the patient, or at least be open to cultural input from the interpreters. It is unclear at this stage whether or how providers can be trained to be culturally aware/competent.

The issue of competence raises a host of related issues that are not yet resolved within the emerging profession of interpreting. There are substantial differences in interpreting philosophy as between legal and medical interpreters, for example with legal interpreters insisting that interpreters must resist any attempt to go beyond literal interpreting. Medical interpreters often "scale" their interpretation to the apparent level of education/understanding of the client or patient.

Legal interpreters avoid such practice altogether. A second issue is patient advocacy, in which interpreters may provide information to patients not requested in order to improve the services available to them. These issues are hotly debated and not close to being resolved within the field. Medical interpreters believe that the fields are simply different and require different standards. The field is still in its infancy.

D. STANDARDS

Where does federal regulation fit into this picture? The professionals and the government administrators are conflicted on this point. Both state and federal government administrators in the region appear to believe that, however much progress has been made, regulations would help to define the standards that providers need to adopt. They would give administrators more leverage. This argument has considerable merit until one examines the system that has merged in Seattle and the state as a whole, without any regulations. What areas are covered by regulations? The main subjects that might be included in a federal regulation are:

- definition of how to determine when a facility is in compliance—generally the definitions require a facility to provide language services whenever a particular language population served by the facility exceeds a fixed percentage of its total service area population. It is noteworthy that in Seattle, this issue did not arise, because the providers appear to understand that they are required under existing statues to provide service, regardless of the size of the linguistic group in the area. Fixing a percentage might arguably change that current system, causing providers to turn away from this relatively comprehensive coverage policy.

- definition of competence — how does a facility know that it is providing culturally competent services? A regulation might define that subject by defining some education or testing standard, neither of which exist on a national level at the moment.

- provider compliance — the regulations would almost surely require someone to collect and maintain data on who is being served relative to the larger potential service population. The regulations would also almost surely require providers to collect such data without recompense, thereby adding to the cost of interpreter services with limited or no overall system benefit gain. Providers (including the state) currently collect data on the population being served. Neither the providers nor anyone else collects data on the overall size or location of ethnic/linguistic groups in the region. The Immigration & Naturalization Service collects and published some data on new immigrants and refugees arriving in the country. These data are not considered accur ate definitions of the region's population.

While regulations would undoubtedly strengthen the hand of state and federal policy officials, the added benefit at this stage is uncertain. Some of the providers believe that the system is still emerging and the field of interpreting is starting to

become a profession. If regulations are defined too early, they might set the standards at some incorrect level and inhibit further development of the emerging system. The best that the professionals hope for is that, if regulations are issued they will define goals, while allowing considerable latitude for local development.

APPENDIX B: BOSTON AND WORCESTER, MASSACHUSETTS

Case Study: Boston and Worcester, Massachusetts

A. Summary

Discussions with service providers in Boston and Worcester, Massachusetts suggest that notable strides have been made in improving service delivery to persons of Limited English Proficiency (LEP). In Boston and Worcester, most hospitals and the Department of Public Welfare (DPW) have some capability to communicate with LEP clients, usually through a combination of bilingual staff, staff interpreters, contract interpreters, and the AT&T language line. While a minimum level of interpreter services seems to be available in both the health and social service areas, it is clear that this level is not yet adequate. Providers are now struggling with issues related to expanding coverage and assuring quality of interpretation.

Both health and social service providers appear to have accepted limited responsibility for serving the LEP population. Providers have undertaken initiatives without a state-wide requirement or the precedence of a court decision. However, there are several forces working together to push providers to accept increased responsibility for the LEP population. The regional OCR office has been actively involved in investigating complaints in the social service area and attempting to change the existing system with whatever mechanisms are available. Legal services and advocacy groups have played a major role in forcing providers to establish interpreter services. OCR has also worked closely with the Department of Public Health and Hospitals to leverage providers into compliance.

While there appears to be a strong commitment among physicians, medical professionals, and those involved directly with interpreter services; there seems to be a critical lack of support among high-level administrators and financial officers to acknowledge their responsibility to serve the LEP population. On paper, most of the hospitals and the DPW in Boston and Worcester have a "communication/interpreter" system in place. Some of these providers are probably doing a reasonably good job serving LEP clients. The degree to which the system on paper matches the reality of what happens when a client walks through the door cannot be determined within the limited scope of this study. We were left with the impression that there are significant gaps in terms of coverage and quality of interpreter services. This raises the issue of what OCR's future role may be in investigating a provider's ability to ensure access and equal treatment.

There are many diverse advocacy groups for interpreter services throughout the State, and several coordinating mechanisms were observed that provide structure to the different parties. Currently Massachusetts does not have a coordinating body that can speak for all.

Payment for interpreter services is a sensitive issue. It appears that communicating with LEP clients is still viewed by a number of providers as a "special service" rather than an obligation on the part of providers to ensure access and equal treatment of all patients. This attitude manifests itself in various ways: inadequate funding to support the needed level

of interpreter services, gap between regular service hours and hours when interpreter services are available, little or no screening of interpreter qualifications, and low levels of compensation for interpreters.

B. LEP Language Groups

Spanish is the dominant language, followed by Portuguese (Brazilians and Cape Verdeans), Vietnamese, and Haitian Creole. Smaller, but sizable language groups include, Greek, Russian, Italian, Cambodian, and Polish.

The inter-relationship between culture and language was stressed repeatedly. The implication is that eliminating the language barrier, although improving access, will not necessarily guarantee equal services. Each language group poses unique challenges to the provider. Clearly, local communities need flexibility to adopt creative solutions. As we expected, lack of health insurance, traditional beliefs about medical and mental health, legal status (fear of being deported), and degree of acculturation were all mentioned as important factors that influence the individual's decision to seek services or comply with a treatment regimen.

C. Catalysts to Improved Service Delivery

Several factors have contributed to provider action on behalf of LEP clients, but it must be mentioned that few hospitals and social service agencies have taken significant action on their own initiative. One exception was the Mattapan Community Health Center whose programming is driven by its mission to respond to the needs of the community. In the social services, OCR and Greater Boston Legal Services, a legal services agency, appear to be the driving forces that brought about change. The impact of OCR on hospital policies is less evident. The Department of Public Health's "Determination of Need" process has played a significant role in forcing hospitals to establish a minimum level of interpreter services.

- **Social Services**. Notably, the OCR regional office successfully negotiated voluntary agreements with a hospital in Maine and the State Department of Public Welfare (DPW) requiring them to develop detailed plans for serving LEP clients. OCR used the threat of a law suit to bring the parties to the table. The regional office is currently negotiating a similar agreement with the Department of Medical Security (which administers the Medicaid program). The driving force behind the OCR/DPW negotiations was Greater Boston Legal Services (GBLS), which threatened to file a class action suit against DPW.

- **Hospital Services**. OCR's role in influencing hospital policies has been limited to an informal strategy of exerting pressure on hospital administrators behind the scenes. Faced with a burgeoning workload, OCR efforts have focused on responding to complaints, which have mainly been filed in the social services' arena, rather than initiating investigations.

- The Department of Public Health's "Determination of Need Process" has played an important

role in forcing hospitals to establish some level of interpreter services. All hospitals in Massachusetts are required to obtain a determination of need (DON) certificate from DPH before undertaking major expansions or purchase of expensive equipment. Starting in 1987, the Office of Refugee and Immigrant Health within DPH began successfully attaching a provision to the DON certificate that required hospitals to provide interpreter services as a condition for approval. As a result, 26 hospitals are required to establish interpreter programs by their DON. While the DON has succeeded in forcing hospitals to develop an interpreter program on paper, there is widespread concern that their true ability to serve LEP patients remains grossly inadequate. There is no effective monitoring or enforcement mechanism in place to assure coverage or quality of services. One of the outcomes from the DON process is the establishment of the "interpreter services coordinator" position, and we noted that these individuals often are involved in networking activities in the community and advocate within their own organizations for increased service delivery.

D. Coordinating Mechanisms

In Massachusetts, there are many fronts to interpreter services and each appears to have a developing system for integrating change at the State and local levels. The different coordinating bodies, task forces, and professional associations are dealing with a number of issues ranging from influencing legislative initiatives on interpreter services to establishing competency standards for interpreters.

The Massachusetts Medical Interpreters Association (MMIA) has been meeting regularly to develop standards of competency for medical interpreters that it hopes eventually will be adopted by area hospitals. Its membership is composed largely of the interpreter services coordinators from a few select area hospitals.

The Massachusetts AHECs have developed a task force to address interpreter services and some of its outcomes have been advocacy at the State level and development of training programs for local communities.

The Massachusetts Law Reform Institute has spearheaded several efforts directed at the State level, appropriately titled the "Babel Series," to increase interpreter services within the legal and medical community. Babel I began by advocating for an added line to legal notices strongly urging recipients to use a interpreter/translator, and ended by attempting to reprint legal forms in other languages. Babel II tackled the court system, resulting in one county requiring competent interpreters for LEP individuals who seek social/health services. Babel III advocates for a statute that would create in the executive branch a Bureau of Interpreter Services and mandate interpreter services at acute care hospitals.

Representatives from several hospitals in the Longwood Medical Area have come together and formed a task force around interpreter services. They have organized a shared pool of contract interpreters who

are assessed and trained using a universal screening tool. In addition, members meet regularly to voice concerns, conduct training around issues, and share information.

E. Models of Interpreter Services

Most hospitals and social service agencies use a combination of "models" to communicate with LEP clients. The Mattapan CHC is perhaps the most advanced in this regard, having integrated bilingual staff at every level of service provision, from reception through medical examination and follow-up, to communicate with its predominantly Spanish and Haitian-Creole speaking patients.

- The DPW relies on bilingual case workers for Spanish speaking clients and operates an internal interpreter pool for less common languages.

- Hospitals in Boston use a combination of bilingual staff, in-house interpreters, contract interpreters (contracted directly with the hospital), and the AT&T Language Line for emergency situations and less commonly spoken languages.

- Hospitals in Worcester use the same types of models as Boston, but also have access to a com munity-wide language bank operated by the Central Massachusetts Area Health Education Center (AHEC).

- One hospital in Boston uses a linking system for pediatric patients and assigns a contract interpreter to a specific patient and family during the entire hospital stay. This reduces the costs in terms of time spent in introductory small talk and increases the level of trust between interpreters, patients, and health care professionals.

- It appears that family members still are relied upon regularly as interpreters. In some cases patients elect to use a family member; in other instances the patient may not be aware that he or she is entitled to an interpreter. Many interviewees expressed ethical concerns about reliance on family members as interpreters. The use of children as interpreters is less common, although it still occurs. Most interviewees were adamant that the practice of using minors under age 18 as interpreters should be prohibited in all cases.

- Use of the AT&T Language Line is discouraged by DPH. Representatives interviewed at area hospitals noted that it was used as a safety net, but emphasized that it was an expensive mode of interpreting. All interviewees cited the need for in-person interpreters, admitting that phone interpretation misses much in terms of the physical dynamics of interpreting. In some cases, such as scheduling, call-backs, and follow-ups, it is considered perfectly appropriate to engage the Language Line as opposed to using staff and contract interpreters.

Issues surrounding cost, coverage, and quality of interpreter services are debated hotly at the local level. It seems clear that each "model" has some merit given the complexity of communicating with di-

verse populations in a variety of unpredictable situations. Adopting a "patchwork" of communication models allows providers more flexibility to respond to different patient/client situations.

F. Costs of Interpreter Services

It is difficult to estimate the true cost of interpreter services at any facility due to the fact that hospitals and social service providers rely on a combination of bilingual staff, interpreters and others to communicate with LEP patients. If cost data is available, it usually reflects only the cost of paying contract interpreters and the salaries of staff interpreters. It is important to realize that when communication between providers and LEP patients occurs through bilingual staff or family members, the true cost of interpretation is likely to be lost in the current service cost data. A full cost calculation for "communication" services would almost surely be higher than the simple cost of paid interpreters. To illustrate this issue, one hospital relies on volunteer interpreters, who receive no compensation for their services, but still need to be managed. In other cases, bilingual staff are used, family members are used, making it difficult to assess the actual cost of serving LEP patients.

At two area hospitals, estimated annual costs of interpreter services were $200,000 and $400,000 respectively. Included within the $200,000 budget were four full-time interpreters (three in Spanish and one in Russian), services for contract interpreters, a services coordinator and support staff, and use of the AT&T Language Line. Wherever possible, hospital representatives cited the use of part-time interpreter staff to reduce costs.

Rates paid to in-house interpreter staff ranged from $11 to $17 per hour. It was not determined what was included within the range of benefits. The rates paid to contract interpreters by hospitals in the Boston/Worcester area range from $10 per hour to $20 per hour. Contract interpreters are usually not eligible for benefits or insurance. In one contract covering social services in the Worcester area, the State Department of Public Welfare pays $39 per hour to the local language bank for interpreter services.

Transportation costs also must be factored into the picture. Some providers cover the parking incurred by their contract interpreters and offer it as a competitive benefit. Other providers do not cover parking and the interpreters must pay between $3 and $6 an hour for parking out of their own pocket.

For contract employees, the minimum number of hours to be billed for services also varies from one to two hours. Some providers pay less per hour but require a minimum of two hours, while others have higher rates and bill by the hour. There is some controversy over standardizing this policy.

Bilingual employees who are asked or required to serve as interpreters, in addition to their primary job function, rarely receive additional compensation for this service. This practice results in two problems. First, since the employee is not recognized as an interpreter, there is no attempt to determine whether the individual possesses the necessary skills to perform this function. Secondly, employees may become resentful when they are asked to assume additional responsibilities without additional compensation, es-

pecially in those cases wherein they are required to complete all of their "regular" work in addition to the interpreting.

Several interviewees discussed the relationship between cost and quality of interpreter services. While cost is not the only measure of quality, there is an assumption that as the cost of a service goes up the consumer's demand for quality assurance will increase accordingly. Until the medical interpreter is recognized as a profes sional and compensated accordingly, the quality of communication will remain problematic.

G. Training and Standards of Competency

Establishing standards of competency for medical interpreters is a highly sensitive, controversial issue at the local level. The issue is complicated by the fact that there are many different patient contact points during a medical encounter for which interpretation may be required. The level of sophistication and skill required by an interpreter at these different points may vary. For example, scheduling an appointment may require a different level of skill than assisting with a medical interview. In Boston and Worcester, issues of quality are being approached on numerous fronts. Many hospitals have instituted internal training programs aimed at staff and contract interpreters.

The AHEC in Worcester, in conjunction with Clark University, has developed a training program for local contract interpreters who wish to work for the local language bank and for bilingual staff from area providers who are serving as interpreters in addition to their regular job duties.

Members of the Massachusetts Medical Interpreter's Association are developing standards of competency in the hope that these standards will be adopted by area hospitals.

One of the physicians at BCH conducts training for area doctors on how to work with medical interpreters and how to conduct cross-cultural medical interviews.

H. Defining "Coverage" at the Local Level

The issues surrounding coverage at the local level do not relate to coverage of specific language groups or LEP thresholds. The idea of establishing thresholds is irrelevant to the debate among local providers. The key threshold is the decision to accept responsibility for serving LEP clients. Once a provider has passed this threshold, they appear to be willing to make substantial efforts to serve any LEP client regardless of the language spoken, or the number of patients who speak that language. The mode of interpretation may differ depending on the prevalence of the language group (staff interpreters may be hired to handle the dominant language groups while AT&T language line is used for uncommon languages). Establishing population thresholds, actively debated in earlier discussions of regulations, could actually have the unintended effect of reducing service levels for some language groups.

Another problem with establishing thresholds is that it is based on the assumption that providers have definable catchment areas and that an assessment of the language groups residing in these catchment areas is possible. This is not the case in Boston where most of the hospitals are physically located in a small geographic

area, but draw from a wide area, sometimes nationally. If a catchment area were defined on geographic location alone, many of the Boston hospitals would share the same target population and could easily "draw the lines" to fit their needs. Coverage issues at the local level relate to assuring that the provider has the capability to communicate with LEP clients during regular service hours without unnecessary delays.

OCR may be able to play a useful role in establishing provider responsibilities to ensuring equal access and treatment for all LEP patients.

APPENDIX C: LOS ANGELES, CALIFORNIA

general, it appears that service providers

of it in the last ten years. In 1980, Hispanics represented 27.6 percent of the

population while whites made up 52.9 percent. By 1990, the percentage of Hispanics had increased to 37.8% while Whites had dropped to 40.8 percent. Numerically, the number of Whites and Hispanics in Los Angeles county are roughly equal. The remaining 20 percent of the population is split almost evenly between Blacks representing 10.6 percent and Asians comprising 10.2 percent.[1]

The State of California has collected data on language groups taken from the AFDC recipient rolls. In Los Angeles County, the major language groups were identified as:

- Spanish (the dominant language);
- Armenian, Russian, Cambodian, Vietnamese, Cantonese (representing at least 3,000 individuals); and,
- Laotian, Farsi, Mandarin, and Korean (comprising at least 1,000 individuals).[2]

In addition, Los Angeles has been one of the nation's top urban destinations for newly arriving immigrants and refugees for the last ten years. Consequently, nearly every world language can be found in the county. The dominance of Spanish presents a different case than was observed in the other two cities due to the sheer numbers involved. To many individuals the term "bilingual" is understood as a reference to Spanish/English bilingual capability. Discussions of "language services" for non-Spanish speaking LEP clients are often viewed as peripheral to the central dilemma facing providers: how to create a Spanish/English bilingual serv ice system? An important caveat related to the development of a bilingual Spanish/English service system should be noted . In some instances, the pervasiveness of Spanish in commercial interactions, may create the perception that bilingual (Spanish/English) health services are readily available and easy to access. The study team observed that this is not always the case. In Los Angeles, the concepts of the "bilingual provider" and the "bilingual service system" need to be examined carefully.

C. Catalysts to Initiating Language Services

In contrast to Seattle and the greater Boston area, pressure from the Office of Civil Rights (OCR) or legal services agencies has not been the driving force behind the development of language services in Los Angeles County. (It is possible that OCR and legal services have had more of an influence in other California service areas. However, mention of OCR or legal services as critical players in the debate surrounding language access was noticeably absent in our discussions with Los Angeles County providers.) Three factors were identified in Los Angeles as having a significant impact on the devel-

1 Ashley Dunn, In California, the Numbers Add Up to Anxiety, NEW YORK TIMES, October 30, 1994, E3.

2 Data Source: California Department of Health Services, Office of Minority Health. Data Tables: Beneficiary Language Preference by County July 29, 1994.

Case Study: Los Angeles, California

This site visit report describes the programs and processes in place within selected institutions in the Los Angeles County geographic area. Although the site visit team engaged in a number of conversations, both in person and by telephone, with persons from different parts of the state of California, the report includes only the insights gained during the visit to Los Angeles. Other parts of California appear substantially different from the Los Angeles region in terms of practices regarding health and social services to persons of Limited English Proficiency. The site visit team intends to incorporate the information gained from other regions of the state in the final report.

A. Summary

Los Angeles is a sprawling urban area populated by an extremely large number of diverse ethnic population groups. Hispanic populations have had a significant impact on the development of language services in the County. In many ways, Los Angeles presents a different "model" for addressing the language barrier than was observed previously in Seattle or Boston. The Los Angeles model might be characterized as a bilingual (Spanish/English) service system struggling to develop a multi-lingual language service capability. Currently, in Los Angeles, there is a heavy reliance on bilingual providers and volunteer bilingual staff interpreters, unlike the models observed in Seattle and Boston. Unlike those cities, the model of a professional medical interpreter has not been adopted widely in Los Angeles. In general, it appears that service providers have yet to develop a systematic method for adequately meeting the needs of the many different language groups.

In comparison to other service systems (especially mental health and social services) hospitals have at least a minimum level of capability to communicate with LEP patients. Nonetheless, legal advocates expressed the view that most hospital interpreter programs are generally inadequate. Except within the private, for-profit sector, resources for expanding and exploring language services are scarce.

Collaboration around language issues at the local service level is rare. Most facilities have developed their interpreter programs or bilingual service systems independently. There is little exchange among providers regarding issues such as certification or training of interpreters or sharing resources to expand coverage for less common languages. Also, there is within the Los Angeles region, an apparent divisiveness around language issues that stems from the general racial/ethnic tension found in the Los Angeles area.

B. LEP Language Groups

In many ways Los Angeles functions as a bilingual city in Spanish and English. Spanish language newspapers, radio stations, television programs, and billboard advertisements abound. Businesses routinely market to Spanish speaking consumers as evidenced by Spanish instructions on automatic teller machines and fast food marquees. The New York Times recently published an article describing the dramatic demographic shift that has occurred in Los Angeles, much of it in the last ten years. In 1980, Hispanics represented 27.6 percent of the

population while whites made up 52.9 percent. By 1990, the percentage of Hispanics had increased to 37.8% while Whites had dropped to 40.8 percent. Numerically, the number of Whites and Hispanics in Los Angeles county are roughly equal. The remaining 20 percent of the population is split almost evenly between Blacks representing 10.6 percent and Asians comprising 10.2 percent.[1]

The State of California has collected data on language groups taken from the AFDC recipient rolls. In Los Angeles County, the major language groups were identified as:

- Spanish (the dominant language);
- Armenian, Russian, Cambodian, Vietnamese, Cantonese (representing at least 3,000 individuals); and,
- Laotian, Farsi, Mandarin, and Korean (comprising at least 1,000 individuals).[2]

In addition, Los Angeles has been one of the nation's top urban destinations for newly arriving immigrants and refugees for the last ten years. Consequently, nearly every world language can be found in the county. The dominance of Spanish presents a different case than was observed in the other two cities due to the sheer numbers involved. To many individuals the term "bilingual" is understood as a reference to Spanish/English bilingual capability. Discussions of "language services" for non-Spanish speaking LEP clients are often viewed as peripheral to the central dilemma facing providers: how to create a Spanish/English bilingual serv ice system? An important caveat related to the development of a bilingual Spanish/English service system should be noted . In some instances, the pervasiveness of Spanish in commercial interactions, may create the perception that bilingual (Spanish/English) health services are readily available and easy to access. The study team observed that this is not always the case. In Los Angeles, the concepts of the "bilingual provider" and the "bilingual service system" need to be examined carefully.

C. Catalysts to Initiating Language Services

In contrast to Seattle and the greater Boston area, pressure from the Office of Civil Rights (OCR) or legal services agencies has not been the driving force behind the development of language services in Los Angeles County. (It is possible that OCR and legal services have had more of an influence in other California service areas. However, mention of OCR or legal services as critical players in the debate surrounding language access was noticeably absent in our discussions with Los Angeles County providers.) Three factors were identified in Los Angeles as having a significant impact on the devel-

1 Ashley Dunn, In California, the Numbers Add Up to Anxiety, NEW YORK TIMES, October 30, 1994, E3.

2 Data Source: California Department of Health Services, Office of Minority Health. Data Tables: Beneficiary Language Preference by County July 29, 1994.

opment of language services or bilingual capability among providers.

1. California Health and Safety Code

The California State law (section 1259 of the Health and Safety Code), enacted in 1991, requires acute care hospitals to establish a policy for *"providing language assistance services to patients with language or communication barriers"*. The intent of the statute is "*to ensure that patients with limited English proficiency and those who are deaf are not denied access to basic health care services.*" The law requires acute care hospitals to take specific actions to ensure that their services are language accessible to LEP groups comprising a minimum of 5 percent of the population in the geographical service area. For example, hospitals are required to prepare and maintain a list of bilingual employees who could serve as interpreters and post notices advising patients that interpreter services are available. The law specifies the minimum skill and knowledge levels an interpreter must possess in order to be considered "qualified."

All of the hospital representatives interviewed for this study were keenly aware of the State's legal requirements regarding interpreter services. The law appears to have been effective in galvanizing hospitals to assess their internal language resources but has had less of an impact on forcing hospital administrators to develop systems for deploying those resources. For example, many hospitals have conducted internal surveys of employees to identify those on staff who speak a language other than English. However, with some notable exceptions, most hospitals do not have a coordinated system in place to link LEP patients with bilingual staff or interpreters and provide little training to bilingual staff on how to serve as interpreters. Consequently, while language resources may be available in a particular facility, the burden falls heavily on the LEP patient to figure out how to access and use the resource. This situation is in marked contrast to the system observed in the Seattle area, where many of the area's health providers follow a relatively standard process of identifying LEP patients and then employing a formal system that links those patients to interpreter services at each point in the patient's contact with the delivery system.

2. Market Interest in LEP Populations.

A second factor which has influenced the development of language services, is the increased competition for patients among HMOs, hospitals, and other health care providers as they attempt to offset rising health care costs. In Los Angeles, fierce competition for new patient "markets" has resulted in HMOs and other health care providers taking a second look at LEP groups who historically have not been part of their target client populations. Marketing efforts have focused on the dominant LEP language groups: Spanish in Los Angeles, and Chinese in the San Francisco Bay area. For these language groups, increased competition may result in better access and linguistically appropriate care. However, as will be discussed in a later section of this report, there is some skepticism over whether bilingual/bicultural marketing strategies will translate into more broadly available language-accessible health services. It is important to note that smaller, though still sizable, language groups have not yet become the focus of marketing efforts.

3. Medi-Cal Managed Care Initiative.

The State of California plans to shift all Medi-Cal recipients into a managed care health plan by 1996. State-wide there are approximately 2.5 million Medi-Cal recipients, roughly one million of whom reside in Los Angeles county. California's Department of Health Services (DHS) plans to contract with commercial HMOs to serve 30-40% of the Medi-Cal population. The remainder will be served through a new entity called the Local Initiative Health Authority which is currently being established in each county and that will function like a non-profit HMO made up of a network of "traditional providers".[3]

The Medi-Cal Managed Care Initiative has the potential to have a significant impact on the development of la nguage services although its effects are only beginning to surface. DHS has established cultural and linguistic requirements for the Medi-Cal managed care program. The requirements are fairly detailed and include several provisions of special interest to OCR including:

- an interpretation of the provider's responsibility to serve LEP patients under Title VI of the Civil Rights Act of 1964;
- required 24-hour access to interpreter services for all members;
- provision of linguistic services to LEP population groups residing in the proposed service area who meet a numeric threshold; and
- required assessment of linguistic capability of interpreters or bilingual employed and contracted staff.

DHS released the first request for applications, which included these provisions, and was directed at commercial HMOs in September 1994. There is intense interest among HMOs to enter the Medi-Cal market particularly in Los Angeles county where nearly 40 percent of the state Medi-Cal population resides. The study team observed that many HMOs are already attempting to incorporate some level of Spanish language capability into their service systems as part of their effort to market to Medi-Cal recipients. For example, one HMO described outreach activities aimed at the Medi-Cal population which included hosting school health fairs in predominately Spanish-speaking communities. Bilingual/Spanish staff from the HMO also invite residents to attend an open house, held at the community clinic, where the HMO plan is described in both Spanish and English. Currently, 26 commercial HMOs are approved to accept Medi-Cal clients.

Traditional providers are also watching the developments closely to see whether DHS will monitor and enforce provisions related to linguistic requirements. It was not clear at the time of the study team's visit whether the Local Initiative Health Authority will be held to the same linguis-

3 Telephone interview with Mr. Castalo de la Rocha, Local Initiative Health Authority for Los Angeles County, January 5, 1995.

tic and cultural requirements as the commercial HMOs although it seems likely that it will be.

D. Models of Hospital/Clinic Communication Services

Further evolution of language services in Los Angeles is being shaped by two additional factors: (1) the dominance of the Spanish language, and (2) the sheer numbers and diversity of other language groups. In Los Angeles, the study team observed a heavier reliance on bilingual employees than was observed in the other two cities visited. Such employees are able to communicate directly with their clients, or serve informally as interpreters on an ad-hoc basis. The concept of a professional "medical interpreter" whose primary job responsibility is interpreting has not been adopted widely.

To describe the myriad of communication approaches employed by providers and to highlight the complexities associated with a "bilingual model", this section of the report is divided into two parts. The first section describes the role of the individual responsible for communicating with LEP clients in the organization. The second section describes how communication or language services are integrated into the service system as a whole.

Los Angeles is among the most multi-cultural, multi-ethnic cities in the country, presenting challenges to providers who face the need to develop service systems that can respond to perhaps forty language groups. It also means that potentially, there are greater bilingual resources available in Los Angeles than in many other cities. This may explain, in part, why the bilingual provider model and the volunteer staff model are more common in Los Angeles.

1. Bilingual Provider:

Around the Los Angeles area, we observed a heavy reliance on the bilingual provider model, as opposed to interpreter services. In this model, health care services are provided directly by professionals who speak the primary language of the patient. Bilingual "support" staff are responsible for performing essential functions such as patient registration and appointment scheduling to facilitate language access to services. This model was in place in several programs visited by the study team including: a hospital-based group family practice in which *all* staff spoke Spanish and English, a women's health clinic which served Asian and Hispanic patients, and an outpatient mental health clinic for Asian Pacific Islanders (API) that provided outpatient services in four primary languages (Korean, Vietnamese, Japanese, and Cantonese), and other secondary languages (Mandarin, Filipino, Cambodian, Laotian, and Thai).

The bilingual provider model is most commonly adopted by relatively small programs located in linguistically homogenous communities. Professional and support staff are recruited on the basis of their ability to speak the desired language. The benefits of this model are that it is perceived to be the most cost-effective way to provide services to LEP populations, and that patients feel more comfortable speaking in their primary language rather than through an interpreter, especially in the mental health arena. The limitations of this model are that only a small number of languages can be accommodated. The end result is that the

language assistance at every possible entry point into the service system and a way of linking the client with a language resource at all critical contact points. In one fully bilingual model such client identification is assumed. In that Group Fam-

as noted on the patient's registration form, is entered into the patient's computerized patient record. (In-patient and out-patient computerized record systems are linked).

4 This system resembles that found in many of the facilities in the Seattle area.

bilingual provider model often excludes all but the dominant language groups in the service area.

2. Volunteer Staff Interpreters

In this model, staff members with second language capabilities are asked to serve periodically as interpreters in addition to their normal job duties. The decision to serve as an interpreter is voluntary on the part of the bilingual staff member who retains the option to turn down interpreting

competent interpretation, (3) lack of additional compensation for extra responsibilities surrounding interpreting, (4) conflicting priorities as employees balance interpreter requests with the demands of their daily work and (5) the hidden costs involved in diverting staff resources to interpreting.

3. Paid Interpreter Staff

The primary job responsibility of these individuals is interpretation. We observed

- Language preference is imprinted on all inpatient identification plates and bracelets. All papers in the patient charts contain the ID. imprint (similar to a credit card). Staff can easily refer to the patients chart to identify whether an interpreter may be needed.

- Interpreters are arranged through a central number. All hospital departments have received repeated education about how to use this number and access an interpreter.

- Two portable speaker phones are maintained on rolling carts. These phones are used only for AT&T language line interpreter encounters. The portability of these phones ensures that interpretation in any language can be provided in any place in the hospital regardless of whether there is a phone jack in the room.

As mentioned earlier, most hospitals have language resources available, but lack the type of integrated system needed to deploy these resources effectively. For example, one hospital had a method for identifying LEP patients during outpatient registration but not during inpatient registration. Consequently, the LEP patient's ability to access language services depended on whether they entered the system as an inpatient or an outpatient. Another program did not have a centralized procedure for arranging interpreter encounters, relying on the judgment of the receptionist for initial arrangements and requiring all Spanish-speaking staff to wear special pins identifying them as interpreters. The absence of a fully integrated system shifts the burden of accessing language services to the patient.

F. Costs of Interpreter Services

In the Los Angeles region, cost data pertaining to interpreter services is not as readily available as in the other two cities because of the strong emphasis on development of bilingual service models. Much of the interpretation in Los Angeles, is done by bilingual staff who are not designated as "interpreters". While there is a hidden cost involved in deploying these staff to serve as interpreters, none of the providers interviewed for this study had assessed the actual cost per interpreter encounter. Some of the programs pay bilingual staff a salary differential. To be eligible for a salary differential, employees must pass a language proficiency exam and their supervisors must verify that they will either interpret or translate on a regular basis in addition to their normal job duties.

Providers that had the most highly developed interpreter programs were also the ones who had invested heavily in the planning and design stage. County facilities have been given almost no additional money to support interpreter services. In contrast, one of the private hospitals had been given a start-up budget which enabled them to hire a full-time interpreter coordinator, conduct a needs assessment, and hire a consultant to develop a computerized system to track interpreter encounters. Staff associated with this program indicated that this initial investment had been critical to the program's success.

1. Salary differentials

Many facilities pay salary differentials to bilingual employees who provide volunteer interpreter services in addition to their regular duties. One organization began paying salary differentials to Spanish-

quest of the patient, the burden for language service provision falls upon the patient, and the element of control surrounding the language issues throughout the medical encounter is raised. When volunteers are used and supplied by the service provider, there is greater control, but unless the volunteers are screened, trained, and monitored, just as if they were paid staff, the quality, accessibility, and availability are in jeopardy.

E. Integrating Communication and Language Services into the Service System

Even when a language resource is available (in the form of an interpreter or bilingual staff member), access to services cannot be assured unless there is a systematic method of linking the LEP client with the language resource. Moreover, unless there is a systematic method in place to screen, train, and monitor interpreters, the quality of an interpreter encounter cannot be assured. With several notable exceptions, the study team observed that many facilities had the internal language resources available but did not have a coordinated system in place to deploy the resources in an efficient manner.

In order to facilitate language access, programs need to have a way of systematically identifying those in need of language assistance at every possible entry point into the service system and a way of linking the client with a language resource at all critical contact points. In one fully bilingual model such client identification is assumed. In that Group Family Practice, all staff from the receptionist to the physicians spoke the p rimary language of the client population, Spanish. This program was located in a community that was largely Spanish or Spanish/English speaking. In this situation the language barrier was essentially eliminated at every contact point for Spanish-speaking clients. As long as the patient spoke English or Spanish there was no need to "identify" him/her as a patient in need of a language service.

In contrast to the bilingual model, most health facilities exhibit more diversity both in terms of the linguistic composition of their staff and the client population in the catchment area. In such programs, formal systems to identify client language needs is vital. Yet, in only one of the programs visited — a hospital — did a fully integrated system exist for identifying LEP patients and linking them with the appropriate resource. This hospital's "system" for facilitating language access includes the following components:[4]

- All outpatient and inpatient registration forms include a place for patients to indicate what language they are most comfortable speaking and whether they have any specific communication needs.

- The patient's preference language, as noted on the patient's registration form, is entered into the patient's computerized patient record. (In-patient and out-patient computerized record systems are linked).

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1. Salary differentials

Many facilities pay salary differentials to bilingual employees who provide volunteer interpreter services in addition to their regular duties. One organization began paying salary differentials to Spanish-

speaking employees as a result of union contract negotiations. The salary differentials ranged from $35 to $80 per month. A representative from one of the HMOs stressed that building a bilingual service system was not inexpensive. The HMO has spent approximately $150,000 to develop and operate a testing program. However, th e salary differentials represent the greatest expenditure—nearly $1,000,000 per year.

2. In-kind Compensation

One provider offered bilingual employees other in-kind incentives, to serve as "volunteer" interpreters, such as gift certificates to family amusement parks, restaurants, and stores. The gift certificates were viewed as a way to express the organizations appreciation rather than a true incentive to participate in the interpreter program.

3. Salary levels

In the County system there is no job classification for an "interpreter". Hospitals may hire bilingual "community health workers" whose official starting salary is $20,500. Historically community health workers were hired to perform case management, advocacy, health counseling and outreach. These individuals are now also being asked to serve as interpreters. An organizational survey of hospitals in the Los Angeles area was conducted in 1992 by Kaiser Permanente's Organization Effectiveness Unit. Findings from this survey indicated that hospital staff interpreters were paid in the range of $10 to $15 an hour, and most hospitals compensated bilingual employees with salary differentials.

4. Reducing Operating Costs

One hospital developed an innovative method for reducing operating costs of the interpreter program. The hospital needed a mechanism to be able to contact and deploy interpreters 24 hours a day/seven days a week. Instead of directly hiring staff to perform this duty, the hospital contracted with a dispatch service at a cost of $12,000 per year. If the hospital had used its own employees to run this service, the costs would have included, staff salaries for at least three individuals and benefits.

5. Hidden Costs

Regardless of the language services model chosen, hidden costs should be a factor in projecting expenditures related to service. Most language services budgets are absorbed within the general and administrative costs of an agency or organization, but there often are accountable measures that can be used to attribute specific costs with language services. Each model discussed in the earlier section on language services has its own hidden costs.

- Bilingual staffing models rely on recruiting and retaining competent professionals and efforts to attract such individuals into a bilingual setting may require additional resources, although, according to a study conducted by the Association for Asian and Pacific Islander Community Health Organizations, the service provided has been determined to be cost effective as opposed to using interpreters.

- On the other hand, use of bilingual staff as volunteer staff interpreters has a plethora of hidden

costs. "Volunteer" employees need to be screened, trained and supervised; and hours spent on these activities are simply absorbed by the cost division in which the employee resides. In addition, contrary to the perception of volunteerism, the actual time spent interpreting is not free to the provider: an hour of a bilingual physician's time spent interpreting would be paid for through another cost center within the organization, but would appear to be "free" to the interpreter services department.

- There are other cost effectiveness issues surrounding the use of higher level staff in interpreting situations as opposed to support staff. The employee with medical knowledge might be more expensive, but may ultimately provide better language service, whereas using the receptionist in a complicated medical encounter may be less expensive, the interpretation may have errors that could produce consequences for the provider. Another hidden cost around any volunteer model would be its inherent reliance on voluntary participation by the interpreters. When situations arise in which there are no available interpreters, providers reported that their backup service was the AT&T language line.

The hidden costs of using community volunteer staff are shared by the health care provider and the social services provider. Often, community volunteers accompany patients to appointments and wait with them throughout the entire visit. The cost to the social service agencies of case workers/interpreters has been reported to be enormous at times when patients must wait for hours to see the doctor. On the other hand, if the interpreter is provided from an outside source, the health care professional may not be familiar with the interpreter's level of medical knowledge or interpreting skills and additional time during the medical visit may be spent on communication. There are also liability issues around patients bringing their own interpreters into the health care setting, or reliance on interpreters who have not been screened and trained by the health provider agency that have not been fully addressed in the Los Angeles area. Often community interpreters engage in cultural advocacy, assisting patients in making medical decisions and understanding the health car e system, which could pose difficulties for the health provider.

Although the AT&T language line is regarded as a very expensive means of interpreting, it was also mentioned that billing data for the services are rarely delineated and analyzed to support interpreting needs. Many pr oviders stated that the costs were absorbed into the monthly AT&T invoice; some did not have an idea of how much was spent on the language line, but were trying to minimize its use.

G. Health Maintenance Organizations

The study team visited two types of HMOs: a group model (where the HMO is also the health provider), and a network (where the HMO contracts with independent physicians and group practices to provide health care). As mentioned earlier in the report, in response to stiff competition for new patient markets,

HMOs are increasingly interested in the possibility of serving LEP groups who historically have not been part of their target client population. Not surprisingly, HMOs are interested in identifying sizable LEP groups that potentially represent viable patient markets. In the Los Angeles area, HMO bilingual marketing and service initiatives have focused almost exclusively on Spanish. Other language groups, although significant in size, are as yet unaffected by HMO initiatives.

Both HMOs are developing Spanish language capability in the context of larger program development goals. Neither HMO set out to develop a "language service". As a provider, a Group HMO has more control over policies related to language access at the service level than a network HMO. Because the network HMO serves as a broker between the patient and the provider, its involvement in language access at the service level is necessarily limited.

The Group HMO is in the process of developing a Spanish/bilingual service system as part of a new Latino Model of Care Initiative. This initiative aims to make the HMO service system more responsive to the particular health needs of Latino members. Representatives from the Group HMO stated that it is not their intent to develop an "interpreter program". Rather they are trying to develop a Spanish/bilingual service system in those HMO facilities located in service areas with a high concentration of Spanish speaking residents. (The Group HMO includes eleven medical centers in the Southern Region). To date, 2,500 of the HMO's 33,000 employees have been identified as Spanish/English bilinguals. Using the assessment tool developed by the U.S. Department of State's Foreign Service, the HMO has begun testing the language proficiency level of all Spanish/bilingual staff. Spanish/bilingual staff who pass the assessment are eligible to serve as interpreters (in addition to their regular jobs) and receive a salary differential of $65 per month. Bilingual staff wear a pin that identifies them as an interpreter. At present, each HMO health facility is responsible for establishing its own system for linking LEP clients with a designated "interpreter".

The Network HMO is developing Spanish language capabilities as part of its larger effort to serve the Medi-Cal population. In contrast to the Group HMO described in the previous section, the Network HMO is not directly involved in the provision of health services. The Network HMO has hired Spanish/bilingual sales representatives and member services representatives and has translated all of its membership materials into Spanish. They have also made a concerted effort to recruit more Spanish/bilingual physicians into the network of providers. The HMO does not get involved in the assessment of provider language proficiency. Each member is given a list of network providers which indicates which ones speak a language other than English. The nature of this system inherently places the burden of ensuring language access on the patient and the provider.

As part of its regular member services, the HMO offers a complaint line where members can report any problems they have with providers. The HMO uses the complaint line to monitor problems with language access and works with LEP clients on an individual basis to find a

provider that speaks their primary language.

H. Mental Health Services

In Los Angeles County, DHS contracts with community-based organizations to provide outpatient mental health services. The study team identified several small programs that are specifically designed to serve Asian Pacific Islander (API) populations. The site that was visited is the largest outpatient mental health counseling center targeting API groups with a caseload of 1,000 clients at any one time. The center is staffed by seven full and part-time psychiatrists and twenty therapists. All staff are bicultural/bilingual and collectively they can provide services in ten Asian languages. Thirty-three percent of the patient population is Korean. The majority of patients are young to middle-aged adults. Children make up 10 percent of the caseload.

1. Excess Demand for Language Specific Mental Health Services.

Staff expressed the view that the issues surrounding mental health counseling are so complex and of such a sensitive nature that it would be difficult, if not impossible, to conduct effective sessions with interpreters. Counseling sessions are conducted in the language most comfortable to the client. It was felt that there is a growing awareness and acceptance of mental health services in the API community which is resulting in an increased demand for counseling. As an example, following the 1992 riots in Los Angeles, in which many Korean businesses were the focus of violence, the Center had 600 walk-in clients requesting services.

At any one time, the Center has a waiting list of two-three months. Frequently, clients have disappeared or are no longer interested in receiving services by the time there is a space available. The Center maintains a referral list of all the bilingual mental health resources available for API individuals. Even with a referral network, the Center is unable to accommodate promptly the high level of requests for counseling. Staff stated that there is a growing number of API bilingual mental health professionals in California and that, given additional resources, the Center would be able to hire staff to accommodate the demand for services.

2. Hospitalization of LEP Patients is Problematic.

Staff stated that one of the most difficult situations they face is the issue of how to handle the hospitalization of LEP patients. In Los Angeles County, the state-operated mental hospital is the only inpatient facility with API bilingual capability. Indigent patients receive priority at the state hospital. Medi-Cal and privately insured patients are usually referred to private inpatient psychiatric units where there is typically no language service available. Center staff described the trauma this imposes on patients who are already in an emotionally compromised state.

3. Requests for Interpreters. Because of the heavy client load, Center staff usually do not serve as outside interpreters although they do receive calls from agencies in need of interpretation. The Center frequently receives calls from the County Psychiatric Mobile Response Team whose charge is to respond to crisis situations that may require immediate hospitalization. Counseling staff are also

occasionally asked to interpret for brief sessions around prescription and medical instructions between their client and a staff psychiatrist speaking a language other than the client's.

I. Training and Standards of Competency

1. Assessing Competency

Several of the programs visited had some mechanism in place to assess the skill level of bilingual employees who might be called upon to serve as interpreters on an ad hoc basis. There was some variation in how this assessment was administered both within and among programs. For example, one program assessed the bilingual capabilities of Spanish-speaking staff only. Another program assessed the language proficiency level of all staff who declared they spoke a language other than English and expressed an interest in serving as an interpreter on an ad-hoc basis. It is worth noting that many hospitals compile a roster of "bilingual employees" as a way to comply with California Health and Safety code 1259. Bilingual employees are identified through a survey where individuals are asked to self declare their bilingual capability. It is not clear whether such hospitals routinely assess the skill levels of "bilingual employees" once they have been identified.

Among those persons in the field of health care consulted by the site visit team, it was agreed generally that anyone who serves as an interpreter should be tested on their oral proficiency in the second language and on general knowledge of body parts and basic medical terms. The ability to read and write in the second language was viewed as a specialized skill that was needed but not critical for everyone involved in interpreting. Interestingly, all three of the competency tests described during the interviews were developed independently for the respective programs. Two of the programs mentioned outside sources which were consulted during the development of their testing instruments. The University of Phoenix (which operates the certification program for court interpreters in the Federal Courts), Berlitz, the State Department, and individuals involved in certifying California court interpreters were mentioned as valuable resources. The State of California runs its own program to certify "medical interpreters". Many providers expressed the view that the State certification program is prohibitively expensive to providers and interpreters and is unnecessarily rigorous in its assessment of required language proficiency.

2. Training

Several programs are in the early stages of developing training for interpreters. Only one hospital program had institutionalized a formal orientation for individuals involved in interpretation. At this hospital, full-time interpreters and bilingual staff who may serve as interpreters are required to go through the same screening and training program before they are allowed to interpret.

Because most facilities rely on bilingual staff whose primary job responsibility is **not** interpretation, the issue of defining the role of the interpreter was seen as critical in Los Angeles. Bilingual staff are frequently asked to assume different, often conflicting roles within the organization. For example, a bilingual community health worker may serve as a patient advocate in one situation and be asked to

interpret for a monolingual doctor in another. Several individuals stressed the need for training to assist bilingual staff in learning to move between these roles.

J. Legal Services

The study team met with representatives of four legal advocacy organizations to discuss the issue of language access. All of the attorneys interviewed recognized the difficulty in relying on the laws and regulations to change the current service systems. The National Health Law Program is in the process of submitting an article for publication which presents an analysis of the legal obligations of health care providers to offer language services as stated in a number of federal and state laws. In contrast to the other cities visited for this study, legal services has not had a direct influence on the development of language services in health care or social services. Legal advocacy on behalf of LEP clients has focused on employment discrimination cases. Most complaints surrounding language access have been filed by interpreters or providers. Without an LEP client as a plaintiff, legal services cannot move forward on language access cases. While the attorneys agreed that a landmark malpractice case could serve as a catalyst to the development of language services in a hospital setting, they expressed the view that the likelihood of such a case being successfully pursued in Los Angeles county was slim.

The political climate in Los Angeles is noticeably different than in the other two cities. While legal advocates are concerned about language access, other issues such as Proposition 187 have taken the center stage.

APPENDIX D: BIBLIOGRAPHY

Research Studies

Association of Asian Pacific Community Health Organizations. 1993. The Language Access Project Final Report. Report prepared by AAPCHO under contract to the Office of Minority Health, Department of Health and Human Services.

Association of State and Territorial Health Officials. 1992. ASTHO bilingual health initiative, Report and recommendations: State health agency strategies to develop linguistically relevant public health systems. Washington, D.C.: Association of State and Territorial Health Officials.

Ginsberg, C., V. Martin, D. Andrulis, Y. Shaw-Taylor, and C. McGregor. 1995. *Interpretation and translation services in health care: A survey of US public and private teaching hospitals.* Washington, D.C.: National Public Health and Hospital Institute.

Louis Harris and Associates., Inc. 1995. The Commonwealth Fund National Comparative Survey of Minority Health Care. New York, NY: Louis Harris and Associates, Inc.

Siegel, W. 1992. Immigrants at risk: Language and cultural barriers experienced by multi-ethnic patients in a sample of Chicago hospitals and health associations. Chicago, IL: Chicago Institute on Urban Poverty, Travelers and Immigrants Aid.

Tran, T. 1988. Sex differences in English language acculturation and learning strategies among Vietnamese adults aged 40 and over in the United States. *Sex Roles* 19(11/12):747-758.

U.S. Department of Health and Human Services, Office of the Inspector General, Office of Evaluations and Inspections. 1990. Serving non-English speaking clients. Washington, D.C.: Office of Inspector General.

Newspaper Articles

Acuna, A. 1990. A kindred heart for refugee women: Culture, *Los Angeles Times*, 7 November 1990.

Arocha, Z. 1986. Influx from suburbs strains district clinics: More Hispanic immigrants seek care in city, *Washington Post*, 28 June 1986.

Associated Press. 1994. U.S. should absorb costs of immigrant services, Mayors' conference says, *Arizona Republic*, 11 June 1994.

Bronson, B. 1991. Struggling to help troubled immigrants, mental health: Many recent arrivals develop emotional problems, but a lack of services and cultural barriers hinder getting aid, *Los Angeles Times*, 17 February 1991.

Bryant, M. 1990. The plight of illegal immigrants: When an undocumented worker is disabled, who pays?, *The Washington Post*, 10 July 1990.

Carroll, N. 1993. Seeking care in a strange land, medical culture shock: Russian immigrants miss personal touch when they navigate U.S. health system, *Newsday*, 10 October 1993.

Carroll, N. 1993. Translating medicine's mysteries, *USA Today*, 11 May 1993.

Christian Science Monitor. 1989. Boston upgrades services for immigrants, *Houston Post*, 15 January 1989.

Davis, A. 1992. Translators misleading migrants, leaders say, *Miami Herald*, 26 June 1992.

Dietz, J. 1984. Boston for some southeast Asian refugees, war continues. Brighton Marine Hospital's Indochinese clinic aids those with psychiatric problems, but language and cultural barriers exist, *Boston Globe*, 14 October 1984.

Donovan, S. 1991. Language barriers hinder health care, *USA Today*, 15 April 1991.

Douglas, W. 1993. Many tongues spoken: Students translate at clinics, hospitals, *Newsday*, 3 January 1993.

Drexler, M. 1992. Soviet immigrants struggle with needs, new culture, *(Cleveland) Plain Dealer*, 17 November 1992.

Foster, D. 1994. TB an unwelcome hitchhiker with immigrants, Medicine: Nurse says highly contagious disease is entering U.S. along with a variety of newcomers, *Los Angeles Times*, 13 February 1994.

Gebrehyiwot, W. 1994. Patients get the facts in translation, *Newsday*, 16 February 1994.

Gelman, M. 1994. Breaking down the barrier of fear, doctors unlikely to report immigrants, *Newsday*, 11 April 1994.

Gupta, H. 1994. Building bridges between doctors and patients: Trainers help link ethnic communities, health care providers, *Seattle Times*, 20 February 1994.

Haldane, D. 1990. Meeting medical needs of refugees, *Los Angeles Times*, 10 March 1990.

Halsema, J. 1986. Lending a needed voice: Interpreters bring relief to pressure situations, *Los Angeles Times*, 9 October 1986.

Hart, J. Lowell walks an ethnic tightrope as city confronts wave of refugees, *Boston Globe*, 4 August 1994.

Hernandez, E. 1992. Warming the welcome, immigrant services offered, *Boston Globe*, 29 October 1992.

Herscher, E. 1990. Health care for Asians called poor, study finds a language barrier with newly arrived immigrants, *San Francisco Chronicle*, 14 December 1990.

Joe, S. 1994. Hospital needs interpreters in maternity, group says. *Baltimore Sun*, 12 July 1994.

Keeler, G. 1993. Bridging the culture gap: Translators keep hospitals in touch with their patients, *The Fresno Bee*, 12 May 1993.

Kelley, T. 1994. Words of healing, interpreters a boost to refugee health care, *Seattle Intelligencer*, 12 May 1994.

Kurtzan, L. 1992. Troubled immigrants suffer in silence, mental health clinics lack language skills, *San Jose Mercury News*, 9 January 1992.

Matsuda, J. 1993. It's caring, in any language translation program assists Russian immigrants with medical needs, *Sacramento Bee*, 9 December 1993.

McConnaughey, J. 1992. The language of healing: Interpreters help doctors learn cross-cultural medicine, *Union News*, 9 July 1992.

Monroe, L. 1989. Cultural differences snarl health care for immigrants, *Arizona Republic*, 27 August 1989.

Monroe, L. 1989. Cultural differences impair health care for minorities, *Seattle Times*, 23 November 1989.

Morgan, D. 1994. Expanded medical safety net still has holes, *The Washington Post*, 2 February 1994.

Mott, P. 1988. Immigrants clinic to culture while adapting to a new, fast way of life, *Los Angeles Times*, 13 February 1988.

Negron, E. and C. Woodard. The language of debate, Suffolk considering English-only bill with far-reaching effects, *Newsday*, 14 February 1989.

Nolan, M. 1990. Concern snips a language barrier: Woman uses knowledge of Russian to help new immigrants, *Seattle Times*, 4 September 1990.

Novello, A. 1992. Hispanics feel effects of poor health care, *Miami Herald*, 25 October 1992.

Page, L. 1993. Hospitals tackle the language barrier: Need for interpreters booms, *The Record*, 19 April 1993.

Paterno, S. 1992. Minority groups at-risk of diabetes, *Los Angeles Times*, 21 July 1992.

Porter, L. 1991. Soviets are latest wave of refugees. *St. Paul Pioneer Press*, 14 July 1991.

Rakowski, J. 1992. Quest to bridge growing language gap, City agencies are adapting to meet needs of immigrants, *Boston Globe*, 4 October 1992.

Ray, E. 1992. In another country Haitian immigrants in greater Boston face a daunting array of problems, from health care to housing to financial responsibility for family members back home, *Boston Globe*, 26 July 1992.

Reid, B. 1994. Poor mothers, healthy babies: Woman offers prenatal care, immigrants trust practice, *Phoenix Gazette*, 12 June 1994.

Richman, R. 1993. Failure to communicate. *The Chicago Reporter* 22(3):5-11.

Rochell, A. 1994. Grady opens two clinics to serve area's immigrants, *Atlanta Constitution*, 13 January 1994.

Rotella, S. 1990. Latinos search far, wide for bilingual help in high desert, *Los Angeles Times*, 18 November 1990.

Snow, A. 1993. Teaching Hispanics about AIDS risk, For thousands of health workers, it's a labor of love to educate hard-to-reach immigrants, *Philadelphia Inquirer*, 18 April 1993.

Sun, L. 1994. Some immigrants build lives without English cornerstone. *Washington Post*, 27 November 1994.

Sylva, B. 1993. In any language: Hope to Mien and to Mexican, to Russian and Laotian, A corps of interpreters at UCD Medical Center struggles each day to explain the inexplicable, *Sacramento Bee*, 5 May 1993.

Vrana, D. 1993. Some at hospitals perform double duty: Interpreting: Under a 2-year old state law, bilingual em employees help doctors communicate with non-English speakers, *Los Angeles Times*, 21 July 1993.

U.S. Department of Health, Education, and Welfare. 1978. Recommendations concerning a Congressional stud y entitled "Assessment of bilingual and bicultural awareness activities in health professions schools." Health Resources Administration.

Waugh, D. 1990. Health care for Asians criticized, Language, culture are called barriers, *San Francisco Examiner*, 14 December 1990.

Weaver, N. 1993. Care not lost in the translation: Doctors form group to treat Asian immigrants, *Sacramento Bee*, 30 March 1993.

Wielawski, I. 1993. Health systems in bind on care for illegal immigrants finances: Federal law requires treatment but funds for state and county are scarce, *Los Angeles Times*, 31 August 1993.

Witt, R. 1989. Flood of Soviets capital Jews, Christian groups gear up to aid immigrants, *Sacramento Bee*, 4 September 1989.

Interpreter and Physician Training

Benhamida, L. 1988. Interpreter training: A review and discussion of existing interpreter training programs. Report prepared for the Refugee Assistance Program—Mental Health, University of Minnesota.

Benhamida, L., B. Downing, and A. Yao. 1988. Professional standards and training for interpreters in mental health for refugees and others. Report prepared for the Refugee Assistance Program—Mental Health, University of Minnesota.

Bernstein, E. 1993. Medical interpreters at Children's Hospital: A guide for health care providers. Prepared by the Interpreter Service Program, Boston Children's Hospital.

Buchwald, D., P. Caralis, F. Gany, E. Hardt, M. Muecke, and R. Putsch. 1993.

The medical interview across cultures, *Patient Care*, April 15, 1993:141-166.

Dunn, D., ed. 1992. Delivering health care to refugees: Cross-cultural training to enhance the delivery quality health care to culturally diverse persons. Denver, CO: Spring Institute for International Studies.

Durham, M. 1994. Bilingual medical interpreter training program. University of Massachusetts Medical Center, Worcester, MA.

Harwood, A. 1981. Guidelines for culturally appropriate health care. In: *Ethnicity and Medical Care*, ed. A. Harwood. Cambridge, MA: Harvard University Press.

Hardt, E. 1991. The bilingual medical interview I and the bilingual medical interview II: the geriatric interview. Prepared by the Section of General Internal Medicine, Boston City Hospital, in collaboration with the Department of Interpreter Services and the Boston Area Health Education Center.

Isham, W. 1985. The role of message analysis in interpretation. In: *Proceedings of the 1985 RID convention.*

Krupat, E. 1986. A delicate imbalance: Has modern medicine, with all its technological advances, lost sight of the human element in heating?, *Psychology Today*, November.

Putsch, R. 1990. Language in cross-cultural care. In: *Clinical methods*, eds. Walker, H, W. Hall and J. Hurst. Boston, MA: Butterworths.

Refugee and Immigrant Health

Ahearn, F. . Refugees, immigrants, migrants, and undocumented aliens. Unpublished paper, The Catholic University of America.

Barker, J.C. 1991. Pacific island migrants in the United States: Some implications for aging services. *Journal of Cross-Cultural Gerontology* 6:173-192.

Bell, S.E., and M.B. Whitford. 1987. Tai Dam health care practices: Asian refugee women in Iowa. *Social Science Medicine* 24(4):317-325.

Brainard, J., and A. Zaharlick. 1989. Changing health beliefs and behaviors of resettled Laotian refugees: Ethnic variation in adapting. *Social Science Medicine* 29(7):845-852.

Chavez, L.R., W.A. Cornelius, and O.W. Jones. 1985. Mexican immigrants and the utilization of U.S. health services: The case of San Diego. *Social Science Medicine* 21(1):93-102.

Cheng, L. 1989. Service delivery to Asian/Pacific LEP children: A cross-cultural framework. *Topics in Language Disorders*. 9(3):1-14.

D'avanzo, C. 1992. Barriers to health care for Vietnamese refugees. *Journal of Professional Nursing* 8(4):245-253.

Dolnick, B., and A. Chambon. 1987. Illinois refugee assistance program—mental

health needs assessment report. Prepared by Travelers and Immigrants Aid of Chicago under contract to the Illinois Department of Mental Health and Developmental Disabilities.

Faller, H. 1985. Perinatal needs of immigrant Hmong women: Surveys of women and health care providers, *Public Health Reports*, 100(3):340-343.

Gilman, S.C, J. Justice, K. Saepharn, and G. Charles. 1992. Cross-cultural medicine a decade later. Use of traditional and modern health services by Laotian refugees. *The Western Journal of Medicine* 157(3):310-315.

Gim, W., and T. Litwin. 1980. Indochinese refugees in America: Profiles of five communities. A case study. Executive seminar in national and international affairs, U.S. Department of State report.

Goodman, C. 1990. The care giving roles of Asian-American women. *Journal of Women and Aging* 2(1):109-120.

Hoang, G.N., and R.V. Erickson. 1985. Cultural barriers to effective medical care among Indochinese patients. *Annual Review of Medicine* 36:229-39.

Hubbell, F.A., H. Waitzkin, S.I. Mishra, J. Dombrink, and L.R. Chavez. 1991. Access to medical care for documented and undocumented Latinos in a southern California county. *The Western Journal of Medicine* 154(4):414-417.

Lew, L.S. 1991. Elderly Cambodians in Long Beach: Creating cultural access to health care. *Journal of Cross-Cultural Gerontology* 6:199-203.

Loue, S., and S. Oppenheim. 1994. Immigration and HIV infection: A pilot study. *AIDS Education and Prevention* 6(1):74-80.

National Coalition of Hispanic Health and Human Services Organizations. 1994. Growing up Hispanic: Leadership report. Washington, D.C.: National Coalition of Hispanic Health and Human Services Organizations.

Office of Refugee Resettlement, U.S. Department of Health and Human Services. Report to the Congress refugee resettlement program, 1993.

Pachter, L. 1994. Culture and clinical care: Folk illness beliefs and behaviors and their implications for health care delivery, *Journal of the American Medical Association*, 271(9):690-694.

Massachusetts Department of Public Health, Office of Refugee and Immigrant Health. 1994. Refugees and immigrants in Massachusetts: An overview of selected communities.

Mattson, S. 1989. Providing services to southeast Asian refugees. *Migration World* 17(1):30-35.

Minkler, D.H. 1983. The role of a community-based satellite clinic in the perinatal care of non-English-speaking immigrants. *The Western Journal of Medicine* 139(6):905-909.

Muecke, M.A. 1983. Caring for southeast Asian refugee patients in the USA. *American Journal for Public Health* 73(4):431-438.

Raspberry-McCubbin, C. 1994. Understanding the impact of immigrant/refugee status on clients. *ADVANCE for Speech-Language Pathologists and Audiologists*, (8)8-9.

Sakauye, K. 1990. The elderly Asian patient. Paper presented at a scientific meeting of the Boston Society for Gerontologic Psychiatry, April 7.

Schauberger, C.W., B. Hammes, and P.H. Steingraeber. n.d. Obstetric care of a southeast Asian refugee population in a midwestern community. *Journal of Perinatology* 10(3):280-284.

Taylor, E. and L. Barton. 1994. *Southeast Asian refugee English proficiency and education in Texas*. Findings from The Texas Refugee Study, Texas Office of Immigration and Refugee Affairs, Austin, TX.

Wilk, R. 1986. The Haitian refugee: Concerns for health care providers. *Social Work in Health Care* 11(2):61-74.

Uba, L. 1992. Cultural barriers to health care for southeast Asian refugees. *Public Health Reports* 107(5):544-548.

U.S. Public Health Services. 1993. One voice, one vision—Recommendations to the Surgeon General to improve Hispanic/Latino Health. Report on the Surgeon General's National Hispanic/Latino Health Initiative.

Yee, D. 1992. Health care access and advocacy for immigrant and other underserved elders. *Journal of Health Care for the Poor and Underserved* 2(4):448-463.

Legislative Documentation

Crivella, B. n.d. circa 1984. Memorandum from deputy director, DHHS, Office of Management and Policy to Nathan Dick, deputy director, Office of Program Operations.

Hernandez, A. 1993. Correspondence from Mexican-American Legal Defense and Educational Fund to Dennis Hayashi, Office of Civil Rights, July.

Hogan and Hartson. 1978. Correspondence written on behalf of MALDEF to the Honorable Joseph A. Califano re: proposed regulation for non-English speaking and limited-English speaking persons.

Hogan and Hartson. 1979. Memorandum dated February 27, 1979 re: "Use of quantitative standards in Proposed HEW Regulations Governing Bilingual Staff Assistance in Federal Social Services Programs."

Mexican-American Legal Defense and Educational Fund. 1992. Policy recommendations on language rights to the Clinton/Gore transition team by the Mexican-American Legal Defense and Educational Fund ("MALDEF"). Los Angeles, CA.

Office for Civil Rights, DHHS. 1989. Voluntary compliance agreement between OCR, Region I and Maine Medical

Center, Portland Maine, Docket Number 01-89-3040.

Office for Civil Rights, DHHS. 1992. National Origin Minority Task Force Interim Report.

Serrano, J. 1993. Press release statement of rep. Jose Serrano, chairman of the Congressional Hispanic Caucus, October.

Serrano, J. 1994. Correspondence from the Congressional Hispanic Caucus to the Honorable Donna Shalala, Secretary, HHS, February 3.

U.S. Department of Health and Human Services. 1993. Proposed rule 45 CFR Part 80.

Language Services in Health Care and Social Services

Woloshin, S., N. Bickell, L. Schwartz, F. Gany, and Chavez, J. 1993. Breaking through the language barrier, *Urban Medicine*, February: 9-10.

Commonwealth of Massachusetts. 1995. Interpreter Services Bill, H. 2319.

Diaz-Duque, O. 1982. Overcoming the language barrier: Advice from an interpreter, *American Journal of Nursing*, September:1380-1382.

Downing, B. 1992. Professional interpretation: Insuring access for refugee and immigrant patients. Report prepared for the Refugee Assistance Program, University of Minnesota

Freeman, H., L. Avila, and V. Balderrama. 1973. "Chichi" in paradise: Helping agencies and the Spanish-speaking, *Public Welfare*, Spring:40-47.

.Grasska, M. and T. McFarland. 1982. Overcoming the language barrier: Problems and solutions, *American Journal of Nursing*, September:1376-1381.

Haffner, L. 1992. Cross-cultural medicine, a decade later: Translation is not enough, interpreting in a medical setting, *The Western Journal of Medicine* 157(3):255-259.

Latino Coalition for a Healthy California. 1994. Draft request for application and executive summary of decisions. San Francisco, CA: Latino Coalition for a Healthy California.

Massachusetts Department of Public Health. 1994. Interpreter guidelines. Boston, MA.

Putsch, R. 1985. Cross-cultural communication: The special case of interpreters in health care, *Journal of American Medical Association*, 254(23):3344-3348.

Vasquez, C. and R. Javier. 1991. The problems with interpreters: Communicating with Spanish-speaking patients, *Hospital and Community Psychiatry* 42(2):163-165.

Vera, Y. and J. Perkins. In press. "No habla ingles"—Ensuring linguistically appropriate health care. *Houston Law Review*.

Winsor, E. 1994. Correspondence to M. Stone, Center for Community Planning, University of Massachusetts re: Wisely redrafting & getting a credible cost estimate for the Interpreter Services Bill, H. 2319.

G. Welch. 1995. Language barriers in medicine in the United States, *Journal of American Medical Association*, 273(9):724-728.

Language issues in Mental Health

Arce, A. 1993. Transference issues in cross cultural therapy. Paper presented at the annual meeting of the American Psychiatric Association, May, San Francisco, CA.

Benhamida, L. 1988. Interpreting in mental health settings for refugees and others: A guide for the professional interpreter. Report prepared for the Refugee Assistance Program—Mental Health, University of Minnesota.

Benhamida, L. 1988. Language planning in mental health for refugees and others: Obtaining quality translations. Report prepared for the Refugee Assistance Program—Mental Health, University of Minnesota.

Benhamida, L. 1988. Proposed code of ethics for interpreters in mental health for refugees and others. Report prepared for the Refugee Assistance Program—Mental Health, University of Minnesota.

Boehnlein, J.K. 1987. A review of mental health services for refugees between 1975 and 1985 and a proposal for future services. *Hospital and Community Psychiatry* 38(7):764-768.

Cuffel, B., M. Masland, and G. Piccagli. 1994. Summary of the town hall meeting on program realignment, 27 May 1994, San Francisco, CA. Sponsored by the California Mental Health Planning Council and the Institute for Mental Health Services Research.

Deinard, A. and G. Hoshino. 1986. Gaps in the service delivery system. Report prepared for the Refugee Assistance Program—Mental Health, University of Minnesota.

Egli, E. 1987. The role of bilingual workers without professional mental health training in mental health services for refugees. Paper prepared for the Refugee Assistance Program—Mental Health, University of Minnesota.

Gong-Guy, E., R. Cravens, and T. Patterson. 1991. Clinical issues in mental health service delivery to refugees. *American Psychologist* 46(6):642-648.

Hall, L.K. 1988. Providing culturally relevant mental health services for Central American immigrants. *Hospital and Community Psychiatry* 39(11):1139-1144.

Holtz, W., and T. Bornemann, ed. 1990. Mental Health of Immigrants and Refugees. Proceedings of a conference sponsored by the Hogg Foundation for Mental Health and World Federation for Mental Health, Austin, TX.

Hussain, M.F., and J.D. Gomersall. 1978. Affective disorder in Asian immigrants. *Psychiatric Clinician* 11:87-89.

Jaranson, J., and P. Bumford. 1987. Program models for mental health treatment of refugees. Report prepared for the Refugee Assistance Program—Mental Health, University of Minnesota.

Mezzich, J., A. Kleinman, H. Fabrega, D. Parron, B. Good, G. Johnson-Powell, K. Lin, and S. Manson. 1993. Revised proposals for DSM-IV. Submitted to the DSM-IV Task Force by the Steering Committee, NIMH-Sponsored Group on Culture and Diagnosis.

Olmedo, E. 1981. Testing linguistic minorities. *American Psychologist* 36(10):1078-1985.

Rodriguez, O., J. Lessinger, P. Guarnaccia, and V. Santiago-Irizarry. 1990 Report on bilingual bicultural psychiatric programs at Bronx Psychiatric Center, Lincoln Hospital and Pilgrim Psychiatric Center, Hispanic Research Center, Fordham University.

Rogler, L. 1989. The meaning of culturally sensitive research in mental health. *American Journal of Psychiatry* 146(3):296-303.

Rogler, L. 1992. The role of culture in mental health diagnosis: The need for programmatic research. *The Journal of Nervous and Mental Disease* 180(12):745-747.

Rogler, L. 1993. Culturally sensitizing psychiatric diagnosis: A framework for research. *The Journal of Nervous and Mental Disease* 181(7):401-408.

Rogler, L. 1993. Culture in psychiatric diagnosis: An issue of scientific accuracy. *Psychiatry* 56:324-327.

Rogler, L., and D. Cortes. 1993. Help-seeking pathways: A unifying concept in mental health care. *American Journal of Psychiatry* 150(4):554-561.

Westermeyer, J. 1987. Prevention of mental disorder among Hmong refugees in the U.S.: lessons from the period 1976-1986. *Social Science Medicine* 25(8):941-947.

APPENDIX E: LANGUAGE BARRIERS TO HOSPITAL CARE: STRATEGIES FOR CHANGE

LANGUAGE BARRIERS IN HOSPITAL CARE: STRATEGIES FOR CHANGE

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Presented at the Language Rights Conference Los Angeles, California

April 13, 1991

Introduction

The community of Seattle has over 10 years of experience in the use of interpreters within various medical settings. I am the director of two interpretation programs operated by a consortium of community clinics: the Community Health Interpretation Service which, with grant funding, has provided interpreters to community health centers since 1980; and the Hospital Interpretation Program which, funded entirely by the hospitals, has served over 20 hospitals since 1982. I have been involved with these programs since their beginnings and would like to share with you information on the history and development of the relatively sophisticated interpretation network we have in Seattle. In the early 80's, a coalition of organizations successfully influenced hospitals to provide interpretation services to refugees. A number of strategies were used to negotiate institutional change within hospitals. My remarks today will focus on the strategies we employed, obstacles encountered, and replicability of our efforts in other communities.

The Problem

A few words about numbers are in order here. The unprecedented influx of refugees in the past 15 years has provided a driving force and urgency to do something about the language needs of this huge new population. Between 1975 and September 1990, almost 1 million Southeast Asian refugees arrived in this country, about half having arrived by late 1980, (166,000 in 1980 alone). California has absorbed the lion's share with almost 400,000. Washington State ranks third (after Texas) with about 45,000, the majority of whom settled in the Seattle area. Speaking many different languages and coming from a variety of locales and customs, this heterogeneous group arrived without either a cultural or language base in our country, and now represents a substantial minority in our community. All of this has had a major impact on municipal institutions, including and especially health care services.

In Seattle, the first movers on the local health scene to address the emerging needs of new Americans were groups already involved in health care for low-income, disenfranchised populations: i.e. community clinics and the health department. In 1980, the community clinics formed the Indochinese language Bank to make general health care services more accessible to the refugee population by providing a rotating pool of interpreters to work in neighborhood clinics. This was grant-funded, and continues today as the Community Health Interpretation Service, one of the two programs I direct, with funding primarily provided by the city, county, and United Way. Around the same time that my program was starting, the Health Department built its own team of bilingual health workers for initial

screening and primary care services. The formation of these two services was a big step in meeting the medical interpretation needs of refugees. But lack of interpretation services at hospitals, the refugee population's main source for specialty and, emergent care, remained a major problem.

Although same hospital staff and administrators recognized a problem, most hospitals saw little need for their involvement in looking for a solution. Hospitals identified a lack of funding for interpretation services as a major barrier. In addition, there were three major disincentives to changing the status quo:

- Refugees often brought friends or relatives to interpret, although some were barely conversant in English, barely knowledgeable about medical terminology and practice, and never trained in medical interpretation.

- Availability of interpreters from local health and social service organizations severely reduced the hospitals' need to: hire interpreters, yet interpreters from these agencies were spending so much time in hospitals that they neglected their regular duties.

- Some hospitals hired Indochinese clerical and housekeeping staff and used those persons as interpreters when necessary, despite a lack of qualification to function as interpreters.

The paramount problem we faced was:

How do we get hospitals to recognize and deal with the necessity of providing qualified medical interpreters for limited-English-speaking patients on a 24-hour basis?

The Strategy: A Dual Approach

The first approach was directed at having the hospitals acknowledge the need for bilingual services and the advantages of having interpreters on-site or readily available. Starting in 1980, a group of individuals interested in language harrier issues and mostly representing social and health services began meeting with the hospitals and the local hospital council to share our observations about patient complaints, to indicate the inadequacy of the present system, and to suggest various remedies.

To induce the hospitals to act, we let them know that certain agencies would no longer be able to provide interpreters except in emergencies. Staggered by the 1980 influx of refugees, we set internal policies that our interpreters would give priority to our own agencies' needs. To further encourage voluntary hospital participation, the local Health Department offered to pay half the salary of an interpreter that could be shared among three hospitals. When funding ran out at the end of the year, two of the three hospitals hired interpreters for the day shift. While this was a step in the right direction, it affected only two hospitals and provided day-time only interpretation for a limited number of languages and patients.

The second approach was directed at having the hospitals recognize their responsibility and obligation to provide adequate and accessible care for the non-English speaking. During the first months of 1980, a health care accessibility bill had been introduced into the state legislature but was defeated. With the failure of a legislative approach to solving the language barrier problem, our group explored an alternative strategy to have hospitals recognize their legal responsibility. Title VI of the Civil Rights Act of 1964 prohibits any organization which receives Federal funds from discriminating on the basis of race, color, or national origin. Because most hospitals receive Federal funds, for instance, reimbursement from Medicare and Medicaid programs, they are subject to this law.

Compliance with Title VI by hospitals is monitored by the Office of Civil Rights (OCR) of the U.S.. Department of Health and Human Services. OCR has determined that hospitals which do not provide communication assistance for limited-English-speaking persons are violating Title VI. As a result, OCR has ordered a number of hospitals around the country to provide, without charge, translation assistance to limited-English-speaking persons.

To have OCR investigate a hospital, a complaint claiming a civil rights violation must be filed within six months of the date of violation. Since OCR has the power to stop Federal funds from going to a hospital if it fails to comply,: hospitals usually agree to provide interpretation services after complaints are filed.

(The Title VI language and its interpretation is further reinforced by the Joint Commission of Hospital Accreditation. The Accreditation Manual for hospitals states that "*when the patient does not speak or understand the predominant language of the community, he should have access to an interpreter. This is particularly true where language barriers are a continuing problem.*")

Our strategy in using Title VI as a weapon for health care access had the following steps:'

- agreed on "target hospitals with which various refugee groups were having access problems
- documented cases of language barriers and obtained patients' authorization to negotiate with hospitals and to pursue administrative complaints
- contacted hospitals and alluded to possible civil rights complaints, malpractice actions, etc., attempted to negotiate an enforceable contract requiring hospitals to hire or contract for interpreters
- filed civil rights complaints with OCR when the above steps failed
- provided OCR with substantial s support and documentation so they would encourage hospitals to negotiate an enforceable contract for interpreters.

In March 1981, a local legal services attorney working with our group filed complaints with OCR on behalf of three different clients at three different hospitals. This complaint was equivalent to a class action suit in that it covered all

those similarly situated. The cases were not extraordinary, but did have in common that hospitals: 1) failed to provide necessary and essential communication assistance in provider-patient encounters, and 2) failed to use qualified interpreters, i.e. interpreters who were bilingual and had- knowledge of medical terminology. To support the complaint action the organizing group informed local ethnic leaders and others about the process and requested their assistance in sharing their knowledge with OCR about similar incidents. OCR was provided a list of those with relevant information.

It is important to realize that the use of Title VI is not a litigation strategy since lawsuits entail years of delay. Instead, it is an organizational strategy utilizing the threat of legal action and the persistent political pressure of various groups. Once one hospital reaches agreement, contracts with other hospitals can be negotiated more easily.

Results

OCR and the hospitals signed voluntary agreements in the spring and fall of 1981, five to seven months after the complaints were filed. Our community group had input to those negotiated agreements through our lawyer. Although the agreements do not specify haw interpretation services will be provided, they do establish that the hospital is responsible for ensuring the availability of qualified interpreters. Since then, OCR has produced written guidelines for hospitals to follow in the development and implementation of an interpretation program.

The OCR complaints and voluntary agreement forced all hospitals in the Seattle area to explore alternatives for providing bilingual services. Options they considered included: a) hiring bilingual staff in housekeeping and other jobs, training them as interpreters, and using them as needed; h) each hospital hiring its own interpreters; c) hospitals collectively establishing their own language bank; and d) the hospitals collectively contracting for services from a community-based organization.

Most hospitals in Seattle have utilized a combination of strategies. In the fall of 1982, the hospital council finalized a contractual agreement with my agency to establish a 24-hour on-call interpretation service. Initially serving only Indochinese patients, this service has now expanded to cover about 15 languages, serves over 20 hospitals, and is the primary resource for most hospitals. Currently, we have a budget of almost half a million dollars, totally reimbursed by the hospitals, we have over 50 on-call interpreters, and we provide about 13,000 hours of interpretation service per year. We consider the program a tremendous success in helping to remove the language barrier to hospital-based 'care.

Conclusion

The success of the hospital interpretation program can be attributed to many factors:

1) The hospitals have come to recognize and accept their legal responsibilities under Title VI and under the hospital accreditation standards. This acceptance of responsibility came only after the threat of legal action and is sustained, in part, by the knowledge that the ongoing cost of professional interpreter services is

much smaller than the one-time cost of a legal suit, court action, and settlement.

2) The community at. large is aware and supportive of the service so that when a hospital calls an agency inappropriately for interpretation, that agency refers

the hospital to HIP. Problems in obtaining an interpreter, am well as inappropriate use of interpreters, are often reported to me and others in the community. This network of communication and support is essential in order to get quality services to the refugee.

3) The patients have become more assertive in requesting interpretation during hospital visits. This is due to education by sponsors and community agencies, as well as by the hospitals' own education efforts, e.g. they are required to post translated signs informing patients of the availability of interpreters.

4) The sponsoring agency, CSCHC, had previous experience in providing medical interpretation, has maintained a cooperative relationship with the hospitals, rather than an adversarial one, and has been able to solve problems through friendly discussion, now that hospitals are aware of their responsibility.

5) The hospital council has been an outstanding organizer of the local hospitals, maintaining responsibility for the interpretation contract, handling hospital billings, and coordinating regular meetings between hospital administrators and the interpretation services.

6) The OCR has been outspoken in its interpretation of Title VI, investigation of complaints, and monitoring of hospitals for compliance. Knowing that there is legal support and enforcement has forced many hospitals to seriously consider their interpretation options.

The apparent success of the program is not to say that the system is perfect. We still hear stories of patients who are instructed to "bring your own interpreter or we won't be able to help you." We still hear stories of hospitals using an untrained janitor to interpret. We hear stories of hospitals hiring their own contractual interpreters for $10 per hour who lack fluency in the target language – providers may understand their English, but patients do not understand the interpreted language.

The ideal solution to the language barrier in the health care setting would be to have bilingual professionals, thereby doing away with the need for interpreters. This is, of course, difficult to achieve, because of the scarcity of licensed individuals from minority groups, but it is certainly something we should strive for.

APPENDIX F: Review of Literature

A. INTRODUCTION

Macro International was contracted by the U.S. Department of Health and Human Services' (DHHS) Office for Civil Rights (OCR) to conduct an exploratory evaluation of barriers to health and social services for persons with limited English proficiency. This literature review was written as one of the study's components. It represents an analysis of research findings, journal articles, and newspaper articles that exist within the public domain.

B. DEFINITION OF TERMS

It becomes obvious, after an examination of the literature, that definitions of key terms are not easily agreed upon. This section provides a range of definitions of key terms and discusses their merits and limitations.

1. Communication

An understanding of communication is key to this study, and it represents the heart of any issue explored around language services. Webster defines communication as "*the act of giving or sharing information, or exchanging messages.*" Interpreting and translating are both functions of effective communication. Key to communication is understanding the message. If two individuals converse and understanding does not take place, then effective communication has not occurred. William Isham states that understanding is largely drawn from our background information and prior experiences.[1] Communication, according to Woloshin is key to the clinician's use of the medical interview as a tool in patient treatment.[2] Although interpreters can assist physicians in communicating with LEP patients and thus overcoming language barriers, it is now being recommended that health care professionals become more involved in the communication process by seeking a greater understanding of cultural differences among their patient population.[3]

Language is, after all, only one of many ways in which we can communicate to others. We also communicate by mannerisms, gestures, body language, and individual and organizational actions and policies. Misunderstandings can arise when LEP patients fail to understand the U.S. health care system. The following examples offer some insights into other forms of communication:

- the brisk efficiency communicated by many medical staff in doctors' offices is frequently interpreted by

1 William Isham, *The Role of Message Analysis in Interpretation*, In Proceedings of the 1985 RED Convention, p. 112.

2 Woloshin et al., and Eric Hardt, M.D., *Discussion Leader's Guide for the Bilingual Medical Interview I and the Bilingual Medical Interview II: the Geriatric Interview*, Boston Area Health Education Center, 1991.

3 Woloshin et al.; Hardt, p7; Putsch; and Debra Buchwald, M.D., Panagiota Carolis, M.D., Francesca Gany, M.D., Eric Hardt, M.D., Marjorie Muecke, Ph.D., and Robert Putsch, M.D., *The Medical Interview Across Cultures*, PATIENT CARE, April 13, 1993, p.142.

Japanese patients as anger rather than customary politeness.[4]

- Latino cultures typically designate one member of the family as the leader and decision maker, and physicians and interpreters who do not pay this family member the appropriate respect may unintentionally disrupt the social order of the family and interfere with the medical communication.[5]

- the Mien people, Laotian highlanders, perceive sickness as a community affliction and when they visit a hospital for treatment, often they are accompanied by the entire clan, posing difficulties for them as most hospital policies only allow for a small number of visitors in the room at one time.[6]

2. Limited-English Proficiency

The OCR defines limited English proficiency (LEP) to mean "*persons with a primary language other than English who must communicate in that language if they are to have an equal opportunity to participate effectively in and benefit from any aid, service or benefit provided by a recipient.*" This definition has gained acceptance throughout the Federal government and in State governments.[7] Woloshin also accepts this definition, adding that LEP would also include those patients who are non-English speaking.[8] Louis Harris does not specifically use the term LEP in its findings from a survey of minority health, but notes that language problems for 21 percent of minority Americans receiving health care are most often found in those populations that do not speak English as a primary language.[9] Quite frequently, it is assumed that the LEP population is comprised of

4 Linda Monroe, *Cultural Differences Impair Health Care for Minorities*, SEATTLE TIMES, November 23, 1989, G8.

5 Linda Haffner, *Cross-cultural Medicine: A Decade Later*, THE WESTERN JOURNAL OF MEDICINE, September 1992, p.157.

6 Bob Sylva, *In Any Language: Hope to Mien and to Mexican, to Russian and to Laotian, a Corps of Interpreters at UCD Medical Center Struggles Each Day to Explain the Inexplicable*, SACRAMENTO BEE, May 5, 1993, p.SC1.

7 U.S. Department of Health and Human Services, Office for Minority Health, *Draft Work plan for the Center for Linguistic and Cultural Competence in Health Care*, March 10, 1995.

8 Steven Woloshin, M.D., Nina Bickell, M.D., Lisa Schwartz, M.D., Francesca Gany, M.D., and Gilbert Welch, M.D., *Language Barriers in Medicine in the United States*, JAMA, March 1, 1995, Vol. 173, No.9.

9 Louis Harris and Associated, Inc. "News Release," The Commonwealth Fund National Comparative Survey of Minority Health Care, March 20, 1995.

recent refugees and immigrants, and language and cultural barriers are inherent to new populations. Another perspective on language is shared by Eduardo Berinstein, coordinator for interpreter services at Boston Children's Hospital, and others working in medical interpretation. Many hospitals are renowned worldwide and serve an international clientele. A commitment to cultural diversity within the medical setting ensures that communication around delicate subjects can be done in the patient's primary language (even when the patient can speak English), enhancing the communication and reducing anxiety and fear.[10] Under the OCR definition, provision of an interpreter in such situations would be at the discretion of the provider, but for those providers who maintain a commitment to international patients, such a policy might indeed be a powerful marketing tool.

3. Interpreter

Bruce Downing, a professor of Linguistics at the University of Minnesota and an expert in the field of medical and mental health interpreting, defines interpreting as the following: "*the conversion of an oral message from one language (the source language) into oral form in another language (the target language)*". As such, an interpreter is defined by Downing as "*a person who interprets the speech of others into another language, especially one skilled in interpretation.*" Although the term "translator" is often used interchangeably with "interpreter" in the field and in articles appearing in newspapers and journals, as will be seen below, the two are very different and should not be confused.[11]

With specific regard to the complex duties of medical interpreters, Robert Putsch describes the following attributes: "... *interpreters must describe and explain [medical] terms, ideas and processes that lie outside of the linguistic systems of clients. The interpretation process must account for divergent world views since individuals and cultures have varying perspectives regarding the cause, presentation, course and treatment of sickness, as well as the risk it represents to others.*"[12] According to Putsch and most other experts in the field, separation of culture from interpretation cannot be done without losing critical elements of the communication.

4. Translator

Translation, according to Downing, is the "*conversion of a static source language message into written form in the target language.*"[13] It is the written form of communication, whereas interpretation is verbal. Although the two terms are often confused by many in the field, it is clear

10 Eduardo Berinstein, *Medical Interpreters at Children's Hospital*, Boston Children's Hospital, July 1993.

11 Bruce Downing, *Professional Interpretation: Insuring Access for Refugee and Immigrant Patients*, University of Minnesota, 1992, p4-5.

12 Robert Putsch, M.D., *Cross-Cultural Communication: The Special Case of Interpreters in Health Care*, JAMA, Vol 254, 3344-8.

that translators and interpreters have two different functions.

Written communication is usually produced in a thoughtful manner, using research when necessary, and rewriting and editing until the final product is suitable for distribution. Ideally, translation should occur in the same way. The original text (or the source language) should be translated into the target language by using a process called *back translation*. This process allows the translation to be checked for quality. The three steps involved in back translation are: (1) translation of the source language text into the target language, (2) translation of the target language text back into English or the source language by another individual besides the translator, and (3) comparison of the original and the back translation. If there is a great amount of difference between the two versions, the result may be a translation of poor quality.[14]

5. Culture

The U.S. Office of Minority Health defines "culture" as: "*thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. Additionally, cultural beliefs, values, and practices are learned behaviors, usually acquired through one's family.*"[15] Including culture in the provision of health and social services is viewed as critical in overcoming barriers to care faced by minority populations. In particular, within the health settings, culture can influence individual perceptions of health and illness, and may affect choice of health care.[16] When culture is not considered by medical interpreters, physicians, and other health care professionals, miscommunication can result, even though language barriers are being addressed. And although it may require extra time from physicians, it is now being recommended that cultural histories on patients be obtained.[17]

Interpreters are frequently viewed as "culture brokers," bridging the gulf between the U.S. medical system and other cultures. Cross-cultural communication, a theory developed by Putsch and other experts in medical interpreting, is strongly influenced by the degree to which the physician, patient, and interpreter share the same understanding and beliefs about medical issues. To understand how cross-cultural communication works within the

13 Bruce Downing, p.5.

14 Laura Benhamida, *Language Planning in Mental Health for Refugees and Others: Obtaining Quality Translations*. University of Minnesota, 1988.

15 U.S. Department of Health and Human Services, Office of Minority Health, p.5.

16 Ibid.

17 Robert Putsch, *Language in Cross-Cultural Care*, In H. Walker, W. Hall and J. Hurst, eds., *Clinical Methods*, Boston: Butterworths, 1990, p.1064; Buchwald, et. al, p.148.

medical setting, an ideal model is established wherein the physician uses a trained medical interpreter who is also a member of the patient's ethnic and cultural group, possessing medical knowledge and the ability to converse within the culture of the medical community. In addition, the interpreter must understand the human complexities of interpreted communication. Against the criteria of this ideal, real world medical interpreting often falls short.

In the ideal model, a common, shared database exists from which all three participants draw upon and contribute to within the context of the exchange. The real world model, on the other hand, works with two shared data bases—patient and interpreter, and interpreter and physician—as well as independent knowledge held by each of the participants. These independent beliefs can account for bias in the interpretation, resulting in miscommunication. Ways in which culture affects interpretation are a lack of linguistic equivalency of biomedical terms and concepts, substitution or addition of terms, incorrect numbers and names, garbling of the message, self image of the interpreter, and different views of events terms, and transactions.[18] Other determinants of culture that must be factored into the overall medical experience that compare the level of acculturation of the patient or client to American norms of behavior.

These eight determinants, according to Harwood, can be stated as the following: (1) level of formal education, (2) generational distance from immigrant status, (3) degree of encapsulation in family social networks, (4) experiences with medical services using patient education and personal care in treatment, (5) previous experiences with particular disease within a family background, (6) immigration to U.S. at an early age, (7) urban or rural origin, and (8) visits to country of origin.[19]

C. UNDERSTANDING THE PROBLEM

Although several journal articles address the barriers faced by refugees and immigrants in communicating health needs and obtaining access to the existing service system, the most vivid examples found tended to be in newspapers in many major cities across the country.

- In 1983, a Chinese immigrant was released from a mental institution after being confined for over 30 years simply because no one could speak to him in his language.[20]
- An emergency medical technician riding in an ambulance in Boston finds himself alone, delivering the baby of a Vietnamese woman after pleading to a neighbor, "don't leave me, I can't communicate with her."[21]

18 Buchwald, p.142.

19 Alan Harwood, *Guidelines for Culturally Appropriate Medical Care*, In Ethnicity and Medical Care, ed. Alan Harwood, 1981, p.483.

20 Associated Press, *Mental Patient Wins Settlement*, WASHINGTON POST, May 5, 1983.

- In 1986, Hispanic patients in Montgomery County, Maryland were foregoing visits to local clinics for clinics in the District of Columbia to avail themselves of Spanish language services provided by the District's clinics. When Spanish-speaking patients called Montgomery County clinics, they were told "sorry, no Spanish."[22]

While these examples are indicative of the vast numbers of problems that LEP clients and providers face in trying to wrestle with language barriers, they only anecdotally support the need for improved services. This section describes research efforts around language barriers, reviews a collection of newspaper articles, and discusses issues around some special populations.

1. Review of Research Studies

The data from research conducted thus far indicates a critical gap in service delivery to people of limited English proficiency. It must be noted though that there have been few studies conducted addressing language barriers within the health and social services arena, and most of the studies presented in this section were published recently. Limited research information exists now in four critical areas of interest to this study: (1) needs assessment information on the numbers of people with LEP in specific areas of the country, (2) the impact of LEP on health care, (3) the responses by health and social service providers to the needs of the LEP population, and (4) program evaluation and implementation.

a. Needs Assessment

The 1990 U.S. Census provided data in the following categories relevant to language issues: the numbers of residents in the U.S. who report not speaking English "very well," the numbers of foreign born persons, and the numbers of persons speaking a language other than English at home. In 1992, the Association of State and Territorial Health Officials (ASTHO) analyzed the Census data and stated in its report to the Office of Minority Health that 6 percent of the entire U.S. population does not speak English "very well." Furthermore, in an analysis of individual states, ASTHO found California to have the highest percentage of LEP residents (16 percent), followed by Hawaii (12 percent), and New Mexico, New York, and Texas (10 percent each). Additionally, breakouts on Spanish and Asian languages for LEP were developed by ASTHO.[23] Looking at cities with populations of 200,000 or more reveals the top 10 ranked cities with persons

21 Judy Rakowsky, *Quest to Begrudge Growing Language Gap City Agencies Are Adapting to Meet Needs of Immigrants*, BOSTON GLOBE, October 4, 1992, p.1.

22 Zita Arocha, *Influx from Suburbs Strains District Clinics: More Hispanic immigrants Seek Care in City*, WASHINGTON POST, June 28, 1986, p.B1.

23 Association of State and Territorial Health Officials, *ASTHO Bilingual Health Initiative: Report and Recommendations: State Health Agency Strategies to Develop Linguistically Relevant Public Health Systems*, ASTHO, July 1992, p.2

speaking a language other than English at home to be the following: Miami (73%); Santa Ana, California (69%); El Paso, Texas (67%); Los Angeles (50%); San Antonio, TX (47%); San Francisco (42%); Corpus Christi, Texas (42%); Jersey City, New Jersey (41%); New York City (41%) and San Jose, California (38%).[24] Clearly, the 1990 Census provided valuable information to health and social service policy makers in determining sheer numbers of LEP residents living within particular service areas.

Other needs assessment data can be found in the U.S. DHHS Office of Refugee Resettlement's Annual Report to Congress. In its 1993 Report, ORR indicated that total immigration and refugee admissions to the U.S. from 1983-1992 was over 7 million people. It can be assumed that a large percentage of these new Americans are part of the LEP population. In addition, individual breakouts by State of immigrant and refugee resettlement are available from ORR.[25]

The U.S. Conference of Mayors conducted a survey of 78 U.S. cities to assess the impact of immigration on America's cities and identify key issues for city planners and other policy makers. Among its findings, the study reported that foreign born persons account for an average of 11 percent of the population in the surveyed cities (as determined from the 1990 Census), and 25 percent of administrators responding believed Census figures reflected substantial undercounting. Over half of the cities surveyed cited problems with service delivery to immigrants. Many of these problems were related to the provision of or the lack of language services.[26]

b. Impact on LEP to Health and Social Services

The effects of limited English proficiency on individual access to health and social services cannot be determined by Census data. Findings from small studies on specific ethnic populations have supported the premise that communication is a determinant of health care utilization.[27] In ad-

24 U.S. Bureau of the Census, *Cities with 200,000 or More Population Ranked*, Table 3.

25 U.S. Department of Health and Human Services, Office of Refugee Resettlement, *Report to the Congress, FY 1993, Refugee Resettlement Program*, 1993.

26 U.S. Conference of Mayors, *Immigrant Policy Issues for America's Cities*, U.S. Conference of Mayors, Washington, D.C., 1994, p.1-5.

27 Sue Bell and Michael Whiteford, *Tai Dam Health Care Practices: Asian Refugee Women in Iowa*, SOCIAL SCIENCE MEDICINE, 24(4), 1987, p.323; Laura Uba, *Cultural Barriers to Health Care for Southeast Asian Refugees*, PUBLIC HEALTH REPORTS, 107, 1992, p.547; Leo Chavez, Wayne Cornelius, and Oliver Jones, *Mexican Immigrants and the Utilization of U.S. Health Services: The Case of San Diego*, SOCIAL SCIENCE MEDICINE, 21(1), 1985, p.93; Marjorie Muecke, *Caring for Southeast Asian Refugee Patients in the USA*, AMERICAN JOURNAL

dition, a vast amount of anecdotal evidence existed through personal accounts reported in the media and collected by individuals in Regional OCR offices, legal services, and advocacy organizations. Until recently, there was a dearth of national data on language and minority health care. However, findings from the "National Comparative Survey on Minority Health," presented in March 1995, indicate that language differences are a barrier to health care for 21 percent of minority Americans.[28] (According to Census data, racial and ethnic minorities account for approximately 25 percent of the entire U.S. population.) This survey contained detailed questions regarding medical care where language and communication were variables within the response set. Examples of such questions included choices of doctors and hospitals, problems with medical encounters, satisfaction with health professional staff, use of alternative medicines, reasons for not feeling welcome, reasons for not obtaining medical care, and reasons for being refused health care.[29] Clearly, the data collected by this study provides the field with indicators of need in language planning and culturally appropriate approaches to health care. Further analysis of this data set may expand the associations between LEP and health care.

c. Research on Health and Social Service Providers

Although advocates and legal services organizations relayed personal accounts of providers' lack of responsibility in offering language appropriate services, little data exist on providers' policies and practices to substantiate such claims on a broader scale. Difficulties in obtaining such information have contributed to a dearth of knowledge around how State and association policy requirements and recommendations are being implemented at the local level. In 1991, Traveler's and Immigrants' Aid Society of Chicago conducted a preliminary study with ten area hospital administrators. None of the study participants reported using trained medical interpreters, but instead maintained a list of bilingual employees within the hospital who speak another language.[30] In 1993, The Chicago Reporter published its findings of a survey it conducted on Chicago area hospitals and clinics regarding the availability of interpretation services for non-English speaking patients. Although 30 percent of Chicago's population speaks a lan-

OF PUBLIC HEALTH, 73(4), 1983, p.431.

28 Louis Harris and Associates, *Minority Health Care Survey Highlights*, The Commonwealth Fund National Comparative Survey on Minority Health, March 20, 1995.

29 Louis Harris and Associates, *Survey Questionnaire*, The Commonwealth Fund National Comparative Survey of Minority Health Care, 1994.

30 Wendy Siegel, *Immigrants at Risk: Language and Cultural Barriers Experienced by Multi-Ethnic Patients in a Sample of Chicago Hospitals and Health Associations*, Travels and Immigrants Aid, 1992, p.5.

guage other than English at home,[31] 71 out of the 84 hospitals surveyed had not hired interpreters. Almost 85 percent of providers used bilingual employees with other jobs to interpret, and most did not train these employees. Approximately one-fourth of the responding facilities ask patients to bring their own interpreters, and comments from providers indicated that family members were frequently used to "help out."[32]

Another recently released national study found similar results among a randomly sampled group of public and private teaching hospitals. The National Public Health and Hospital Institute surveyed interpreter services in 120 providers with a detailed questionnaire (response rate approximately 70%). Administrators were asked questions about interpreter services on utilization, costs, financing, structure and documentation, staffing, recruiting, training, evaluation, and hospital practices and procedures. Some of the key findings from this impressive and timely study were the following: (1) while some hospitals employed full- and part-time interpreters, most relied on other hospital staff and volunteers, as well as family and friends; (2) less than one-fourth of hospitals provided any training for staff in medical interpreting; and (3) almost half of the hospitals did not have a specific department responsible for interpreter services. This study also provides valuable cost-utilization and staffing information.[33]

Comparatively little research exists concerning social services. In the late 1980's, DHHS's Office of the Inspector General (OIG) conducted an assessment of how the Social Security Administration (SSA) addressed special needs of non-English speaking clients. The study revealed that the LEP population was not receiving the same level of service as others. Because of difficulties in using SSA's modern telecommunications system (due to language barriers), most LEP clients came into the SSA regional offices, and over 70 percent came in without appointments. LEP clients frequently waited for hours to be served or were sent away with appointments for later dates when bilingual staff would be available to help them. SSA management felt that it was the client's responsibility to provide their own interpreters, and thus did little to recruit bilingual staff and did not include bilingual skills within job descriptions. One of OIG's findings was that SSA had insufficient numbers of bilingual staff to adequately serve the non-English-speaking clients. Although recommendations were made for improvements to the current operating system, it

31 U.S. Bureau of the Census on Population and Housing, Table 3.

32 Ruth Richman, *Failure to Communicate*, THE CHICAGO REPORTER, 22(3), March 1993, p.6.

33 Caren Ginsberg, Vanessa Martin, Dennis Andrulis, Yoku Shaw-Taylor, and Carla McGregor, *Interpretation and Translation Services in Health Care: A Survey of U.S. Public and Private Teaching Hospitals*, National Public Health and Hospital Institute, March 1995, p.vii-ix.

appeared that the SSA planned to modify its structure for Spanish-speaking clients only.[34] Freeman discusses many of these same issues within the social service arena for Spanish-speaking clients, stating that these clients receive less effective service because agencies lack the staff capable of speaking with them.[35]

d. Program Evaluation and Implementation

Many state and Federal agencies, and health provider associations have developed laws and policies that require or recommend hospitals and other health care providers to offer language services to LEP clients.[36] Although such policies may exist on the record, enforcement and monitoring of compliance are difficult to implement. State and local resources are waning in many parts of the country for enforcement of these language services. If the wording of a law or policy is vague, loopholes are established for providers who are not interested in offering an effective response to LEP patients. Often, hospitals do little more than maintain lists of bilingual employees in the facility, since the maintenance of such lists can constitute minimal compliance. Digging further into actual implementation issues usually uncovers problems with such a system, but officials must first establish an auditing process around interpreter issuers.

Recognizing the need for further systemic development, the Office of Minority Health funded a two-year multicultural project conducted by the Association of State and Territorial Health Officials. The objective of this project was to develop capacity within state health agencies to decrease language and cultural barriers to the public health services. ASTHO in turn funded Multicultural Pilot Projects in California, Colorado, Massachusetts, Michigan, Minnesota, North Carolina and Rhode Island. These state agencies then developed programs to train medical interpreters and community health outreach workers, to train local health department staff and other health professionals in cultural competency, and to improve data on racial and ethnic health indicators and services. Medical interpreter training programs were implemented in Colorado, Minnesota, and Rhode Island. Cultural competency training and training of outreach workers occurred in Colorado, Massachusetts, Michigan, North Carolina and Rhode Island. Evaluation of ASTHO Project was based on measuring process outcomes in

34 Richard Kusserow, *Serving Non-English Speaking Clients*, Department of Health and Human Services, Office of Inspector General, Office of Evaluation and Inspections, April 1990, p.i-ii.

35 Hal Freeman, Lorenzo Avila, and Virginia Balderrama, *"Chichi" in Paradise: Helping Agencies and the Spanish-Speaking*, PUBLIC WELFARE, Spring 1973, p.43.

36 Yolanda Vera and Jane Perkins, *"No Hablo Ingles"—Ensuring Linguistically Appropriate Health Care*, In process, p. 5; Ginsberg, et. al, p.7-13; Woloshin, et. al., p.725-726.

relation to meeting project goals and objectives. Although other forms of evaluations were considered, the short time period did not allow for more rigorous evaluations on training and implementation outcomes.[37]

The Office of Minority Health also funded another project that specifically targeted the health needs of Asian and Pacific Islanders, entitled *Development of Models and Standards for Bilingual/Bicultural Services for Asian and Pacific Islander Americans*. The project, known as the "Language Access Project," was conducted by the Association of Asian Pacific Community Health Organizations and studied during 1992-93. The study looked at utilization of nine community health centers in the provision of primary care services to LEP patients within the Asian and Pacific Islander population. Although AAPCHO provides recommendations and study conclusions, findings from this study are not available for general use at this point in time.

The NPHHI study addressed evaluation of local provider services in its survey instrument. Slightly over one-third of responding hospitals evaluate the quality of interpreter services programs, and approximately 60 percent reported not evaluating such services. Of those hospitals conducting evaluations of services, many reported using a variety of mechanisms, such as patient surveys, feedback, and monitoring of patient satisfaction; provider feedback and evaluation; and staff or patient complaints. Other language services, such as AT&T interpreters and language training, were also evaluated.[38]

2. Review of Newspapers

Newspaper articles can provide a valuable service in educating the public about the problems of the LEP population. By bringing stories of language and cultural barriers and services to life and making them available to the general pubic, they can increase awareness around other cultures and provide examples of viable, working solutions. A special review of articles from various newspapers in U.S. major cities during the period 1989-1994 reveals much about the state of current services for LEP residents, specific ethnic and cultural groups, and how language and cultural barriers affect the service delivery system. A total of 53 newspaper articles were reviewed, with the distribution among U.S. cities as follows: Los Angeles, 8; New York City and suburbs, 7; Boston area, 6; Seattle area, 5; Sacramento, 4; Washington, D.C. area, 4; Minneapolis/St. Paul, 3; San Francisco, 3; San Diego, 3; Chicago, 3; Miami, 1; Phoenix, 1; Cleveland, 1; and Atlanta, 1.[39] The State of California yielded a combined total of 18 articles.

37 Association of State and Territorial Health Officials, *ASTHO Multicultural Public Health Capacity Building Pilot Projects*, ASTHO, 1994, p.i-4.

38 Ginsberg, et. al, p.30.

39 Some of the articles were not specific to any one city, thus the total number of articles reported for cities does not equal 53.

In general, articles about hospital interpreters provided descriptions about either the paid interpreter model or the bilingual staff model. The use of community volunteer interpreters in hospitals was discussed as a way to fill an existing need in the community, and these individuals were often associated with other agencies that worked with LEP clients. Case workers and outreach workers were often mentioned as functioning as interpreters. In many instances, individual interpreters were interviewed and their work featured, providing a personal insight into their lives and their cases. Interpreters are usually refugees or immigrants themselves, and bring their own understanding of cultural issues to the job. For example, a community volunteer interpreter working with Russian refugees has set aside her real estate career to assist Russian women throughout their pregnancies. She stands with them at welfare offices and doctors' offices, and coaches them through the birthing process—a child of Russian immigrants herself, she feels a duty to provide this type of assistance.[40] The stories of three hospital interpreters working for UC Davis Medical Center were featured in a 1993 issue of the *Sacramento Bee*. An older Nicaraguan immigrant with a medical background interprets in Spanish, displaying compassion and sensitivity to patients who may not be legal immigrants in this country. A Cambodian interpreter balances advice from the hospital's doctors with his clients' need to believe in spiritual mysticism and home remedies—a partial believer in home remedies himself, he straddles both cultures with almost effortless aplomb. A young Russian interpreter, studying to be a doctor, finds her job immensely rewarding, but at times the emotional trauma of working within the life and death situations common to the medical setting can be extremely painful.[41]

Specific populations discussed within these articles included Asian Americans (Cambodians, Hmong, Laotians, Chinese, and Vietnamese), Hispanics, Haitians, Somalis, and Russians.

Programs to overcome language and cultural barriers were described in detail, usually with special mention of the funding source. Although Federal, State and county funds sponsored most of the programs, some were funded through foundations grants. In Seattle, the Robert Wood Johnson Foundation and the Kaiser Foundation are funding a two-year project called "Community House Calls." Trained medical interpreters and advisers are sent into the community to work with refugees and immigrants.[42] Another project in Seattle funded by the W. K. Kellogg Foundation, the Cross Cultural Health Care Program, provides cross-cultural training for health care professionals and seeks to expand community involve-

40 Mary Nolan, *Concern Snips a Language Barrier: Woman Uses Knowledge of Russian to Help New Immigrants*, SEATTLE TIMES, September 4, 1990, B1.

41 Sylva, SC1.

42 Tina Kelley, *Words of Healing, Interpreters a Boost to Refugee Health Clinic*, SEATTLE POST-INTELLIGENCER, May 12, 1994, p.C1.

ment to work with hospitals and improve participation in the health care system.[43] The Boston Foundation and the Hyams Foundation jointly funded the "Refugee Training and Interpreter Services Initiative" to help refugees overcome language and cultural barriers.[44]

Research findings and policy recommendations and requirements were often presented in articles alongside census data and illustrations of actual life situations. For instance, when the Joint Commission on the Accreditation of Hospital Organizations (JCAHO) adopted guidelines around language services for LEP patients, USA Today presented census data on immigration and supported the new policies with statements from prominent physicians about the effects of language barriers on medical care.[45] Similarly, an article in the New Jersey Record described how hospital doctors and administrators are struggling to meet the challenge of the many different languages now spoken in this country. After a discussion of immigration policies over the past 20 years and issues around language barriers, the article described policy and regulatory initiatives by JCAHO, AMA, and OCR with a follow-up of actual hospital practices gleaned from a 1992 survey of Chicago hospitals.[46]

Several conclusions can be made from an examination of newspapers articles. First, at least in the more densely populated, multicultural cities in the U.S., *language barriers appear to provide compelling stories for the pubic audience.* In relation to language, cultural barriers are also discussed frequently, leading one to believe that there is a great deal of public interest in cultural differences. Secondly, few hospitals and other health providers are noted as offering interpreter services to LEP clients, and those that do rarely provide training to their interpreters. Thirdly, bilingual staff are often called in to serve as interpreters or hired as outreach workers or case managers to work with LEP clients. Several articles concluded with hope that more bilingual students will enter the health professions.

3. Special populations

Much of the literature uncovered around language and cultural barriers pertains to problems of specific populations. This section describes special issues of various subpopulations of the LEP community. Special issues of refugees, immigrants, and migrant workers will all be examined

43 Himanee Gupta, *Building Bridges Between Doctors and Patients: Trainers Help Link Ethnic Communities, Health Care Providers*, SEATTLE TIMES, February 20, 1994, p.I1.

44 Christian Science Monitor, *Boston Upgrades Services for Immigrants*, January 15, 1989, P.A20.

45 Sharon Donovan, *Language Barriers Hinder Health Care*, April 15, 1991, 1D.

46 Leigh Page, *Hospitals Tackle the Language Barrier: Need for Interpreters Booms*, (NEW JERSEY) THE RECORD, April 19, 1993, b3.

separately, followed by discussions of ethnic populations and concluding with a brief look at problems of the elderly.

a. Refugees

Since World War II, more refugees have found homes in the U.S. than in any other country in the world. Refugees and immigrants enter the country through different admission processes. Although they often experience many of the same problems in terms of language barriers within the health and social service system, the special plight of the refugee must be understood by providers. The definition of "refugee" according to the Refugee Act of 1980 is as follows:

(A) Any person who is outside any country of such person's nationality or, in the case of a person having no nationality, is outside any country in which such person last habitually resided, and who is unable to unwilling to return to, and is unable or unwilling to avail himself or herself of the protection of, that country because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion, or

(B) in such special circumstances as the President after appropriate consultation (as defined in section 207(e) of this Act) may specify, any person who is within the country of such person's nationality or, in the case of a person having no nationality, within the country in which such person is habitually residing, and who is persecuted or who has a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion. The term "refugee" does not include any person who ordered, incited, assisted, or otherwise participated in the persecution of any person on account of race, religion, nationality, membership in a particular social group, or political opinion.[47]

Since the mid-1970's, the many refugees entering this country have posed some very special problems for health and social service providers. They often spend time in refugee camps overseas, and are then flown to this country and resettled throughout the country with the assistance of local community-based agencies. According to ORR's latest Report to Congress, the 10 largest refugee source countries are the former Soviet Union, Vietnam, Laos, Iraq, Cuba, Ethiopia, Somalia, Yugoslavia, Haiti, and Afghanistan. The 10 States that received the largest numbers of refugees for that year were California, New York, Washington, Texas, Florida, Illinois, Pennsylvania, Massachusetts, Georgia, Minnesota.[48]

Much research has been conducted on health care provided to refugees, especially to Southeast Asian refugees. Muecke asserts that Southeast Asian refugees have distinguishing characteristics for providers to understand: (1) Most

47 Section 101(a)(42) of the Refugee Act of 1980 within the Immigration and Nationality Act.

48 U.S.DHHS, Office of Refugee Resettlement, *Report to Congress, FY 1993, Refugee Resettlement Program*, p.5-7.

have come to the U.S. by second, not first choice; (2) They come with few belongings and few family to help them; (3) They do not have the option of ever returning to their home again; and (4) They are survivors.[49] This commentary could probably be made about all refugees entering the country.

Although refugees are immediately enrolled in English classes, becoming proficient may not be their top priority when considering the other daunting challenges of understanding various systems of employment, health care, child care, and education. D'Avanzo concluded that for Vietnamese refugees, length of time in the U.S. was a factor in reducing the language barrier.[50] Communication problems for the refugees are compounded by the fact that their cultural barriers inhibit them from understanding and using our health care system. Many do not understand such medical concepts as "informed consent," "medical regimen," and "making an appointment."[51] Providers and interpreters who work with refugees, especially those who have newly arrived, must communicate more than the standard medical message. For instance, most refugees regard prescribed medicine as very powerful and often expect immediate results. If they do not feel better soon, they often stop taking the medicine. This practice can even affect the public health in situations, such as tuberculosis control, where noncompliance can do serious harm.[52]

b. Immigrants

Refugees accounted for only 12 percent of all new entrants from 1983-1992. Most new residents do not enter the country under refugee status, but apply for residency as "immigrants."[53] According to U.S. Immigration Law, immigrants are persons granted legal permanent residence in the United States. The top five source countries for immigrants from 1981 to 1992 were Mexico, the Philippines, Vietnam, China, and Korea. These patterns are quite different in respect to ethnicity compared to trends seen up until 1960 when most immigrants were from Europe.[54]

49 Marjorie Muecke, *Caring for Southeast Asian Refugee Patients in the U.S.A.*, AJPH, 73(4), 1983, p.432.

50 Carolyn D'Avanzo, *Barriers to Health Care for Vietnamese Refugees*, JOURNAL OF PROFESSIONAL NURSING,. 8(4), p.250.

51 Bell and Whiteford, p.323; Uba, p.544-47. and Muecke, p.433.

52 David Foster, *TB and Unwelcome Hitchhiker with Immigrants: Nurse Says Highly Contagious Disease is Entering U.S. Along with a Variety of Newcomers*, LOS ANGELES TIMES, February 13, 1994, p.B3.

53 According to the ORR 1993 Report to Congress, from 1983-1992, 6,302,785 (88%) people entered the country as immigrants and 867,950 (12%) entered as refugees.

Mexican migration has sharply increased over the years and in many U.S. cities close to the Mexican border, where Mexican immigrants choose to live, Spanish is spoken freely. In particular, these cities must also cope with huge numbers of undocumented immigrants. Spanish-speaking Mexican immigrants are often regarded with prejudice and distrust for their perceived stubbornness in continuing to communicate in a "foreign" language. But to many Mexican-Americans, the Southwestern United States is still thought of as being part of "occupied Mexico," and English is regarded as the foreign language.[55] Overcoming communication barriers is often not simply about language, but combating the cultural and prejudicial differences that prevent providers and clients from trusting each other.

In a study of Mexican immigrants living in San Diego County, Chavez determined that Mexican immigrants generally underutilize health services, especially preventive services. Compared to the general U.S. population, they use hospitals and clinics to a much greater extent, relying less on private doctors. In addition, new and undocumented immigrants tend to use hospital emergency rooms for care, neglecting health problems until they become extreme situations.[56] Their findings are supported by other studies conducted in Los Angeles, San Diego, and Orange Counties in California, as well as anecdotal stories across the country.[57]

c. Migrants

Migrants have temporary permission to live in this country, but plan to return to their country of origin. They are usually agricultural farm workers employed on a seasonal basis.[58] (Migrant workers can also be legal or undocumented immigrants.) Migrants rarely have a good command of the English language or sufficient medical insurance to access medical systems outside of public clinics. Even when using public clinics, migrant workers are often told to bring an interpreter. Some interpreters in Florida were reported to be charging migrant workers in need of health care anywhere from $25 to $50 for the visit, and then the migrant

54 U.S. Department of Justice, Immigration and Naturalization Service, *1992 Statistical Yearbook of the Immigration and Naturalization Service*, 1993, p.13-14.

55 Freeman, et. al, p.41

56 Chavez, Cornelius and Jones, p.93-98.

57 Irene Wielawski, *Health Systems in Bind on Care for Illegal Immigrants*, LOS ANGELES TIMES, August 31, 1993, p.A1; Meg Bryant, *The Plight of Illegal Immigrants; When an Undocumented Worker is Disabled, Who Pays?*, WASHINGTON POST, July 10, 1990, p.z7..

58 Frederick Ahearn, *Refugees, Immigrants, Migrants, and Undocumented Aliens*, Unpublished paper, The Catholic University of America, p.2.

was also responsible for the medical bill.[59]

d. Asian and Pacific Islanders

According to a 1990 study, Asian and Pacific Islanders in many parts of California have great difficulty accessing health care due to language and cultural barriers. The study, conducted by the Asian Pacific Islander Health Coalition, found that health conditions for the API population has worsened over the years and recommended that health care professionals receive education around bilingual services. A lack of sufficient interpreters at county facilities often resulted in extremely long waiting periods for service or refusal of service.[60]

e. Hispanics

In 1993, former Surgeon General Antonia Novello reported on Hispanic/Latino health status, citing that their numbers now comprise 22 million and will increase to 31 million by the year 2000. Over one-fourth live in poverty and large numbers have limited access to health care and health insurance.[61]

There is concern across the country for the recognized poor health within the Hispanic/Latino population. Several initiatives focused on increasing awareness of preventive health and participation in health care have been developed during the last few years.[62]

f. Russians

Most Russians struggling with the language barrier are newly arrived immigrants or refugees from the former Soviet Union. There are two very distinct religious groups that are represented within the large numbers of newly arriving Russians. Whereas Russian Jews account for most of the immigrants, Pentecostal Christians have also formed their own communities in this country. Most of the Pentecostals have huge families, migrated from rural environments, and are poorly educated. Many of the former Soviet Jews, on the other hand, were experienced professionals in the Soviet Union

59 Ann Davis, *Translators Misleading Migrants, Leaders Say*, MIAMI HERALD, June 26, 1992, p.4B.

60 Dexter Waugh, *Health Care for Asians Criticized Language, Culture Are Called Barriers*, SAN FRANCISCO EXAMINER, December 14, 1990, p.A11; Elaine Herscher, *Health Care for Asians Called Poor: Study Finds a Language Barrier with Newly Arrived Immigrants*, December 14, 1990, p.B8..

61 Antonia Novello, *Hispanics Feel Effects of Poor Health Care*, MIAMI HERALD, October 25, 1992, p.1M; Novello, *Message from the Surgeon General*, In One Voice, One Vision: Recommendations to the Surgeon General to Improve Hispanic/Latino Health, June 1993, p.2.

62 Anita Snow, *Teaching Hispanics About AIDS Risk for Thousands of Health Workers*, PHILADELPHIA INQUIRER, April 18, 1993, p.A5.

and are totally stymied by language and cultural barriers. Many of the younger immigrants work long hours and then study English late into the night, but the elderly immigrant finds learning English almost impossible.[63]

Equally difficult is trying to understand the American culture and its health care system. Every citizen in Russia was assigned a primary care physician and appropriate medical care was provided to citizens at no cost. Each neighborhood had a fully staffed outpatient clinic where one could go for immediate care. The primary care physician knew the patient's medical history and gave personal attention to each complain. If the problem was acute, the primary care physician would make a home visit. Many Russians, especially the elderly, find it difficult to locate replacements for these neighborhood clinics and primary care physicians in the U.S. Even with interpreters assisting with the visits, encounters with American doctors seem brief and impersonal with too much emphasis placed on cost[64]

g. The Elderly

The elderly as a subset of the entire LEP population must be examined separately. Although elderly individuals also belong to specific ethnic and cultural groups, they all share certain characteristics, such as their age, status in the community, and difficulties learning the English language. In addition, elderly immigrants and refugees must maneuver within a health care system that is becoming increasingly difficult to understand. Insurance tends to pose specific problems: they do not qualify for Medicare until they have resided in the country for at least 5 years, yet many are not able to work at full-time employment.[65] In addition, most private insurance policies do not allow holders to add an elderly parent to a "family plan."[66]

Many people assume that families will continue to support the LEP elderly out of respect and an intergenerational value system. Although this assumption was believed for many years to be true of the Asian cultures, intergenerational research on immigrants indicates that family ties may become strained due to the immigration and acculturation process.[67]

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63 Michael Drexler, *Soviet Immigrants Struggle with Needs, New Culture*, PLAIN DEALER, November 17, 1992, p.1B.

64 Linda Carroll, *Seeking Care in a Strange Land*, NEWSDAY, October 10, 1993, p.1.

65 Linda Carroll, *Seeking Care in a Strange Land*, NEWSDAY, October 10, 1993, p.1.

66 Kenneth Sakauye, *The Elderly Asian Patient*, Presentation to the Scientific Meeting of the Boston Society for Gerontologic Psychiatry, April 7, 1990

67 Ibid.

h. Mental Health

While many Americans have difficulty accessing the mental health service system, LEP individuals have special issues around culture and language that compound the jobs of mental health professionals. In addition to the stresses of adjusting to a new country and culture, many refugees and immigrants have undergone extremely painful experiences in their former life and try to shut themselves off from remembering. Memories of horror, torture, prison, or deprivation can surface years after resettlement, although most mental illness occurs in recent arrivals.[68]

Because using interpreters within the client-therapist relationship presents issues of confidentiality and problems with cultural interpretations, most experts recommend conducting mental health services in the primary language of the LEP client by a bilingual/bicultural professional. Yet, severe shortages of trained bilingual/bicultural professional exist in the mental health field.[69] The symptoms displayed by many LEP immigrants and refugees may be influenced by cultural differences and only a professional with in-depth familiarity of the patient's culture could establish a diagnosis of depression from psychosis.[70] In Asian cultures, there are no words for "depression," and many Asian Pacific Islanders believe that the only time they should seek mental health services is when they are afflicted with a very serious psychiatric disorder.[71]

D. LANGUAGE SERVICES AVAILABLE TO LEP POPULATIONS

In reviewing the literature around language services being used in the field, three main models of language services appear to be dominant. Bilingual/bicultural staff, whether professional or support staff, are widely used in those facilities where large numbers of LEP clients speak a common language or within the mental health setting. Staff interpreters are described as being used mostly in hospitals, and still widely used are the interpreters who are also community volunteers. When none of the these interpreters is available, hospital staff reportedly still use family members, even children, in a crisis situations.[72]

68 Elizabeth Gong-Guy, Richard Cravens, and Terence Patterson, *Clinical Issues in Mental Health Service Delivery to Refugees,* AMERICAN PSYCHOLOGIST, June 1991, p.643-644; Kenneth Sakauye.

69 Gong-Guy, et. al..

70 Jean Dietz, *For the Southeast Asian Refugees, War Continues*, BOSTON GLOBE, October 14, 1984.

71 Gong-Guy et. al; Barbara Gray, *Struggling to Help Troubled Immigrants: Mental Health*, LOS ANGELES TIMES, February 17, 1991, p.8.

72 Haffner, p.256.

1. Bilingual/Bicultural Staff

Many hospitals identify staff who speak other languages and involve them in medical interpreting encounters. According to Ginsberg this is currently the most widely used method within public and private teaching hospitals.[73] In small informal surveys of hospital practices, several newspaper articles substantiated this practice, claiming interpreting capability for dozens of different languages. Often, the list of bilingual hospital staff is referred to as the hospital's "language bank."[74] Other reports documented bilingual staff discomfort with this practice, since such staff are usually not provided training around medical terms or techniques of interpreting.[75]

Another form of the bilingual/bicultural model that is popular within small settings is a fully bilingual/bicultural medical staff who work as a team to provide services to clients.[76] One such program for Asian Americans is being pilot tested in Sacramento as part of a new managed care initiative. Vietnamese doctors use their valuable experience and background to treat Southeast Asian patients. Cultural differences often prevent patients from discussing treatment issues with their doctors. One doctor cites his expertise as, "*. . . I can anticipate the instructions not being followed, the frustration, the break in communications.*"[77]

Another frequent model within LEP communities is the use of bilingual staff as outreach workers or case managers. Interpreting and translating for clients are re-

73 Ginsberg, et. al, p.21.

74 Guy Keeler, *Bridging the Culture Gap: Translators Keep Hospitals in Touch with Their Patients*, THE FRESNO BEE, May 12, 1992, p.D3; Sherry Joe, *Hospital Needs Interpreters in Maternity, Group Says*, BALTIMORE SUN, July 12, 1994, p.B1; Richman, p.6.; Jane Halsema, *Lending a Needed Voice; Interpreters Bring Relief to Pressure Situations*, LOS ANGELES TIMES, October 9, 1986, p.1.

75 Debora Vrana, *Some at Hospitals Perform Double Duty/Interpreting: Under a 2-year-old State Law, Bilingual Employees Help Doctors Communicate with Non-English-Speakers*, July 21, 1993, p.B5; Mitch Gelman, *Breaking Down the Barrier of Fear: Doctors Unlikely to Report Immigrants*, NEWSDAY, p.B7; Grasska and McFarland, *Overcoming the Language Barrier, Problems and Solutions*, AMERICAN JOURNAL OF NURSING, September 1982, p.1378.

76 Donald Minkler, *The Role of a Community-Based Satellite Clinic in the Perinatal Care of Non-English-Speaking Immigrants*, CROSS CULTURAL MEDICINE, December 1983, p.906; Linda Monroe, *Cultural Differences Snarl Health Care for Immigrants*, LOS ANGELES TIMES, August 17, 1989, p.AA2..

77 Nancy Bee, *Care Not Lost in the Translation: Doctors Form Group to Treat Asian Immigrants*, SACRAMENTO BEE, March 30, 1993, p.B1.

garded as part of their job duties, in addition to social work functions. For instance, a program in Los Angeles sends teams of bilingual health workers into the community to provide outreach to elderly Cambodians.[78]

2. Staff Interpreters

Due to many factors, such as laws, market forces, and changes in Medicaid, many more hospitals and other facilities are providing full- and part-time staff interpreters to LEP patients. And for those facilities that have sought to integrate an interpreter services system, the demand for such services has increased rapidly over the years. Many have special training programs, offer a variety of languages, and are viewed as a vital part of the system. While these programs are not cheap—some exceed budgets of over one million dollars per year—they are helping to increase access to thousands of LEP patients and bring in business to the hospitals.[79]

Some hospitals use student volunteers from nearby universities as staff interpreters. The students go through an intensive training program and receive college credit for their work as interpreters in local hospitals. The training and experience allow many to move into the medical interpreting profession.[80]

3. Community volunteer interpreters

Community volunteer interpreters are often individuals interested in serving others with the same ethnic and cultural background. Although they may be working independently with members of the their community, many discover interpreting needs through their work with agencies providing services to LEP populations. Many of these agencies express anger at hospitals using community volunteers instead of accepting the responsibility for training and hiring their own medical interpreters.[81]

4. Training

Training for certified medical interpreters can take many forms. Benhamida's review describes some of the different models. Training programs may be based within the provider or hospital, sponsored by a State or local government agency, offered by for-profit firms, or based in a university or college. Some university programs offer a double major to undergraduate students seeking to become qualified interpreters. Many community colleges award associate degrees to individuals interested in community interpret-

78 David Haldane, *Meeting Medical Needs of Refugees*, LOS ANGELES TIMES, March 10, 1990, p.19.

79 Sylva;

80 Nicole Carroll, *Translating Medicine's Mysteries*, USA TODAY, May 11, 1993; William Douglas, *Many Tongues Spoken: Students Translate at Clinics, Hospitals*, NEWSDAY, January 3, 1993, p.39.

81 Joe;

ing, although several programs have recently been tailored to fit the needs of the medical community. Because so many communities have discovered such a great gap in interpreting service delivery, another recent development has been the addition of one-year interpreting programs at community colleges.[82]

Since many hospitals tend to use bilingual staff for interpreting encounters, other less intensive training programs have been introduced recently to accommodate the training needs of bilingual staff. Especially in California, where a law requires hospitals to supply interpreters in acute care facilities, such programs are becoming increasingly popular.[83]

E. CONCLUSIONS

It appears that recent research and media efforts to promote language services for the LEP population have provided the field with much new information around policies, practices, and health status of LEP populations. Whether recent findings will increase awareness and subsequently affect service delivery remain to be seen. Changes in organizational structures are not easily implemented, but research around language needs clearly supports such changes. In addition to providers recognizing their responsibility in supplying interpreters for LEP clients, it is hoped that recommendations around screening, training and evaluating of interpreter services will be taken seriously. In addition, a system of care must be established that will link the LEP client into interpreter services and continue to maintain that link throughout the client's contact with the provider.

82 Laurel Benhamida, *Interpreter Training: A Review and Discussion of Existing Interpreter Training Programs*, University of Minnesota, p.13-17.

83 Debora Vrana; Jeff Matsuda, *It's Caring in any Language: Translation Program Assists Russian Immigrants with Medical Needs*, SACRAMENTO BEE, December 9, 1993, p.N1.

APPENDIX G: Participants Interviewed During the Study

A. Congressional Participants

Congressional Hispanic Caucus
Esther Aguilera, Legislative Assistant

Congressional Subcommittee on Health and the Environment
Julia Fortier, Professional Staff Member

B. Federal Participants

Administration for Children and Families
Ms. Virginia Apodaca, former OCR Regional Director for the San Francisco Office, currently Director of Human Resources and Equal Opportunity, Administration for Children and Families

Administration on Aging
Fernando Torres-Gil, Ph.D., Assistant Secretary
Michelle Puccinelli, Special Assistant
Centers for Chronic Disease Control and Prevention
Ms. Donna Garland, Analyst, Immunization Control Program

Commission on Immigration Reform
Ms. Susan Forbes-Martin

Federal Administrative Office of U.S. Courts, U.S. Department of Justice
Mr. Edward Baca, Legislative Analyst

National Institutes of Health, National Institute of Mental Health
Juan Ramos, Ph.D., Director, Office of Prevention and Special Projects

Office of Minority Health
Mr. Clay Simpson, Acting Deputy Director
Mr. Guadalupe Pacheco, Special Assistant
Ms. Betty Lee Hawkes, Project Officer

Office of Refugee Health
JoAnne Luoto, M.D. Director
Tom Bornemann, Ph.D.

Office of Refugee Resettlement
Ms. Regina Lee, Deputy Director

Substance Abuse and Mental Health Services Administration
Ruth Sanchez-Way, Representative on

Minority Health Concerns and Director of Community Training Services
Dina Birman, Ph.D. Research Officer, Refugee Mental Health Branch

C. Advocacy

Association of Asian and Pacific Islander Community Health Organizations
Steven Jang, Executive Director

International Rescue Committee
Mr. Ray Evans, Director Resettlement Program for DC area

Latino Coalition for a Health California
Carmela Castellano, J.D., Coalition Director

D. Professional Associations

American Hospital Association
Ms. Ellen Joss, Research Analyst

American Medical Association
Mr. Mike Zarski, Policy Analyst

American Speech, Hearing, and Language Association
Ms. Diane Scott

DC Hospital Association
Ms. Holly Constant

Joint Commission on the Accreditation of Health Care Organizations
Mr. Paul Mullen

National Association for Public Hospitals
Ms. Vanessa Martin, Policy Analyst

Registry of Interpreters for the Deaf, Inc.
Shaundra Williams, Staff Analyst

E. Site Visits

1. Seattle

Office for Civil Rights, Region X
Ms. Carmen Palomera Rockwell, Regional Manager

Asian Counseling and Referral Service
Raymond Ishii, Deputy Director
Elisa Del Rosario, Director, Managed Care

Children's Hospital of Seattle
Ms. Patty Hencz, Director, Interpreter Services Program

Community Health Interpretation Services/Hospital Interpretation Program
Ms. Sherry Riddick, Director

Pacific Medical Center: Cross-Cultural Health Care Program
John Larson, Clinic Administration
Robert Putsch, M.D., Medical Director
Ms. Cynthia Roat, Medical Interpreter Program Director
Thu Van Nguyen, Interpreter

Group Health Cooperative
Michael Wander, M.D. Family Practice Residency Director
Erika A. Steinbacher, M.D., Family Practice Resident

Seattle/King County Health Department
Ms. Shari Wilson, Coordinator of Refugee Screening and Interpretation

Seattle Area Hospital Council
Peggy Shapiro, Director, Office & Financial Management

Washington Department of Social and Health Services
Mr. Ed Rodriguez, Director of Diversity Initiative Office

2. Boston

Office for Civil Rights, Region I
Ms. Caroline Chang, Regional Manager
Mr. Jerry Malone, Division Director
Ms. Deborah Coppa, Investigator
Ms. Linda Connor, Assistant Manager

Boston Children's Hospital
Mr. Eduardo Berinstein, Coordinator, Interpreter Services

Boston City Hospital
Eric Hardt, M.D., Medical Director, Geriatric Division

Central Massachusetts Area Health Education Center- Language Link Program
Ms. Gail Lewis, Executive Director
Ms. Ana Mulgoza, Manager, Language Link Program

Clark University
Thomas P. Massey, Ph.D., Dean, College of Professional and Continuing Education
Leo Ortiz-Minique, Ph.D., Professor/Coordinator, Medical Interpreter Training Program

Commonwealth of Massachusetts, Department of Health and Human Services
Ms. Victoria Mederos, Director of Affirmative Action/Human Rights/ADA Coordinator/ MBE Coordinator

Commonwealth of Massachusetts, Department of Public Welfare
Ms. Agnes Young, Affirmative Action Manager

Greater Boston Legal Services
Ms. Melanie Malherbe, Staff Attorney

Mattapan Clinic
Rodney Taylor, M.D., Director
Ms. Brenda Carruthers, Coordinator

Massachusetts Law Reform Institute
Mr. Ernest (Tony) Winsor, Staff Attorney

Massachusetts Medical Interpreter Association
Ms. Raquel Cashman, President
Ms. Margarita Battle, Vice President

Massachusetts Department of Public Health
Mr. An Ton That, Director, Office of Refugee and Immigrant Health
Ms. Jennifer Cochran, Director, Refugee Health Program

Massachusetts General Hospital
Ms. Patricia Rowell, Director, Volunteer and Interpreter Services

University of Massachusetts Medical Center
Ms. Maria Durham, Director, Interpreter Services
Mr. James Wells, Director, EEO/Human Resources

3. Los Angeles

Office for Civil Rights, Region IX
Mr. Joe Kennedy, Acting Director
Ms. Sharon Meyers, Investigator

Altamede Health Services Corporation
Ms. Castalo de la Rocha, President

Asian Pacific American Legal Center of Southern California
Ms. Kathryn Imahara, Staff Attorney and Director Language Rights Project

Asian Pacific Counseling and Treatment Center
Ms. Jiun Shin, Staff Psychiatrist

Asian Pacific Health Care Venture
Ms. Kazue Shibata

California Department of Health Services
Mr. Calvin Freeman, Director, Office of Multicultural Health
Ms. Barbara Marquez, Chair, Cultural and Linguistic Requirements Subgroup

Cedars Sinai Medical Center
Ms. Ruth West, Manager, Interpreter Services

Kaiser Permanente of Southern California
Jean Gilbert, Ph.D., Director, Organizational Effectiveness
Mr. Jose Deando, Assistant Director of Human Resources

Martin Luther King, Jr. Drew Medical Center
Tessie Cleveland, D.S.W., Director of Social Services
Mr. Edward Padilla, Coordinator, Interpreter Services

Mexican American Legal Defense and Educational Fund
Ms. Irma Rodriguez, Staff Attorney

National Health Law Program
Ms. Yolanda Vera, Staff Attorney
Ms. Lourdes Ria, Staff Attorney

National Immigration Law Center
Ms. Susan Drake, Acting Directing Attorney

PacifiCare of California
Mr. Richard Irwin, Manager, MediCal Member Services

Public Advocates, Inc.
Ms. Carmella Castellano, Attorney, Public Advocates and Executive Director of the Latino Coalition for a Healthy California

Stanford University Medical Center
Ms. Linda Haffner, Director, Interpreter Services
Mr. John Chavez, Coordinator of Interpreter Training

T.H.E. Clinic
Ms. Sylvia Drew-Ivie, Executive Director

White Memorial Medical Center
Hector Flores, M.D., Co-Director, Family Practice Residency Program

APPENDIX H: Legislative Initiatives

A. Introduction

Although OCR has been invested in this issue over a 15-year time period, other Federal agencies have supported service delivery to the LEP population through regulatory or programmatic initiatives. During its site visits, the study team identified several programs that were recipients of Federal, state or local funding, or were initiated in response to state regulations. This section will document how various Federal and state agencies have participated in shaping the service delivery system.

Although Title VI would appear to affect all services provided within and for the Department of Health and Human Services (DHHS), health and social services have historically been managed separately. Policies around services for LEP populations have not been developed for the entire Department, but rather for each agency within the Department. Separation of health and social services is not unique to the Federal government, however, for most states have been structured in a similar fashion. Many DHHS efforts have promoted services to support increased health access to minority populations, but it is only recently that efforts to remove or address cultural and linguistic barriers have been initiated.

Removal of language and cultural barriers from health care has been a stated goal within PHS and, although all of its agencies share responsibility for this goal, the Office of Minority Health is designated as the leader within PHS in spearheading a movement towards changing an existing system.

B. Office of Minority Health, Public Health Service

The Office of Minority Health (OMH) exists to improve the health of racial and ethnic minority populations in the United States. Historically, OMH was perceived as an agency that served mainly African Americans, but recent congressional initiatives have sought to extend its goals and objectives. Section 1707 of the Public Health Service Act (otherwise known as the "Minority Health Improvement Act of 1990") expands the scope of OMH's efforts to target the LEP population by the following activities: (1) establishment of an advisory committee that would provide advice, assistance, and oversight; (2) interagency agreements with other agencies to support work in research, demonstrations, and evaluations to test innovative models of delivering services, (3) contracts with health care providers to develop or increase providers' capacity to provide bilingual or interpreter services, (4) establishment of the Center for Linguistic and Cultural Competence in Health Care, and (5) establishment of individual offices of minority health within agencies of the Public Health Service.

OMH funds demonstration programs to extend access to persons with limited English proficiency. Some programs develop and test cultural orientation training for physicians; others fund case managers and outreach workers to racial and ethnic communities, or translation and interpreter services. Grant awards range from $37,000 to $75,000. Other OMH demonstration efforts—such as the Minority Community Health Coalition Program, the Coalition Enhancement Initiative, the Hispanic/Latino Community Health Coalition Development Initiative, the Minor-

ity Male Program, and HIV/AIDS projects— promote health services in broader areas, while lending support to removal of language and cultural barriers. OMH has also funded research efforts, such as the "Language Access Project," that developed models and standards for bilingual/bicultural services for Asian and Pacific Islander Americans conducted by the Association of Asian Pacific Community Health Organization (AAPCHO), and the "ASTHO Bilingual Health Initiative." conducted by the Association of State and Territorial Health Officials (ASTHO).

OMH operates the Office of Minority Health Resource Center (OMHRC) through a contract with a private firm. The OMHRC provides health professionals with information about and for minorities. It also maintains listings of programs operating at the national, State and community levels.

In June of 1994, the U.S. Congress, House Committee on Appropriations recommended that OMH implement certain initiatives specified in the Minority Health Improvement Act to assist health care providers in delivering health services to individuals with limited-English proficiency. OMH was asked by this Committee to "*establish a center to develop and evaluate models, conduct research, and provide technical assistance to providers on removing language barriers to health care services.*" [1]

The Center for Linguistic and Cultural Competence in Health Care (CLLCHC) is currently being planned within OMH as an internal component integrating OMH's different initiatives. Within its plan for this Center, OMH has recognized the significance of Title VI in specifying the need for language services and sees its role as one of focusing on systemic change within Federal, state and local communities to assist health care providers in accepting responsibility for providing competent language services to LEP patients and increasing the information and resources available to providers. The Center will attempt to accomplish the following goals: (1) foster access to literature, research and programmatic information on removing language and cultural barriers to health care for the LEP; (2) collaborate with other agencies (Federal, state, managed care, institutions of higher learning, and community-based organizations) to promote research on removing language and cultural barriers; (3) develop demonstration programs to remove language and cultural barriers; (4) conduct program evaluations on demonstration programs to determine replicability and transfer programmatic knowledge to the field; and (5) provide assistance to health care providers on removing language and cultural barriers to health care for the LEP populations.[2]

Other existing OMH initiatives will also be integrated into the Center. An important part of the Center is sharing information around LEP issues with other

1 The Office of Minority Health. 1995. "Final Draft Plan for The Center for Linguistic and Cultural Competence in Health Care (CLCCHC)."

2 Ibid.

agencies within the Public Health Service that currently support a Minority Health Representative. These agencies currently include the Agency for Health Care Policy and Research, the Centers for Disease Control and Prevention, the Federal Drug Administration, the Health Resources and Services Administration, the National Institutes of Health, and the Substance Abuse and Mental Health Services Administration. It is expected that the research and programs supported by these agencies will be planned in such a way as to include ways to remove language and cultural barriers to health care.

Plans are underway within the Center to develop a minority fellowship program in collaboration with the Centers of Excellence Program within the Bureau of Health Professions, Health Resources and Service Administration (HRSA). This program will involve recruitment of minority candidates and the provision of research, clinical and community experiences necessary to obtain tenured status at teaching universities participating in the Centers of Excellence program.

C. Centers for Disease Control and Prevention, Public Health Service

The CDC holds a major responsibility for the surveillance, prevention, and treatment of infectious and chronic diseases in the U.S. Quite often their work cannot be conducted effectively without the inclusion of services to the LEP population.

The following descriptions are a sample of CDC's involvement in promoting services for the LEP.

The CDC's Division of Tuberculosis Elimination (located within the National Center for Prevention Services) has been assessing, monitoring, and treating all individuals in the U.S. for tuberculosis infection. They work closely with state governments to ensure compliance at the local levels and develop policy around working procedures. Because local TB programs often involve outreach and care to persons of limited English proficiency, the CDC has promoted the use of bilingual outreach workers and, where necessary, has funded efforts to staff state and local programs with bilingual workers. In addition, the CDC advocates the use of interpreters in a recent publication, "*Improving Patient Adherence*," and devotes a brief, but well-researched section to "*Working with an Interpreter*." Although promoting the use of trained medical interpreters, the authors freely admit that trained interpreters are not always available and suggest some guidance around not using family members, especially children, and community volunteers.[3]

The CDC's National Immunization Program has also become involved in studying and employing methods of reaching the LEP population. The recently created Childhood Immunization Initiative includes develop of an Immunization Action Plan for each region of the country. Within some of the regions, "brainstorm-

3 Centers for Disease Control and Prevention. 1994. "Improving Patient Adherence," U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, Division of Tuberculosis Elimination; Atlanta, GA.

ing" meetings were conducted around developing the plans that included examining the issues of the LEP population. Specific recommendations were targeted to the integration of interpreter services and bilingual staff within the service delivery model. The CDC supports such efforts and in some instances has funded proposals to augment the existing infrastructure.[4]

To promote the prevention of HIV/AIDS, the CDC's Division of Adolescent and School Health (DASH) has, since 1987, funded cooperative agreements with all State Education Agencies and several city and local agencies to promote training, policy development, curriculum development and collaboration efforts. In 1991, DASH began emphasizing services to minority youth and encouraging bilingual/bicultural services within the local communities. At the local level, many efforts were funded to translate materials on HIV prevention into other languages. Programs located in areas where LEP youth resided were supported in hiring bilingual outreach workers.

The CDC's Division of Quarantine is also responsible for operating the Refugee Health Screening Program through an interagency agreement with the Office of Refugee Resettlement (ORR). Approximately $5.7 million was s s spent in 1993 on preventive health services for refugees through this agreement, which provided for technical assistance and monitoring of health screening practices overseas, issuing health documentation of refugees entering the country at ports of entry, forwarding of documentation to state and local health departments, and administering the preventive health screening grant program. To ensure that refugees meet public health requirements and are deemed in good health for employment purposes, the State Department strongly recommends that all refugees receive an initial medical screening exam in the domestic resettlement site. Most state health departments and some local agencies receive funding to manage and support health screening services for newly arriving refugees. The purpose of the initial health exam is to screen and treat for the following: (1) those health conditions that could affect the public health, such as tuberculosis and hepatitis B, and (2) health problems that could impair a refugee's resettlement and/or employability, such as hypertension, diabetes, or mental disorders. (Additional funding for these screenings is provided by ORR in the form of Refugee Medical Assistance (RMA)) Wherever possible, state and local agencies also contribute resources to this screening program.

Because most refugees are part of the LEP population, language barriers must be overcome before refugees are provided any type of health service. The domestic health screening program has recommended that interpreters or bilingual staff workers be used to conduct the assessment, and as such, the state and lo-

4 Roger Bernier. 1994. "Toward a More Population-Based Approach to Immunization: Fostering Private- and Public Sector Collaboration," *American Journal of Public Health*, Vol 84, No. 10; and Donna Garland, Centers for Disease Control and Prevention; interview conducted September 14, 1994.

cal grants funded by the CDC are frequently used to fund interpreter services programs. One city health department uses the CDC funding to support interpreter services within its public health clinics. Several states fund bilingual staff salaries in county health department, and at least one state funds a monetary incentive for using an interpreter during the health screening. Even with this assistance, many refugee health screening programs rely on the community assistance provided by voluntary or resettlement agencies working with the refugees. Often, the refugee is brought in for the exam by a bilingual case manager or outreach worker who stays for the duration and interprets for the refugee and the health provider. When asked about barriers to obtaining health assessments for refugees, many providers cited a lack of interpreter services within the local communities.

D. Office of Refugee Health, Public Health Service

The Office of Refugee Health (ORH) focuses on developing and setting policy around refugee health and mental health issues, and identifying problems and solutions to refugee health. They are funded through an interagency agreement with the ORR and maintain close working relationships with the State Department, Department of Justice, ORR, state and local health departments and international organizations, such as the United Nations High Commissioner for Refugees (UNHCR) and the International Organization for Migration (IOM). ORH is currently sponsoring a special study entitled an "*Evaluation of Health Needs of Newly Arriving Refugees*," in which the seven states receiving the largest numbers of refugees will be studied. Within this evaluation, interpreter and translation services are examined in terms of their availability to refugees and health care providers, as possible barriers to health services, and issues to consider for the most newly arriving refugees.

E. Office of the Surgeon General, Public Health Service

Within the Office of the Surgeon General, an initiative was sponsored in 1992-93 by Dr. Antonia Novella, the then Surgeon General, to address the barriers to quality health care faced by the Hispanic/Latino Community. The Hispanic/Latino Health Initiative commenced in September 1992 with a National Workshop on Hispanic/Latino Health, bringing together over 200 Hispanic leaders. In Spring of 1993, intensive, two-day regional meetings were held in five cities in the U.S. with large Hispanic populations: New York, Miami, Chicago, San Antonio, and Los Angeles. Recommendations were developed from these meetings to improve health care for the Hispanic community. In a report on this initiative, it was recognized that governmental and institutional policies were not responsive to the health needs of Hispanics/Latinos. [5] Recommendations included establishing policies around providing linguistically and culturally competent programs, funding research initiatives around Hispanic health

5 U.S. Department of Health and Human Services, Office of the Surgeon General. 1993. *One Voice, One Vision—Recommendations to the Surgeon General to Improve Hispanic/Latino Health*, U.S. DHHS: Rock, MD.

issues, developing programs to increase the numbers of Hispanic health professionals, and seeking ways to foster collaboration around Hispanic health issues. Dr. Aida Giachello, speaking on behalf of one of the workgroups said, "... *in terms of an ideal system, we want to eliminate language and cultural barriers ... We discussed the whole issue of interpreters, and we were concerned about the fact that the role of the interpreter may affect the quality of care. We were concerned also about the issue of confidentiality . There are ethical issues involved when you use interpreters and so the lack of guidance, the lack of training, the lack of really establishing protocols to serve providers was a clear concern of the group ... We need to introduce legislation . There should be policy and guidance to promote bilingual and culturally competent, relevant services.*"

F. Health Resources and Services Administration, Public Health Service

The Health Resources and Services Administration (HRSA) has funded several research and programmatic efforts to promote access to health care for the LEP population. In fact, some of these programs were observed by the study team during site visits. Because HRSA is more service-oriented than other agencies within PHS, their commitment to language services for the LEP population is critical. Many of HRSA's programs are located in areas that are densely populated by LEP individuals and without language considerations within program guidance, it is questionable whether agency goals could be obtained.

Area Health Education Centers (AHECs) are funded by HRSA's Bureau of Health Professions (BHPr) to promote partnerships between community-based agencies and medical schools. In Boston/Worcester, the study team observed an AHEC offering language bank services, task forces around language services, interpreter services training programs, and training programs for physicians. AHECs can be valuable resources within local communities to promote and offer language services to the LEP population.

A few of the programs visited by the Study Team were funded through HRSA's Community and Migrant Health Center (C/MHC) program. C/MHCs are located in areas in which there are large numbers of underserved individuals and few resources to serve them. Their mission has been to serve those in the immediate community, and over the years, this mandate has at times been difficult due to the shifting ethnic changes within the country. When populations shift, the new residents may be LEP individuals and without a shift in C/MHC staffing pattern to meet this need, Centers funded under this program may be judged as nonresponsive to the immediate community.

The Centers of Excellence (COE) Program is located within HRSA's Bureau of Health Professions and has as its objective: to strengthen the national capacity to train minority students in the health professions; and to support the health professions schools which train a significant number of minority health professionals. Often minority students require more assistance from professors and institutions of higher learning to maintain an educational level consistent with non-minority students. The COE program funds efforts by institutions to work more closely

with minority students to understand the needs of these students.

G. National Institute of Mental Health

The National Institute of Mental Health (NIMH) has been involved in conducting research and providing services to the LEP population for a number of years. Providing mental health services to the LEP population can be especially difficult because of cultural and confidentiality issues. In 1993, NIMH's Office for Special Populations sponsored a special group to examine culture and diagnosis, and the findings of this group comprise the *Revised Cultural Proposals for DSM-IV*. Various mental health disorders were revised to include cultural considerations for clinicians whose training reflects traditional Western psychiatry. Observations by the study team in the field of mental health support the need for further research in this area. There was also observed to be a dearth of mental health services available for LEP individuals, as well as professionals who could provide such services. NIMH has participated in and supported research efforts in mental health for LEP individuals, especially those designated as immigrants or refugees. NIMH also publishes several translated publications in Spanish, describing mental illness and specific conditions, such as schizophrenia, depression and panic disorder.

H. Substance Abuse and Mental Health Services Administration

The Substance Abuse and Mental Health Services Administration (SAMHSA) is comprised of three centers that focus on specific areas of service delivery: The Center for Substance Abuse Prevention (CSAP) supports services to prevent problems caused by alcohol and other drugs; the Center for Substance Abuse Treatment (CSAT) funds through block grants to the states intervention programs in a variety of areas; and the Center for Mental Health Services (CMHS) supports the community mental health programs and other mental health services. As of March 1993, SAMHSA issued a policy on "*Inclusion and Attention to the Needs of Females and Racial/Ethnic Minority Populations in Extramural Programs.*" While this policy does not address language issues directly, it does address "*sensitivity to cultural competency to deal with the special needs of the particular racial/ethnic groups proposed for inclusion in the project.*" The existence of such a policy may lead to more specificity on how to provide language services. Within CSAP, the agency directive is to fund programs that use bilingual/bicultural staff workers in communities where there are populations speaking other languages. Interpreters are not funded or encouraged. CSAT, because of its reliance on block grants to states, is not able to offer much guidance in this area and defers to state policies around language services.

Within CMHS is the Refugee Mental Health Program (RMHP) which provides consultation and technical assistance on general refugee mental health issues. It is funded by the Department of Justice through interagency agreements with the Office of Refugee Health and CMHS. The RMHP sponsors and participates in workshops, conferences and conventions that address refugee mental health issues.

Also within CMHS is the Community Mental Health Services Block Grant, which funds programs to support compre-

hensive, community-based services for adults with serious mental illness and children with serious emotional disturbances. Adequate support for such services does not exist currently in insurance and other mechanisms. The types of organizations funded under this block grant were previously classified as Community Mental Health Centers (CMHCs) and included freestanding psychiatric outpatient clinics, freestanding partial care organizations, and multiservice mental health organizations. After the 1981 Block Grant program, definitions for mental health service providers were changed to (1) outpatient mental health clinic, (2) psychiatric hospital, (3) residential treatment center for emotionally disturbed children, (4) a mental health partial care organization, (5) multiservice mental health organization, and (6) general hospitals with separate psychiatric service(s). It is interesting to note that in a recent publication, *Mental Health, United States, 1992*, data were reported for patients and providers across the country on "blacks," "whites," and "other races." Minimal efforts were made to examine mental health problems for the LEP population, although concern was expressed by the authors about the lack of minority health professionals entering the mental health professions, coupled with an interest in serving those minorities with mental health needs.

I. The Office of Refugee Resettlement, Administration for Children and Families

Since 1975, the Office of Refugee Resettlement (ORR) has been the major funder of services to refugees newly entering the country. The Refugee Act of 1980 (section 413(a) of the Immigration and Nationality Act) grants comprehensive authority to ORR for the domestic resettlement program. ORR is responsible for carrying out those activities that provide for effective resettlement of refugees and assistance to refugees in obtaining self-sufficiency. Their primary focus is to integrate refugees into the service system, prepare them for job readiness, and promote full-time employment. As such, various programs funded by ORR and through ORR involve the provision of language services to new refugees.

As mentioned earlier, the CDC domestic health screening assessment program provides some funding for language services. Additional funding for interpreter services is provided through the Refugee Medical Assistance (RMA) program, which provides substantial funding to approved states to assist states in conducting the domestic health screening assessment. RMA funds are frequently used by states to staff local health departments with bilingual outreach workers. States that are not currently approved for RMA expenditures in this manner report difficulties in overcoming barriers related to a lack of interpreter services. It was reported that many local health departments do not have sufficient resources to provide interpreter services to refugees. In some cases, they lack a commitment to refugees and services to the LEP population.

Also in health care, ORR has funded through its National Discretionary Grant Program, an initiative with the Public Health Service to conduct hepatitis B screening and vaccination of children and pregnant refugee women who have been in the U.S. since 1981. This program also provides public information and interpreter services related to hepatitis B issues for refugees.

There is much general concern around refugees receiving access to health care, and it was noted that caring individuals within communities act on this concern when health care providers are unable to offer adequate interpreter services for refugees. Often refugees are provided interpreter services in health care settings by staff in voluntary or resettlement agencies working with them as case managers or volunteers. Funding for these types of services would be paid for by ORR or the State Department. As stated earlier though, ORR's mission (in conjunction with the State Department's) is to fund efforts aimed at employability. When staff hours are used to interpret in health settings, ORR and the State Department are paying for services outside the scope of their agreements with these agencies. Besides governmental cost effectiveness, another issue around the use of staff from community-based agencies to interpret within health settings is the lack of screening, training and assessment provided these individuals. In many cases, an individual is rated as a "good interpreter" because "she's been doing it for over 13 years". Several health care providers working with refugees admitted that interpreters are a necessity for them, but at times they are not comfortable with the quality of interpretation or question whether words are being accurately communicated. It was reported that community volunteers lack formal training as interpreters and can interject an overabundance of patient advocacy into the situation. One nurse reported conveying a simple sentence to a refugee and having a community interpreter then talk to the refugee gee for over ten minutes.

In addition to preventive health services, ORR funds a broad range of social services to assist refugees in obtaining employment and/or self sufficiency. All of these social services require the use of interpreter and translator services for almost every refugee entering the country. Reception services ensure that the refugees are met at the airport, and obtain initial housing, furniture, food and clothing for a minimum of 30 days. Counseling and referral services are provided to orient the refugees to the local community and the service system. Employment-related services, such as English language classes, vocational training, vocational counseling, job placement, and health insurance needs are provided by several resettlement agencies with special funding. Many refugees are also eligible for food stamps, AFDC, WIC, Medicaid, and SSI, and ORR funds case management to resettlement agencies to assist refugees in obtaining services for which they are eligible. ORR has also funded special initiatives within its social services to provide services to special populations. The funding for most of ORR's initiatives is administered through state agencies, with the states being responsible for the effective implementation of community-based programs.

J. Administration on Aging

The Administration on Aging (AoA) is responsible for implementing programs funded under the Older Americans Act of 1965, which designates the Assistant Secretary for Aging to act as an official advocate for the elderly within the Federal government and to work with State and local agencies to implement community programs. The AoA funds programs to states and territories based on the numbers of people in each state or territory who are 60 and older. The elderly bring special issues of language and culture into any service system. The project team

discovered that elderly immigrants found learning English difficult, and often resisted learning, retaining use of their native language. Many parents of refugee and immigrant children are brought to this country and find life in the United States bearable only with the help of relatives to interpret or translate. Because of barriers related to culture, language and education, elderly LEP residents are less able to advocate for themselves. The AoA funds programs to work with special minority populations and has close working relationships with minority advocacy groups for the aging.

Administration and Gingrich pleased with Canadian vote. "We are certainly heartened that the United States will continue to deal with a strong and united Canada," said State Department spokesman Nicholas Burns today, referring to Quebec's vote to remain part of Canada. Prime Minister Jean Chretien called President Clinton last night to discuss the vote, said Burns, who added that the President expressed a very strong interest in maintaining good relations with Canada. White House Press Secretary Mike McCurry said: "The President has often said our ethnic diversity here in America is one source of our greatest strength as we look ahead to the 21st century, and hopefully it will be for the people of Canada as well."

This morning, House Speaker Newt Gingrich commented: "And after yesterday's vote in Quebec, I hope there's no remaining serious argument that it would be good for America to become a multilingual society in which we just disintegrate." Added Gingrich: "We currently teach 82 languages in California public schools. Now this is a direction towards the Tower of Babel. And we simply need to reassert that we have a core civilization and that there is a core language. It's good for people to learn second and third languages. But t

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NATIONAL ASSOCIATION for BILINGUAL EDUCATION

NABE REPORT

Bilingual Education: Separating Fact from Fiction

September 18, 1995

Fiction: ***"Studies prove that bilingual education doesn't work."*** [1]

Fact: There is a consensus in the research community both on the soundness of the theory and effectiveness of bilingual education. The culmination of the research consensus is reflected in two studies, covering thousands of Spanish-speaking limited-English proficient (LEP) students, validated by the National Academy of Sciences (NAS) in 1992.

In 1990, the Department of Education asked the NAS to review these studies and critique their findings. The NAS is the most prestigious research body in the world. Composed of researchers and social scientists recognized by their peers as the best in their fields, the NAS is considered the "all-star team" of the research community. When an NAS review Committee can agree on the validity of research, it is believed that a research consensus has been reached.

The NAS review affirmed the finding that LEP students in bilingual education programs made greater academic gains in content areas, like math, than the students who received all instruction in English.[2]

Fiction: ***"Many 'bilingual' programs use the student's native language almost exclusively in the first few years. Students aren't learning English."*** [3]

Fact: This often heard claim is wholly refuted by the studies validated by the NAS. The studies found that English was used the majority of time in bilingual education programs and by the fourth grade only 3 percent of instruction was in the student's native language. Specifically, the studies found that in transitional bilingual education classrooms, English was used 65.8% of the time in Kindergarten, 69.1% in Grade 1, 74.5% in Grade 2, 80.3% in Grade 3, and 97.3% in Grade 4. Even in developmental bilingual programs, where the goal is fluency in both languages, English was used a majority of the time in Grades 3-6. Every bilingual education program has an English as a second language (ESL) component. That is, every bilingual education program includes significant coursework in teaching English language skills.[4]

Fiction: ***"Studies confirm what common sense would tell you: the less time you spend speaking a new language, the more slowly you'll learn it."*** [5]

Fact: The studies validated by the NAS directly addressed and refuted this claim. "The study concluded that providing LEP students with substantial instruction in their primary language does not interfere with or delay their acquisition of English language skills, but helps them to 'catch up' to their English-speaking peers in English language arts, English reading, and math. In contrast, providing LEP students with almost exclusive instruction in English does not accelerate their acquisition of English language arts, reading or math, i.e., they do not appear to be 'catching up.' The data suggest that by grade six, students provided with English-only instruction may actually fall further behind their English-speaking peers. Data also document that learning a second language will take six or more years [regardless of the instructional approach, English-only or bilingual education]."[6]

Students in bilingual education classes posted superior test scores because bilingual education students were allowed to continue to academically and cognitively develop as soon as they entered school through the use of their native language. Bilingual education students were able to problem solve, analyze, and apply critical thinking skills earlier than LEP students in monolingual English settings because they could explore challenging content matter long before students in monolingual English classrooms.

To use an example from Washington, DC, Public Schools, students at the Oyster Bilingual Elementary School -- where the student body is composed of roughly equal numbers of native English- and native Spanish-speakers -- are taught half of the time in English and half of the time in Spanish. Sixth grade students at the school posted scores equivalent to twelfth grade students in English language arts on the California Test of Basic Skills. In other words, sixth grade bilingual education students were not only performing at the level of high school seniors in English, they were also fully literate in Spanish.[7]

Fiction: ***"How difficult can it be to learn English if Berlitz can teach someone to speak English in 30 days?"***[8]

Fact: There is a great difference between the conversational phrases taught by Berlitz and the high-level academic English needed to succeed in school, college, and high-skills job market. The conversational phrases taught at Berlitz and other short-term language programs permit the student to order food, make hotel reservations, or locate a train station. They do not claim to equip students with the ability to write a high school paper, for example, on the symbolism of the white whale in Herman Melville's *Moby Dick*, at the same level as a native English speaker.

In a soon-to-be-published study that mirrors the findings of studies validated by the NAS and many, many others on the length of time for English acquisition, two researchers from George Mason University examined school records of approximately 24,000 language-minority student records per school year with six to ten years of data on achievement in standardized tests, performance assessment measures, grade point averages, and high school courses in which enrolled. Students reached English fluency, as measured by the 50th percentile on an English standardized test, in 5 to 10 years if taught in English only and in 4 to 7 years if taught in bilingual education.[9]

Fiction: ***"Language-minority parents and communities oppose bilingual education."***

Fact: Polls show that language-minority communities solidly support bilingual education. For example, more than 80% of the Latinos interviewed back bilingual education, according to a poll by the *Los Angeles Times*.[10]

Surveys cited by bilingual education opponents always use loaded questions that border on silliness. For example, English First, a national lobbying organization that helps to funnel campaign contributions to English-only supporters, offers this survey question result in theirpromotional material: "the great majority of Hispanic parents -- more than three-fourths of Mexican-American parents and more than four-fifths of Cuban-American parents -- are opposed to the teaching of Spanish **at the expense of English**." [emphasis added] It is almost surprising

that only 75 percent of Hispanics affirmatively answered such a loaded question that way. The question is not whether Hispanic or other language-minority communities want their children to speak Spanish or another native language only, but rather what is the best way to teach an LEP student and does it produce students who speak both English and their native tongue. As this document shows, bilingual education teaches English and is the most effective way to teach children academic content areas.[11]

Fiction: ***"Kids are being placed in bilingual education who can already speak English fluently just because they have a Hispanic or ethnic minority surname."***[12]

Fact: Anecdotes of inappropriate misplacement of non-LEP students in bilingual education are tragic. They reflect terrible education policy that no bilingual educator would condone and are against federal law. There have been no national studies nor evaluations that have even suggested that inappropriate misplacement of non-LEP students into bilingual education is anything but an abhorrent aberration.[13]

What has been well documented is that there are millions of LEP students who are not provided at all with services that enable them to understand instruction. More than a quarter (26.6 percent) of LEP students currently receives no tailored educational services to allow them to understand instruction, in violation of federal law.[14]

Even more troubling is the misplacement of LEP students into special education classes. A class action suit on behalf of over 1,000 Asian immigrant families accused the City of Philadelphia of misplacing their LEP children into special education classes without parental knowledge or consent in the late 1980's. In the initial case that led to the class action, an Asian refugee child was transferred to three separate middle schools but never received any assistance in learning English, in violation of state and federal law. After years in which the child failed to make any academic progress, the school tested him, found him to be mentally disabled, and placed him in a special education class, all without the knowledge or consent of his parents.[15]

Fiction: ***"LEP dropout rates remain very high despite the widespread application of bilingual education."***[16]

Fact: High dropout rates of limited-English proficient (LEP) students cannot be blamed on bilingual education because over three-quarters of LEP students are not taught through bilingual education. Bilingual education is used to instruct only about one in four LEP students. English as a Second Language (ESL) instruction, in which the student's native language is not used for academic instruction, is used to teach just less than half of LEP students. Over a quarter of LEP students receive neither services to teach them English nor assistance tailored to help them understand what is being taught to them. This is often called a "sink-or-swim" approach toteaching LEP students and is in violation of federal law. If a reading of this data suggests anything, it is that lack of bilingual education, an overeliance on ESL, and the prevalence of sink-or-swim approaches to teaching LEP students may be the real culprits in high LEP dropout rates.[17]

Fiction: ***"Bilingual education is impractical because it costs $8 to $11 billion and there are 180 languages spoken by America's students."***[18]

Fact: The $8 to $11 billion estimates of the costs of bilingual education offered by opponents are outrageous but simple to understand. The number reflects the cost of educating LEP students whether or not they are taught using bilingual education instructional techniques. There are approximately 2.3 million LEP students in the U.S., according to the U.S. Department of Education. If this number of students is multiplied by the average cost of educating a student in the U.S., about $5,000, one arrives at the often repeated $8 to $11 billion estimates. As one can see, $8 to $11 billion would be spent on instructing LEP children even if every school in the U.S. chose to use neither bilingual education nor ESL. The true cost of bilingual education is the additional amount of funds that a school expends to change a monolingual English program to a bilingual educational program. This additional cost is limited primarily to the purchase of additional instructional materials, which is marginal.[19]

The large number of language groups would only be a problem for schools if each school had to instruct students from many different language groups. While it is true that most major school districts have many language groups, most schools are linguistically homogeneous. For example, there are over 75 languages represented in the Tucson public schools, however, no single school has more than four languages represented. In Denver, there are 60 identified language groups, yet no more than three languages are spoken in any given school. In these situations, there is no question that bilingual education can, and should, be provided. Nationally, only one quarter of LEP students attends schools in which the numbers and diversity of LEP students would make it impossible to carry out a bilingual education program, according to data from the General Accounting Office.

Even when the numbers are not large and certified teachers sparse, there are many ways to use the students' native language and culture by drawing upon the resources of the language minority communities. In Fountain Valley, California, for example, Project GLAD students, who come from 12 different language groups, receive one hour each day of content and literacy instruction in the native language, taught by paraprofessionals from their communities. Bilingual education in most U.S. schools is not only desirable, but is also possible.

More important, arguments against the practicality of bilingual education forward the absurd proposition that because one LEP student cannot be served, no LEP students should be served. The Supreme Court in *Lau V. Nichols*, the landmark case that requires schools to ensure that LEP students can understand instruction, wrote that states can and should consider the numbers and diversity of their LEP students when considering what services schools can reasonably offer LEPstudents.[20]

Fiction: ***"My grandparents were immigrants and made it without bilingual education or any other special help."***

Fact: While there are surely extraordinary cases, examples of turn-of-the-century immigrants learning English and succeeding in the American job market are exceptions to the rule that are

usually inapplicable to today's high-skills, high-technology labor market. Contrary to the widely accepted myth that earlier immigrant groups managed without special programs, most immigrant children who entered schools were more likely to sink than swim in English-only classrooms. In 1908, for example, just 13% of the twelve-year-olds enrolled in New York public schools, and whose parents were foreign-born, went on to high school, compared with 32% of white children whose parents were native born. Some immigrants with limited English skills and formal education could succeed because the economy, with its industrial and agricultural base, relied on uneducated and unskilled labor. For example, an immigrant factory worker could do quite well for himself with conversational English skills, but the same immigrant with the same conversational English skills would have much greater difficulty securing even an entry level job today with IBM.[21]

Fiction: ***"Bilingual education is a 1960's creation of the federal government."***[22]

There is a tradition of bilingual education in the U.S. that dates from early nineteenth-century American schools. In the public schools of many states between 1839 and 1880 -- including Ohio, Louisiana, and New Mexico -- German, French, and Spanish were used for instruction. Between 1880 and 1917, German-English bilingual schools, in which both languages were used for instruction, operated in Ohio, Minnesota, and Maryland. In several other states, German was included in the curriculum as a subject rather than as a means of instruction. The same is true for Norwegian, Italian, Czech, Dutch, and Polish.

In private schools, mostly parochial, German-English bilingual education flourished throughout the United States before 1800. Also, during this period, many French schools were established in the northeastern United States (precursors of the modern-day Lycee Francais found in New York City, for example) and Scandinavian and Dutch schools were formed in the Midwest.[23]

Fiction: *"Ethnic leaders use bilingual education as a way to keep their constituencies easily manipulated and disenfranchised."*[24]

Fact: Of all the claims made against bilingual education, this is the single most ridiculous. The nation's highest language-minority elected officials -- Members of Congress -- are democratically elected every two years to represent the largest language-minority communities nationwide and millions of Latino voters. All Latino, all Native American, and the overwhelming majority of Asian American Members of Congress support bilingual education as a key to educational and life success. In contrast, those individuals who accuse Latino leaders of disenfranchising theirconstituencies are usually not democratically elected officials and therefore in a poor position to represent the views of language minorities across the country.

Elected officials critical of language-minority leaders invariably do not represent significant numbers of language-minority voters (they hail from places like Wisconsin, Missouri, Kansas, or Georgia) and therefore are in no position to assert the "true" sentiments of language-minority communities. On the other hand, those non-language-minority elected officials who do represent language-minority communities are some of bilingual education's strongest supporters. Indeed, the claim seems to suggest that language-minority voters are incapable of electing representative leaders.

[1] For example, "No evidence exists to back up the claim that teaching children predominantly in their native tongues is better than other instructional models using intensive English, such as English as a Second Language." From Rosalie Pedalino Porter, "Bilingual Ed Flunks Out," *The American Experiment: A Quarterly Publication of the Center for Equal Opportunity*, Spring 1995, p. 1. Porter is Chair of the Research in English Acquisition and Development, Inc. (READ Institute) and is editor of the READ Perspectives publication. READ was founded with funds and assistance from U.S. English, a national lobbying grouping devoted to making English the official, federal language.

[2] Michael M. Myer and Stephen E. Feinberg, Editors, Assessing Evaluation Studies: The Case of Bilingual Education, Panel to Review Evaluation Studies of Bilingual Education, Committee on National Statistics, and Commission on Behavioral and Social Sciences and Education, National Research Council, (National Academy Press: Washington, DC, 1992). The two Department of Education studies reviewed by the NAS are entitled: *The National Longitudinal Study of the Evaluation of the Effectiveness of Services for Language Minority Limited-English Proficient Students* and *The Longitudinal Study of Immersion Strategy, Early-exit and Late-exit Transitional Bilingual Education Programs for Language-Minority Students*. See Appendix A for the members of the Committee on National Statistics and the Panel to Review Evaluation Studies of Bilingual Education of the National Academy of Sciences.

[3] Linda Chavez, "Bilingual Ed the Real Culprit," *USA Today*, Sept. 6, 1995, p. 13A. Linda Chavez is president of the Center for Equal Opportunity (CEO) and former executive director of U.S. English.

[4] *The Longitudinal Study of Immersion Strategy, Early-exit and Late-exit Transitional Bilingual Education Programs for Language-Minority Students*, p. 90-91, as validated by the NAS review.

[5] Linda Chavez, "One Nation, One Common Language," *Readers Digest*, August 1995, page 90.

[6] Executive Summary, *The Longitudinal Study of Immersion Strategy, Early-exit and Late-exit Transitional Bilingual Education Programs for Language-Minority Students*, p. 1, as validatedby the NAS review.

[7] Results reported in D.C. Public Elementary Schools Median Scores and Percentiles from May 1991 Examinations of Comprehensive Test of Basic Skills. The sixth grade students from Oyster Bilingual Elementary School scored at the 12.2 grade level, grade equivalent scores based on national norms.

[8] Paraphrasing of Jim Boulet, executive director, English First, on numerous radio talk shows.

[9] Wayne P. Thomas and Virginia P. Collier, "Research Summary of Study in Progress: Language Minority Student Achievement and Program Effectiveness," George Mason University, 1995.

Publications to come on this series of studies: Report by Lynn Schnaiberg, *Education Week*, September or October 1995; research monograph by Thomas and Collier for the National Clearinghouse on Bilingual Education, late fall 1995; articles in *Bilingual Research Journal* and other education journals in 1996. For other studies on the length of time to acquire academic mastery of a second language see V.P. Collier, "Age and rate of acquisition of second language for academic purposes, *TESOL Quarterly*, 21, 617-641; Collier, "How Long? A Synthesis of research on academic achievement in second language," *TESOL Quarterly*, 23, 509-531; Collier, "A synthesis of Studies examining long-term language-minority student data on academic achievement," *Bilingual Research Journal,* 16 (1-2), 187-212; Collier and Thomas, How quickly can immigrants become proficient in school English, *Journal of Educational Issues of Language Minority Students*, 5; James Cummins, The Role of Primary Language Development in Promoting Educational Success for Language Minority Students, *Schooling and Language minority Students*, California Department of Education, 1981, and Interdependence of first- and second-language proficient in bilingual children, in Bialystok, ed., *Language Processing and Bilingual Children*, Cambridge University Press, 1991, and Bilingual Education and English Immersion: The Ramirez Report in Theoretical Perspective, *Bilingual Research Journal*, 16 (1-2); and F. Genesee, *Learning through two languages: Studies of Immersion and Bilingual Education,* Cambridge, MA: Newbury House, 1987.

[10] Poll reported in *The Los Angeles Times,* Dec. 7, 1992.

[11] English First, "Statement of English First in Opposition to S.B. 88." The president of English First is Larry Pratt, also president of Gun Owners of America.

[12] Jorge Amselle, "When one language is better than two," Opinion Editorial in *The Washington Times,"* August 24, 1995, page A19. He writes: "Bilingual education today means three to five years in a program where as much as 90 percent of child's [*sic*] day is spent in the native language, even if it isn't his or her native language. I have spoken to many parents and teachers all over the country who have similar horror stories."

[13] "Students shall not be admitted to or excluded from any federally assisted education program merely on the basis of a surname or a language-minority status." Section 7502(b)(4) of the Improving America's School Act.

[14] Data from the California Department of Education as reported by Reynaldo Macias, "More LEP Students Receive No Special Services," University of California Language Minority Research Institute, Volume 4, Number 2, p. 1. Data from California, which enrolls 42.1 percent of all LEP students, gives the best description of educational services to LEP students.

[15] United States District Court, Eastern District of Pennsylvania, Class Action Complaint, *Y.S., a minor, by his father, Yin S., and Yin S. and Lim C., individually and on behalf of all others similarly situated, Plaintiffs, v. School District of Philadelphia, Defendant*, No. CA 85-6924.

[16] For example, see Porter, "Bilingual Ed Flunks Out," p. 5. She writes: "Spanish speaking LEP students who have had the heaviest engagement in bilingual programs still have the highest

dropout rates in the country at nearly 50 percent, compared to about 10 percent for English speakers."

[17] Data from the California Department of Education as reported by Reynaldo Macias, "More LEP Students Receive No Special Services," University of California Language Minority Research Institute, Volume 4, Number 2, p. 1. Data from California, which enrolls 42.1 percent of all LEP students, gives the best description of educational services to LEP students.

[18] Rep. Toby Roth and Jim Boulet in English First promotional materials.

[19] Figures from the Office of Bilingual Education and Minority Language Affairs of the U.S. Department of Education for 1992 as reported by State Education Agencies.

[20] Data cited by Senator Edward Kennedy during reauthorization of the Elementary and Secondary Education Act, 1992. *Lau v. Nichols* (1974).

[21] U.S. Department of Education, *The Condition of Bilingual Education in the Nation: A Report to the Congress and the President,* Office of the Secretary, U.S. Department of Education, Washington, DC: 1991, p. 2.

[22] Rep. Peter King, press release entitled "Rep. King Introduces English Language Bill," Spring-Summer 1995. King writes: "Beginning in 1968, however, the federal government began to reverse this proven policy by mandating bilingual education in our schools which meant that students would be taught in their native language rather than in English." Rep. King is author of HR 1005, a bill that would make English the official, federal language of the United States and eliminate bilingual education.

[23] See James Crawford, *Hold Your Tongue: Bilingualism and the Politics of "English-Only,"* Reading, MA: Addison-Wesley, 1992; Arnold H. Leibovitz, *The Bilingual Education Act: A Legislative Analysis*, Washington, DC: InterAMerica Research Associates, Inc., 1980; Diego Castellanos with Pamela Leggio, *The Best of Both Worlds: Bilingual-Bicultural Education in the U.S.*, Trenton, NJ: New Jersey State Department of Education, 1983; and Bill Piatt, *Only English? Law & Language Policy in the United States*, Albuquerque, NM: University of New Mexico Press, 1990.

[24] For example, see Rep. Newt Gingrich, "English Literacy is the Coin of the Realm," Opinion Editorial in *the Los Angeles Times*, August 4, 1995. He writes "Sadly, there are some ethnic leaders who prefer bilingualism because it keeps their voters and supporters isolated from the rest of America, ghettoized into groups more easily manipulated for political purposes often by self-appointed leaders."

English First Leadership Update

Vol. 1 October 31, 1995

The Meaning of the Quebec Vote

"People fear a close result that fails to settle the issue either way, say 51 percent to 49 percent."--*Maclean's,* October 30, 1995, page 32.

(1) The issue is not settled--even right now. Final vote on independence 49.4% Yes, 50.6% No. This may be subject to a recount as at least 85,000 ballots (1% of the total) were rejected, according to the Canadian Broadcast Company last night.

(2) Quebec separatism is stronger even after years of accommodation by English-speaking Canadians. This vote was a major improvement for the pro-independence forces. In 1980, independence lost by 60%-40%.

(3) This narrow election suggests Canada will eventually break apart. The closest election in U.S. history was the 1960 race between Kennedy and Nixon. Nixon carried 49.6% of the vote. Keep in mind that at the time most voters did not see much difference between the two men, leading a Kennedy supporter to write *Kennedy or Nixon: Does It Make Any Difference?* A close vote on candidates who seem similar is to be expected. A close vote on independence from Canada is cause for alarm.

(4) What language schools teach matters. Quebec insists that French be taught in its schools and that immigrants learn French. Both students and immigrants generally have done so. French is much stronger today in Quebec than ever, despite a world in which English is increasingly common, as noted by R. Kent Weaver's *The Collapse of Canada,* pages 91-92.

If schools expect children to learn French (or English), they will do so. If schools expect that children cannot learn French (or English), they will not.

(5) Official bilingualism does not lead to unity. Canada made French a second co-equal language with English in 1969. Eleven years later, Quebec held its first referendum on independence.

Remember that President Clinton Praised Canadian Language Policy

During his February, 1995, speech to the Canadian Parliament, President Clinton spoke of Canada's policies regarding the nation's French speakers. Canada has been officially bilingual for years. Despite this, French-speaking Quebec continues to seek independence.

What did the leader of the free world say about this?

"In a world darkened by ethnic conflicts that literally tear nations apart, Canada has stood for all of us as a model of how people of different cultures can work together in peace, prosperity and respect."

If Canada is a model for our President of how to handle the language question, we should prepare for secessionist movements in Texas and Florida.

Prepared by the legislative staff of English First, 8001 Forbes Place, Suite 102, Springfield, VA 22151 (703) 321-8818 (voice) (703) 321-8408 (fax). Sent free of charge via first class mail. Available free of charge via fax. Permission is granted to freely reproduce and circulate this information, provided credit is given to English First.

NCLR
NATIONAL COUNCIL OF LA RAZA

News Release

FOR IMMEDIATE RELEASE
November 1, 1995

Contact:
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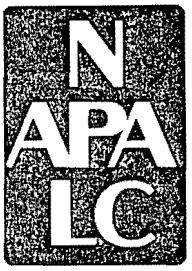
STATEMENT OF RAUL YZAGUIRRE, NCLR PRESIDENT ON LESSONS FROM QUEBEC

Washington, D.C. -- The National Council of La Raza (NCLR) was dismayed to see House Speaker Newt Gingrich invoke the example of Quebec as a reason to adopt English as the official language of the United States. This canard, that somehow the U.S. is headed towards a Quebec-like situation within its own borders, is a old standard sung by those in the English-only movement. And with all due respect to the Speaker's considerable political acumen and his historical expertise, his comparison is deeply flawed and historically inaccurate.

First, as was clear from yesterday's referendum, fully half of those who live in Quebec wish to separate from the rest of Canada, for political and historical as well as cultural reasons. There is no counterpart for the separatist movement here in the United States. The Hispanic community, which English-only advocates seem to fear the most, is overwhelmingly supportive of learning English and are among the most demonstrably patriotic of all Americans. In poll after poll, even recent immigrants have stated an intense desire to become fully American. In fact, if there is a parallel with Quebec, it is that immigrant communities in Quebec, immensely loyal to Canada, were the swing voting bloc which helped defeat the referendum.

Second, much of the divisions in Quebec stem from the unwillingness of the French-speaking majority to accommodate other languages and cultures. French-speaking Quebecers have steadfastly maintained separate institutions that function exclusively in one language, to the detriment of all other groups. This is true not only for English-speaking Quebecers but for new immigrant groups as well, which were subjected to frequent and distasteful immigrant-bashing from the separatists, from the head of the movement on down. The vote of English-speaking and new immigrant Quebecers on Monday was in no small part a repudiation of political monolingualism and an affirmation of cultural pluralism and diversity.

Third, the lesson we can truly draw from Quebec is quite the opposite of what Speaker Gingrich purports -- there is, in fact, an inherent danger in drawing battlelines between those who speak different languages and attempting to legislate the primacy of one language or culture over another, as the English-only movement seeks to do here in the United States. This has caused enormous and painful divisions within Quebec and within Canada which may never heal. It has and will continue to do the same here in our country.



NATIONAL
ASIAN
PACIFIC
AMERICAN
LEGAL
CONSORTIUM

Asian American Legal Defense & Education Fund
New York

Asian Law Caucus
San Francisco

Asian Pacific American Legal Center of Southern California
Los Angeles

PRESS RELEASE

For Immediate Release:
November 1, 1995

Contact: Karen Narasaki
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NAPALC Urges Members of Congress to Oppose English Only Proposals

The National Asian Pacific American Legal Consortium (NAPALC), a non-profit, non-partisan organization, urges all members of Congress to oppose any and all "Official English" and "English Only" legislation. The Asian Pacific American community would be gravely affected by such legislation. One in five Asian Pacific Americans have limited English proficiency (LEP). Prohibiting government employees and agencies from communicating to them in their native language, would impact their access to basic services such as education, police protection, health care and emergency services.

In addition, it would seriously compromise the civil and criminal judicial process. Cases involving LEP parties or LEP witnesses would not get a fair hearing. Moreover, language barriers are one of the greatest barriers to effective law enforcement. Asian Pacific American crime victims have been mistakenly jailed while the real criminals walk away because of communication barriers. Others do not report crimes or cannot assist police or prosecutors because of these barriers. Many would not be able to get 911 emergency assistance if translators were prohibited.

Enactment of any of the proposed measures would jeopardize the education of Asian Pacific Americans. Teachers would be unable to teach or communicate with many of their students if bilingual education were to be eliminated or to become illegal. Nor would the teachers or school administrators be able to talk with the students' parents to discuss problems or to encourage parents' school involvement.

Prohibiting language assistance in hospitals would further limit access to health care for millions of Asian Pacific Americans. Many minorities already do not receive adequate care because of language barriers. Without language assistance, patients cannot communicate symptoms; and doctors cannot explain medical procedures, communicate treatment issues, or even discuss drug dosages or other out-patient needs.

Section 203 has led to increased voter participation. Repealing Section 203 of the Voting Rights Act, which requires bilingual assistance in the voting process in certain areas, would limit the access of Asian Pacific American citizens to the voting booth. For instance, since Los Angeles County provided voting materials in Asian languages, an estimated 25,000 new Asian Pacific Americans have gained access to voting booths. "English Only" legislation would restrict this very access, infringing on these citizens' right to vote.

"Official English" and "English Only" legislation will mean that tax-paying Asian Pacific Americans will not get the services that their tax dollars support. It would endanger their health, safety, and education, as well as their constitutional rights to due process and to vote. If Congress wants to ensure that immigrants learn English, it should instead support funding for English as a Second Language training. Immigrants want to learn English, but there are one- to two-year waiting lists for most courses in urban areas.

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NATIONAL ASSOCIATION *for* BILINGUAL EDUCATION

NEWS RELEASE

For Immediate Release
November 1, 1995

Contact: Rick López
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(202) 898-1829

"THE U.S. IS NOT CANADA"

NABE director urges Hill panel to look carefully at Quebec

Washington, DC -- The Executive Director of the National Association for Bilingual Education (NABE) urged members of a House Subcommittee, which held a hearing on English-Only, to learn from Quebec and not enact an official government language in written testimony today. He also objected to the unfairness of asking seven witnesses to testify in support of English-Only and only one opposed.

"The current divisions within Canada have been exacerbated by the establishment of French as the official language of the provincial government of Quebec," stated James J. Lyons, NABE Executive Director. "Enactment of Bill 101 in 1977, establishing French as Quebec's official language, drove Anglophone residents and businesses from the province. Bill 101 also created a regulatory bureaucracy to police language use in public and private communications. Among the many duties of Quebec's language police include the measurement of commercial signage to ensure that French is always larger than English."

Lyons also emphasized that unlike in Canada, "no responsible person has suggested that the United States should be officially bilingual or that English should be replaced as our common national language," and that "no group of language-minority Americans has ever considered succession from the Union. They are deeply patriotic. American ideals of freedom, democracy, and tolerance -- not language -- have been and always will be the bonds that hold America together."

Lyons opened his testimony lamenting that the hearing was so one-sided with seven witnesses testifying in support of English-Only and only one opposed. "This hearing is imbalanced and unfair to Members of the Subcommittee and the American public. A panel of seven witnesses supportive of English-Only and only one witness opposed to English-Only gives a grossly distorted view of the issue and will not help anyone to make informed policy decisions."

His testimony outlined "10 reasons why English-Only proposals are both highly unnecessary and deeply dangerous," including "English-Only is a debate about new government regulations on language use, not about the importance of speaking English in the U.S." and "English-Only laws would prompt extensive, divisive, and frivolous litigation." The full text is attached.

- ### -

(Editors: The full statement is attached.)

NATIONAL ASSOCIATION for BILINGUAL EDUCATION

Testimony of James J. Lyons, Esq.
Executive Director of the National Association for Bilingual Education
before the House Economic and Educational Opportunities Subcommittee
on Early Childhood, Youth, and Families
November 1, 1995

Mr. Chairman, thank you for the opportunity to submit testimony before the Subcommittee on the topic of "English as our common language."

Let me begin by saying that this hearing is imbalanced and unfair to Members of the Subcommittee and the American public. A panel of seven witnesses supportive of English-Only and only one witness opposed to English-Only gives a grossly distorted view of the issue and will not help anyone to make informed policy decisions.

My name is Jim Lyons and a I am Executive Director of the National Association for Bilingual Education (NABE). NABE is a national, non-profit organization dedicated to improving educational opportunities for language-minority children and to empowering language-minority families. Founded in 1976, NABE and its 26 state affiliates have approximately 15,000 members, drawn from nearly every segment of the educational community. NABE members are teachers, paraprofessionals, researchers, administrators, corporate citizens, and parents. They all have one thing in common: a commitment to top-quality education for language-minority students.

My testimony will be brief. I would simply like to offer the Subcommittee 10 reasons why English-Only proposals are both highly unnecessary and deeply dangerous.

Reason 1: English-Only is a debate about new government regulations on language use, not about the importance of speaking English in the U.S.
You have heard other witness imply that those opposed to English-Only are opposed to speaking English. Nothing could be farther from the truth. Everyone -- English-Only proponents and opponents, immigrants, ethnic minorities, and language minority leaders -- recognizes that it is impossible to take advantage of all the opportunities offered by the U.S. unless one speaks English. In fact, it is organizations like NABE and others who oppose English-Only who are in the front lines offering language minorities the opportunity to learn English and other skills essential to succeeding in America. So the issue is not about the importance of English. Rather -- and I want to underscore this point -- the issue is whether it is necessary or wise to enact new government laws or regulations on language use.

Reason 2: "Official English" is English-Only.
I believe that English-Only is much more appropriate than "Official English" as a way to

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describe the collection of bills before the Subcommittee today. As the ninth circuit court of appeals expressed in its recent decision striking down the Arizona state English-Only case, the purpose and effect of every English-Only bill is to make it illegal for government employees or documents to communicate in a language other than English. Make no mistake, if a government employee were to speak to a taxpayer in Spanish because it was easier to get his or her message across, they would be breaking federal law. Some English-Only bills go further and establish a new federal preference for English in private communications.[1]

Reason 3: English-Only is unnecessary.
Over 97 percent of Americans speak English, according to the Census. It is important to distinguish the ability to speak English and another language and the ability to speak English. Two weeks ago, Congressman Roth testified that over 30 million Americans speak languages other than English. That is true. But what he neglected to say was that the overwhelming majority of Americans who speak foreign languages also speak English. In fact, research shows that today's immigrant are learning English faster than previous generations.[2] In Los Angeles, demand for English class is so great that some schools run 24 hours a day and 50,000 students are on waiting lists. English-Only is also unnecessary because more than 99.9 percent of federal documents are in English, according to a report by the General Accounting Office (GAO).

Reason 4: English-Only laws would prompt extensive, divisive, and frivolous litigation.
The proposed English-Only laws would allow anyone who believes that they have been discriminated against for communicating in English to the federal government to sue in federal court. There are no documented cases of discrimination for communicating to the federal government in English. It could potentially allow those disgruntled with government services to sue over accents or dialects spoken by federal employees. Some proposed English-Only laws would even permit citizens to sue one another in federal court over a violation of the new federal "preference" for English in private communication among citizens.[3]

Reason 5: American ideals of freedom, democracy, and tolerance -- not language -- have been and always will be the bonds that hold America together.
America has remained strong and united because we share a common set of ideals and values based on American political traditions of freedom, democracy, equality, and tolerance. American soldiers in World War II did not fight to "make the world safe for English," but rather

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[1] See Section 162 of HR 739, Declaration of the Official Act of 1995, which states "English is the preferred language of communication among citizens of the United States."

[2] Calvin Veltman, Ph.D., *Language Shift in the United States*, (Berlin: Mouton Publishers, 1983).

[3] See Sections 163 and 164 of HR 123 and Sections 162, 163, and 169 of HR 739.

to "make the world safe for democracy." An official federal language could not have prevented the American Civil War nor could it have prevented the current civil strife in the former Yugoslavia.

Reason 6: The United States is not Canada.
First, no responsible person has suggested that the United States should be officially bilingual or that English should be replaced as our common national language. Second, no group of language-minority Americans has ever considered succession from the Union. In fact, language-minority Americans -- Native Americans, Hispanics, Asian Americans -- are deeply patriotic. They have fought and died for the United States. Third, the current divisions within Canada have been actually exacerbated by the establishment of French as the official language of the provincial government of Quebec. Enactment of Bill 101 in 1977, establishing French as Quebec's official language, drove Anglophone residents and businesses from the province. Bill 101 also created a regulatory bureaucracy to police language use in public and private communications. Among the many duties of Quebec's language police include the measurement of commercial signage to ensure that French is always larger than English.

Reason 7: English-Only gives government officials open license to regulate how Americans talk.
In 219 years of American history, the federal government has neither had an official language nor involved itself in regulating how people talk. By inaugurating a new and an unprecedented role for the federal government, English-Only laws embolden government officials who have already twisted the law to prohibit the speaking of any language but English. In a Texas child custody case, a State Judge threatened to remove a child from custody of her mother because the mother had spoken Spanish to her daughter. The Judge equated the mother's use of Spanish with "child abuse." Indeed, federal regulation of language use is similar to federal regulation of religion. Just as the U.S. has never established an official, federal religion, in contrast to other nations, the U.S. would be ill-served by establishing an official, federal language.

Reason 8: English-Only laws make government more expensive and less efficient.
As the Ninth Circuit Court of Appeals noted in recently striking down the Arizona State English-Only mandate, the use of a language other than English can make it easier to serve taxpayers. In the Arizona case, a bilingual state employee found it easier, quicker, and less expensive to collect medical malpractice information from claimants who were more comfortable conversing in Spanish. The Arizona English-Only mandate outlawed government communication in Spanish or other languages. Federal English-Only laws would outlaw communication between Members of Congress and their constituents in any language but English and prohibit federal law enforcement agents from using languages other than to English to gather information on a crime.

Reason 9: English-Only disconnects millions of Americans from their government.
For millions of American citizens and nationals on the island of Puerto Rico, Native American reservations, or U.S. territories in the Pacific, the right to communicate in a native language is

protected by treaty or custom. It is counterproductive and dangerous to forbid elderly language-minority Americans, who have a difficult time learning English, or those in the process of learning English from communicating with their government. English-Only laws would also forbid official use of American Sign Language (ASL), preventing government communication with the hard of hearing.

Reason 10: America should be thinking how to learning more, not fewer, languages.
Four of five jobs in the U.S. are created through exports, and the majority of exports jobs are service-related. To succeed, American business must follow the credo of a sage Japanese salesman. When asked if English was the most important language to know in international business, he replied: "Not necessarily. The most important language to know is the language of the customer." In this regard, the 32 million Americans who speak languages in addition to English are at a competitive advantage.

A similar point with regard to tourism to the U.S. was made by Congressman Toby Roth, Chair of the Congressional Travel and Tourism Caucus, in an article in the October 30, 1995, *Roll Call* newspaper:

> In today's changing world of high technology and increasing mobility, tourism is an economic sleeping giant. Futurist John Naisbitt writes: 'The more exposure we have to other cultures, languages, and landscapes, the stronger our desire to experience them firsthand. These days everyone wants to reach out and touch someone; we are increasingly likely to do so by airplane as much as by telephone." Naisbitt is right. In 1995, travelers in the United States will spend an estimated $535 billion. They will support 14 million jobs and $493 billion in wages and salaries. The revenue generated by travel and tourism will total $127 billion in federal, state, and local taxes.[4]

Ironically, English-Only legislation, including the measure sponsored by Congressman Roth, would outlaw signs at government owned tourist attractions that include languages of international tourists, customs brochures printed in languages of international tourists, or government provided tourist information in languages of international tourists.

Thank you and I would be happy to answer any questions the Subcommittee may have.

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[4] Rep. Toby Roth, "An Economic Sleeping Giant," *Roll Call Policy Briefing on Travel and Tourism*, October 30, 1995, page 3.

Common Cause

State Issue Brief

January 1994

English as the Official Language

[An English language] amendment is not just a symbolic bolster of the English language. It will disenfranchise voters. It will endanger public safety. It will put up barriers, not tear barriers down, for those seeking to improve their proficiency in English. It will set up a class of 'outsiders' — unable to communicate with their government, and their government unable to communicate with them — all based on language. ... Make no mistake about it — this legislation would be a giant step backward in our efforts to achieve equal opportunity for all Americans.

— U.S. REPRESENTATIVE NORMAN MINETA (D-CA)

Common Cause

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Introduction

During the November 1989 Common Cause National Governing Board meeting, the Board passed the following motion:

> Resolved, that the National Governing Board authorize state organizations, if they so desire, to oppose the adoption of any English as the official language statute or constitutional amendment.

As a result of the vote, opposition to English as the official language statutes or constitutional amendments was added to the list of state issues approved for state action, without the need for authorization by the Special Committee on State Issues.

This issue brief is designed to provide state organizations which are interested in opposing "Official English" measures with background information on this topic.

Background

The potential exists for Official English measures to abridge the civil rights of non-English-speaking and bilingual people in areas such as voting and the criminal justice system. These measures have the potential to interfere with access to education, emergency assistance and social services.

In several states and localities across the country there have been efforts in recent years to make English the official language. While resolutions have been introduced in Congress calling for an English language amendment to the Constitution, these measures do not appear to be moving forward. Activity on this issue, thus, is concentrated at the state and local level.

In 1988, two Common Cause state organizations, Arizona and Colorado, received special permission to oppose efforts to make English the official language. In 1991, after the issue was added to the pre-approved list of state issues, Common Cause/Missouri opposed an official English measure, which was later defeated.

This issue has been raised periodically throughout the history of our nation. As early as 1780, official English measures were suggested and efforts surfaced again in the mid-1800s and early 1900s.[1] In the 1980s there was a resurgence of the Official English movement. There are now 16

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[1]The American Bar Association's Section on Individual Rights and Responsibilities, paper presented to its House of Delegates, June 1988, pp.4-5.

states with statutes or constitutional provisions in varying forms which make English the state's official language (see chart on page seven).

In 1988 at least 30 state legislatures debated Official English bills.[2] In 1990, measures were introduced in 14 states, including implementing legislation in California and Florida.[3] Under California and Florida law, the legislature must pass implementing legislation in order to put a constitutional amendment into effect. In 1991 and 1992 Official English measures were introduced in at least eight states, but all of the measures were defeated.[4] In 1993, attempts to pass English-only measures occurred in the legislatures of at least six states -- Georgia, Massachusetts, Maryland, Ohio, Pennsylvania and Wisconsin. Three of the bills were defeated in committee, Pennsylvania's bills remain in committee, and the Ohio and Wisconsin bills had not received a hearing as of December 1993.

Two court decisions may significantly affect future efforts to establish English as the official language. An Official English constitutional amendment, which was passed by initiative in Arizona in 1988, was struck down by a federal district court in February 1990 on the grounds that it violated First Amendment rights of free speech. Previously, in July 1989, a federal court struck down a Pomona, California ordinance that had required all commercial signs containing foreign alphabetical characters to also contain at least 50 percent English alphabetical characters on the grounds that it violated the First and Fourteenth Amendments of the Constitution.[5]

Since 1989, a decreasing number of Official English measures have been introduced each year and the momentum behind such measures appears to have slowed noticeably.

I. BRIEF HISTORY

As noted earlier, the current movement to make English the official language of the United States is not without precedent. While English has been the predominant language of the United States since colonial days, there have been periodic movements to make English the official language or to bar the use of other languages. These movements typically have coincided with the arrival of waves of immigrants from non-English-speaking countries.

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[2] *Official English/English Only: More Than Meets the Eye*, National Education Association, 1988, p.5.

[3] These states were: California (implementing legislation), Florida (implementing legislation), Iowa, Kansas, Minnesota, Missouri, New York (introduced in both the Senate and Assembly), Ohio, Pennsylvania, Rhode Island, Utah, Vermont, Wisconsin and West Virginia. (*EPIC Events*, March/April 1990, pp.2-4.)

[4] In 1992, these states were: California, Maryland, Massachusetts, Missouri, New Jersey, New York, Ohio and Pennsylvania.

[5] *Asian Week*, July 28, 1989, p.4.

In 1780, John Adams suggested creating an "official language academy" with the aim of "refining, improving and ascertaining the English language." Adams sought a way to "maintain linguistic and cultural unity among separate colonies." His idea was rejected as undemocratic.[6] In the 1870s, the anti-Chinese Workingmen's Party fought for Official English laws in California.[7] In 1911, the Federal Immigration Commission issued a report contrasting "old" and "new" immigrants. The report argued -- in terms remarkably similar to those being used today -- that while "old" immigrants assimilated well, "new" immigrants were less willing to learn English. As a result, English literacy requirements were enacted as conditions for public employment, naturalization, immigration and suffrage.[8] In 1919, Teddy Roosevelt stated:

> We have room for but one language here and that is the English language, for we intend to see that the crucible turns out people as Americans and not as dwellers in a polyglot boarding-house.[9]

Anti-German feelings during and after World War I resulted in some states banning German.[10] During this same time period, 20 midwestern states enacted laws to bar schools from teaching German.[11]

However, in 1980, only two states had official English laws on the books -- Nebraska's constitutional amendment of 1923, which was passed during a wave of anti-German sentiment because of World War I, and Illinois' 1969 statute amending a 1923 law declaring "American" the state's official language.[12] The majority of state Official English measures have passed within the last decade.

Bilingualism also has a long history in this country. In the earliest days of our nation, the Continental Congress printed various official documents in German.[13] In the early 1800s,

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[6]The American Bar Association's Section on Individual Rights, paper presented to its General Assembly, June 1988; p.4. See also "A National Language Academy? Debate in the New Nation," *International Journal of the Sociology of Language*, 1976, pp.19-22.

[7]*Official English/English Only: More Than Meets the Eye*, National Education Association, April 1988, p.15.

[8]"Declaring English the Official Language: Prejudice Spoken Here," *Harvard Civil Rights Civil Liberties Law Review*, vol.24, no.2, Spring 1989.

[9]*Not Only English: Affirming America's Multilingual Heritage*, Harvey A. Daniels, Ed., National Council of Teachers of English, 1990, p.8.

[10]"Declaring English the Official Language: Prejudice Spoken Here," *Harvard Civil Rights Civil Liberties Law Review*, vol.24, no.2, Spring 1989, pp.297-298.

[11]*Official English/English Only: More Than Meets the Eye*, National Education Association, April 1988, p.16.

[12]*EPIC Events*, vol.2, no.5, p.1.

[13]*Official English/English Only: More Than Meets the Eye*, National Education Association, April 1988, p.15.

bilingual German-English public schools were common.[14] Louisiana published ballots in English and French.[15] California printed its original state constitutional proceedings in both Spanish and English and was officially bilingual for 30 years in the mid-1800s.[16] New Mexico was officially bilingual for 20 years in the early 1900s.[17] Its constitution called for "the bilingual publication of official documents" in English and Spanish.[18] And Hawaii has been officially bilingual since 1978.[19]

In 1923, by striking down a state criminal statute that barred individuals and schools from teaching in a language other than English to anyone who had not completed the eighth grade, the U.S. Supreme Court, in Meyer v. Nebraska, cited the due process clause of the 14th Amendment in support of the right to teach in a language other than English. In 1974, the Supreme Court ruled in the case of Lau v. Nichols that failure to provide education to Chinese students in their native tongue violated Title VI of the 1964 Civil Rights Act, which prohibits discrimination based on "national origin." The Court further ruled that a school district receiving federal aid was required to "take affirmative steps to rectify the language deficiency in order to open its instructional program to these students."

In 1975, Congress amended the Voting Rights Act of 1965 to require bilingual election materials, including voting ballots, in counties with significant minority language groups (see page 14).

II. CURRENT STATUS OF OFFICIAL ENGLISH

The leading advocates for constitutional amendments at both the state and national levels are two organizations, U.S. English and English First. The largest of the two, U.S. English, is a national nonprofit organization which, according to information provided by the organization, had 500,000 dues-paying members in 1992 and spent more than $5 million in 1990. Founded in 1983 by the late Senator Samuel I. Hayakawa (R-CA), the group's stated goals are to adopt a constitutional amendment to establish English as the official language of the United States,

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[14] *Not Only English: Affirming America's Multilingual Heritage*, Harvey A. Daniels, Ed., National Council of Teachers of English, 1990, p.80.

[15] *The Orlando Sentinel*, May 24, 1993.

[16] *Official English/English Only: More Than Meets the Eye*, National Education Association, April 1988, p.15.

[17] *State Update and Strategy Options*, English Plus Information Clearinghouse, April 3, 1989, p.5.

[18] *The Orlando Sentinel*, May 24, 1993.

[19] *EPIC Events*, January/February 1989, p.5.

repeal laws mandating multilingual ballots and voting materials, and restrict government funding for bilingual education to short-term transitional programs only.

In March 1992, allegations of misappropriation of funds, improper political contributions, and other financial improprieties led to a highly publicized shakeup within U.S. English. Accused of using organizational funds for personal use, as well as for political activities violating the organization's tax-exempt status, U.S. English's chair resigned and the newly appointed chair announced the closure of the group's Los Angeles and San Francisco offices.

In early 1992, the organization began efforts to soften the message of the English-only movement, using new phrases such as the "common language movement" and "English as the *primary* language of government." Susan Armsby of People for the American Way warned opponents of English-only legislation to beware of this "gentler rhetoric," noting that, "By any name, it's all motivated by the same impulse: marginalize, ostracize and penalize those with limited-English proficiency."[20]

Despite its problems in 1992, U.S. English launched a new $1.6 million "National Voter Education Project" targeted at Members of Congress who resisted the Official English movement. The organization ran a series of advertisements from May to November in publications across the country -- specifically in districts with closely contested races -- asking voters to tell the 297 House members who did not co-sponsor the national Official English bill to do so, "Because you can turn them around. Or turn them out." The bill died in committee in 1992.

In 1993, the organization was found to be out of compliance with the Better Business Bureau and the National Charities Information Bureau's standards for charities. The standards that were not complied with include one requiring that a reasonable percentage (at least 50 percent) of total income and public contributions be applied to programs and activities for which the organization exists and another requiring that total fundraising and administrative costs not exceed 50 percent of total income.[21]

The other leading organization supporting an English language amendment, English First, was formed in 1986. English First claims 200,000 dues-paying members and a $2 million budget (although the group's 1991 financial disclosure form filed with the Internal Revenue

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[20] *EPIC Events*, March/April 1992, p.2.

[21] Copies of the report can be obtained from the Council of Better Business Bureaus, Philanthropic Advisory Service, 4200 Wilson Boulevard, Arlington, VA 22203 or the National Charities Information Bureau, 19 Union Square West, New York, NY 10003.

Service lists only $800,000 in expenditures).

At the state level, a few groups have fought for Official English measures. For example, the California Committee for Ballots in English worked for an Official English ballot initiative in 1984, and the American Ethnic Coalition was formed to press for an Official English constitutional amendment in Texas. In a number of states, U.S. English has established statewide offices such as the Alabama English Committee, Florida English and Arizonans for Official English, to fight for Official English measures.

State Official English provisions

In June 1990, Alabama voters approved a state constitutional amendment proclaiming English as the state's official language. The initiative passed with an overwhelming 89 percent of the vote. Prior to that, in the 1988 elections, voters in three states -- Arizona, Colorado and Florida -- had passed similar ballot measures. In Arizona, the measure passed by a narrow margin of 51 percent to 49 percent of the vote. Coloradans, by a clear majority of 61 percent to 39 percent, voted in favor of Official English. And in Florida, official English captured an overwhelming majority with 84 percent of the vote.

Currently, 16 states make English the state's official language -- 11 by statute and five by state constitutional amendments. However, no enabling legislation has been enacted in California or Florida.[22] Fourteen of the 16 states approved Official English measures within the ten years from 1980 to 1990. No attempts to enact Official English measures have been successful since 1990. In fact, a number of measures have been overturned in the past four years, including the 1988 Arizona Official English Amendment that was declared unconstitutional in 1990.

The wording of the various laws ranges from a simple statement declaring English as the official language, to specific proscriptions as to the acceptable use of languages other than English. States with older legislation tend to have simple statements, while states with more recent legislation tend to have the most detailed and far-reaching measures.

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[22] *The Orlando Sentinel*, May 18, 1993.

Following is a chart of the current status of official language measures:

OFFICIAL ENGLISH MEASURES IN THE STATES[23]

State	Year Passed	Legislation
Nebraska	1923	Constitutional Amendment
Illinois	1969[24]	Statute
Virginia	1981	Statute
Indiana	1984	Statute
Kentucky	1984	Statute
Tennessee	1984	Statute
California	1986	Constitutional Amendment
Georgia	1986	Statute
Arkansas	1987	Statute
Mississippi	1987	Statute
North Carolina	1987	Statute
North Dakota	1987	Statute
South Carolina	1987	Statute
Colorado	1988	Constitutional Amendment
Florida	1988	Constitutional Amendment
Alabama	1990	Constitutional Amendment

The American Bar Association's Section on Individual Rights and Responsibilities described the situation in a June 1988 paper:

> While many states that have enacted English-only legislation in the past see the law as wholly symbolic, akin to a state tree or a state bird, the clear trend in light of the 1986 passage of Proposition 63, California's English Language Amendment, is to make English-only legislation increasingly restrictive. Far from symbolic, such measures provide a private right of action for individuals to challenge state and local government use of any language other than English.[25]

Legislation in six states consists of a concise statement, such as the law in Illinois, which states, "The official language of the State of Illinois is English."[26] Nebraska's constitutional amendment states that English is the official language of the state and that "all official proceedings, records and publications shall be in such language, and the common school

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[23]This chart is from the March/April 1991 issue of *EPIC Events*. Hawaii is officially bilingual, with Native Hawaiian and English as coequal languages.

[24]Illinois declared "American" its official language in 1923. The statute was amended in 1969 to "English."

[25]This report was written by the Section on Individual Rights and Responsibilities of the American Bar Association and was presented to its House of Delegates with a recommendation to oppose any Official English measures.

[26]These states are: Georgia, Illinois, Indiana, Kentucky, Mississippi, and North Dakota. [*CRS Report for Congress: States Designating English as the Official State Language*, Congressional Research Service, The Library of Congress, March 9, 1988, (Revised April 20, 1989; Revised again, January 22, 1992).]

branches shall be taught in said language in public, private, denominational, and parochial schools."[27] Measures in four other states say, in addition, that the legislature has the power to enforce the measure through legislation.[28] Four state laws name specific activities that are exempt from the Official English rule, such as the law in Arkansas, which states, "This section shall not prohibit the public schools from performing their duty to provide equal educational opportunities to all children," or the North Carolina law, which says, "[This section] shall not permit the Division of Motor Vehicles to discontinue providing driver's license examinations in any language previously administered."[29]

Some states have laws both declaring English as the official language and specifically prohibiting certain activities in any language other than English. For example, in Tennessee the law states, "English is hereby established as the official and legal language of Tennessee. All communications and publications, including ballots, produced by governmental entities in Tennessee shall be in English, and instruction in public schools and colleges of Tennessee shall be conducted in English unless the nature of the course would require otherwise."

Alabama and California have the most far-reaching English language amendments, containing provisions declaring English as the official language and stating that no law can be enacted requiring a language other than English to be used. A critical way in which these amendments are distinct from other state official English measures is through the inclusion of an enforcement provision. Persons residing in or doing business in Alabama or California are allowed to bring suit against their state to enforce the law in court.

Municipal-level Official English provisions

In addition to the 16 states with Official English provisions, many local governments have adopted such measures. An October 6, 1986 *U.S. News and World Report* article noted that such measures have been enacted in 39 municipalities, from Los Altos, California to Elmira, New York.

However, in May 1993, the county commissioners of Dade County, Florida voted to repeal Dade's landmark Official English county ordinance -- the passage of which marked the

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[27] *Ibid.*

[28] These states are: Alabama, California, Colorado and Florida. (*Ibid.*)

[29] The other two states are South Carolina and Virginia. (*Ibid.*)

birth of today's English-only movement. According to leaders of the English-only movement, this is the first time an Official English measure has been repealed.[30]

The ordinance was approved in 1980 by 57 percent of voters in Dade County, which includes the city of Miami. It prohibited using county funds "for the purpose of utilizing any language other than English or promoting any culture other than that of the United States." According to an October 26, 1986 *New York Times* article, after passage of the ordinance "the county stopped translating documents and signs into Spanish, and the Latin Affairs office was cut back." Originally, the ordinance exempted activities that were required by federal law, such as bilingual education programs and election ballots. In 1984, the county commission amended the ordinance to exempt as well, medical, social and emergency services from the English-only rule.

Implementing the ordinance -- and its exemptions -- led to county agencies splitting hairs. For example, "warnings about the electrified third rail in transit stations [were] in both languages. Directions and information in those stations, however, [were] in English only, since they do not involve public safety."[31]

At the time of the 1980 census and the passage of the English-only law, non-Hispanic whites comprised 48 percent of Dade County's population, Hispanics made up 35 percent and blacks were 17 percent. According to the *Orlando Sentinel*, "Today, half of Dade's residents are Hispanic, 30 percent are non-Hispanic whites and 20 percent are black."[32]

In April 1993, as a result of district elections ordered by a Federal Court, the largely Anglo at-large Metro-Dade commission was replaced with six Hispanic, four black and three white members. One month later, after embittered debate and a heated public hearing, the commission voted unanimously to overturn the Official English ordinance.

Groups as varied as the National Association for the Advancement of Colored People (NAACP), the Greater Miami Chamber of Commerce and the Anti-Defamation League of B'nai B'rith supported the repeal. However, Citizens of Dade United, which supported the Official English law, sued the county on the grounds that the commission had no authority to repeal a voter-passed ordinance. A Dade County Circuit Judge upheld the commission's

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[30]"Dade County's English-Only Ordinance may be Repealed," National Public Radio Morning Edition, May 18, 1993.

[31]*Governing*, August 1988, p.67.

[32]*The Orlando Sentinel*, May 18, 1993.

action in 1993.[33]

In other municipalities many English-only laws remain.

In Lowell, Massachusetts, where there has been a marked increase in the number of Hispanic and Cambodian immigrants in recent years, a measure making English the city's official language and requiring most city business to be conducted only in English was approved in November 1989.[34]

In early 1989, the county commission in Suffolk County, New York considered, but defeated, a proposal to make English the county's official language. This proposal, which the *New York Times* called "more restrictive than those proposed elsewhere," would have required anyone contracting with the county to conduct their county business solely in English. According to a February 26, 1989 *New York Times* article, under this law, bilingual doctors, consumer advocates, social workers and child-abuse investigators – presumably those under contract with the county – would have been forbidden to speak Spanish to clients. Most county business, brochures and pamphlets would have been required to be conducted or printed in English only. In addition, a February 14, 1989 *New York Times* article stated that this provision would have "blocked the creation of bilingual county jobs and barred the County Human Rights Commission from investigating complaints stemming from the county's conducting its business in English." In fact, this law would have gone so far that U.S. English withheld its support and called the provision "counterproductive." In particular, U.S. English objected to the provision that would have barred investigations of complaints.

Congressional Official English proposals

In 1981, an English language amendment to the United States Constitution was introduced in Congress. Similar legislation has been reintroduced in succeeding Congresses, but has never made it to the House or Senate floor for a vote.[35]

In the 103rd Congress, Representative John Doolittle (R-CA) was the primary sponsor of the English language amendment, H.J. Res. 171. The resolution proposed to amend the U.S. Constitution to make English the official language which "shall be used for all public acts

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[33] *The Phoenix Gazette*, August 6, 1993.

[34] *The New York Times*, February 8, 1990.

[35] *Official English/English Only: More Than Meets the Eye*, National Education Association, April 1988, p.8.

including every order, resolution, vote or election, and for all records and judicial proceedings of the Government of the United States and the Governments of the several states." No similar legislation was introduced in the Senate. If an amendment were to be considered in this or a succeeding Congress, passage would be difficult because constitutional amendments must be approved by a two-thirds majority of both houses of Congress and then ratified by three-fourths of all the states.

During the 103rd Congress, Representative Bill Emerson (R-MO) reintroduced his "Language of Government Act," H.R. 123, which would not amend the constitution, but is designed instead to alter Title IV of the U.S. Code. The bill: declares English the language of the government; obligates the preservation and enhancement of the English language; prohibits discrimination against individuals who speak only English; and gives U.S. residents the right to sue if they feel the law is being violated.

H.R. 123 was introduced in January 1993 as part of a three-tiered "Language for All Peoples Initiative" designed to counteract criticisms that parts of the previous proposal were xenophobic. It contains a companion bill, H.R. 124, which provides a tax credit to employers for 50 percent of employees' qualified language training expenses, and a Sense of the House Resolution, H.Con.Res. 13, recognizing "the cultural importance of the many languages spoken in the U.S. and ... that the United States should maintain the use of English as a language common to all peoples."

As of December 1993, H.R. 123 had 88 cosponsors in the House of Representatives. A similar bill had 138 cosponsors at the end of the 102nd Congress, but it failed to get a committee hearing and died at the end of the session.

Senator Richard C. Shelby (D-AL) introduced S. 426, a Senate counterpart to the "Language of Government Act," in February 1993.[36] Shelby's bill did not include the other parts of Representative Emerson's "Language for All Peoples Initiative". This bill also did not receive a hearing in the first session of the 103rd Congress. A similar bill died without a hearing in the last Congress.

In addition to these bills, Representative Toby Roth (R-WI) introduced the "Declaration of Official Language Act" in February 1993. The act, H.R. 739, declares that "English is the preferred language of communication among citizens of the United States" and extends the

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[36] *EPIC Events*, April/May 1993, p.2.

scope of the bill to the government's promotion of English in personal and business communications. It also outlines "duties of citizenship" providing that "all United States citizens should be able to read, write, and speak English to the full extent of their physical and mental abilities." To this end H.R. 739 seeks to make naturalization requirements more restrictive and repeal all federal bilingual education and voting rights programs. According to Julie Inman, a policy analyst with the Joint National Committee for Languages, which opposes English-only measures, Roth's bill poses "a much greater threat to language freedom than H.R. 123, the Language of Government Act."[37]

H.R. 739 is supported by English First, which strongly opposes bilingualism. The bill received a hearing in August 1993 and as of December 1993 has been cosponsored by 54 Representatives. No companion bill has been introduced in the Senate.

III. PROBLEMS WITH OFFICIAL ENGLISH

> To many, it seems counter-intuitive to vote against English-Only proposals. English is indisputably the primary language of the United States. Ninety-eight percent of the inhabitants of this country speak English well or very well. Thus, declaring English the official language seems benign; why not declare "official" what all of us know to be true -- that English is the national language? However benign it may seem, the declaration of an "official" language would also be used as a tool for prejudice. ... The leaders of the English-Only movement focus their public arguments on the goal of national unity. Hidden inside this velvet glove is the iron fist of prejudice and discrimination.
>
> -- Antonio Califa, *Harvard Civil Rights Civil Liberties Law Review*

The impact of Official English on civil rights

Official English proponents such as English First argue against providing bilingual ballots and publicly funded interpreters in criminal proceedings. But the electoral and criminal justice systems are critical to the rights of all Americans, and restricting access to them could threaten the civil rights of non-English-speaking people.

Proponents of English as the official language also argue for the elimination of government services in any language other than English. This action could interfere with access to education, social services and emergency services for non-English-speaking people. In 1991, Antonio Califa, legislative counsel for the American Civil Liberties Union (ACLU),

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[37] *EPIC Events*, February/March 1993, p.2.

noted that 21 U.S. government agencies provide information in languages other than English; in addition, many agencies provide grants to community service organizations that provide services in non-English languages. The Federal Communications Commission grants licenses to TV and radio stations to broadcast in languages other than English. According to Califa, "Passage of 'English-Only' laws would jeopardize the granting of these licenses and grants, and the distribution of information."[38]

In a June 1988 paper, the American Bar Association's Section on Individual Rights and Responsibilities said:

> This movement threatens to make the lack of English language proficiency a legal barrier to the enjoyment of the equal rights, opportunities and services that should be available to all Americans. English-only legislation threatens to interfere with many aspects of popular access to government and social services. Thus, bilingual emergency services, fire prevention literature, hospital care, court interpreters for victims, housing assistance for the elderly, and many equally important services are all jeopardized when English-only legislation is enacted. ... Proposed constitutional amendments ... have the potential to sweep away fundamental rights of persons charged with crimes and to deny equal access to justice to individuals who are limited-English proficient.

At a 1991 conference on Language Pluralism in the United States, People for the American Way's Susan Armsby described the aftermath of implementing English-only in Dade County, Florida:

> [C]ounty funds could not be used to print bilingual fire prevention literature -- in fact, the fire department could not even distribute the bilingual literature already in its possession. County hospitals could not distribute information on pre-natal care in languages other than English. All county public hearings, meetings and publications were only in English. Marriage ceremonies in Spanish were prohibited and public transportation signs in Spanish were removed. In 1984 the law was amended to allow the use of other languages in certain limited circumstances.[39]

As described on page nine, the Dade County English-only ordinance was repealed in 1993.

In his 1991 testimony before the Committee on State Administration, Massachusetts State Representative Nelson Merced gave examples of discrimination in states where official English laws have been passed:

- bilingual 911 operators have been eliminated;

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[38]Antonio Califa, "The Attack on Minority Language Speakers in the United States," August 11, 1991, p.11.

[39]*Krasniy, Blanc and Azul: The English Plus American*, Susan Armsby, People for the American Way, April 13, 1991.

- hospitals have eliminated interpreter services; and
- public health agencies have eliminated bilingual education programs around AIDS prevention, prenatal care and substance abuse and prevention.[40]

Representative Merced also stated:

> The truth is that the English Only movement is not about making English the official language; it is about legitimizing discrimination on the basis of language. "English Only" is a wolf in sheep's clothing.

Bilingual voting ballots

Although Official English supporters are pushing for the elimination of voting ballots printed in languages other than English, bilingual voting ballots are protected by federal law. In 1975, Congress amended the Voting Rights Act of 1965 to require bilingual election materials, including voting ballots, in counties meeting two criteria. First, more than five percent of the voting-age population must be of a single language-minority group. Second, the English illiteracy rate of the language-minority group in the state or jurisdiction must be higher than the national English illiteracy rate.[41] In 1982, Congress amended the first provision to require that members of a single language-minority group constituting five percent of the voting-age population not be able to "speak or understand English adequately enough to participate in the electoral process."[42] Also in 1982, Congress extended the bilingual provisions of the Voting Rights Act until 1992.

In 1992, Congress extended the bilingual provisions for 15 more years. The reauthorization included two amendments to expand coverage of the Act to Native Americans, as well as large populations of language minorities in large metropolitan areas, previously not covered. The first amendment modifies the threshold for coverage, requiring jurisdictions to provide language assistance to members of a single-language minority if they total either five percent of the voting-age population or 10,000 citizens of voting age in a county. The second amendment provides an alternative coverage standard for Native Americans, requiring counties with reservations to provide assistance where more than five percent of the Native American voting-age population of the reservation has limited English proficiency.

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[40]Statement of Rep. Nelson Merced before the Committee on State Administration, H.3498, H.4797, April 1, 1991, pp.2-3.

[41]"Declaring English the Official Language: Prejudice Spoken Here," *Harvard Civil Rights Civil Liberties Law Review*, vol.24, no.2, Spring 1989, p.306.

[42]Minority Language Provisions, chapter 6, p.15.

Throughout the floor debate on the reauthorization, Members of Congress reaffirmed the importance of providing voting assistance to language minorities:

- Bilingual voting materials do not divide us. Rather, they unite our Nation by bringing groups who have been the recipients of pervasive discrimination into the political arena, a process which joins millions of Americans.
  – Congressman Bill Richardson (D-NM), July 23, 1992

- Providing bilingual voting assistance is a way of encouraging citizens to participate in the most American of institutions – the political process. By giving language minorities a reason to believe in American Government and by giving them a way to become invested in the decisions our Government makes, bilingual voting assistance can cultivate a sense of patriotism and civic duty that is sorely needed in today's anti-Government climate.
  – Congressman Solomon Ortiz (D-TX), July 24, 1992

- If you want to encourage someone to learn to speak English and become fully integrated in society in every way, get them involved in the political process. But if they feel they have no stake in the political process because they cannot even go in and read the ballot with any degree of certainty, then what stake do they have?
  – Senator Joseph Biden (D-DE), August 6, 1992

The Justice Department monitors adherence to the law and in March 1993 successfully sued Dade County, Florida for failing to distribute voter information in Spanish. *The New York Times* reported that a Federal district judge "ruled that the Dade County attorney had misinterpreted the 'letter and spirit' of the Federal Voting Rights Act,"[43] which required the county to print and distribute new voting information in Spanish. Dade County's English-only law was repealed one month later (see page nine).

Employment practices

Official English provisions may also result in unfair employment practices. Hiring practices of employers who restrict the use of any languages other than English could result in discrimination against people who are not fluent in English.

In 1987, the Equal Employment Opportunity Commission (EEOC) established a guideline saying that a rule requiring employees to speak only English in their work place was a burdensome condition of employment. The guideline states:

> The primary language of an individual is often an essential national origin characteristic. Prohibiting employees at all times, in the work place, from speaking

[43] *The New York Times*, March 19, 1993.

> their primary language or the language they speak most comfortably, disadvantages an individual's employment opportunities on the basis of national origin. It may also create an atmosphere of inferiority, isolation and intimidation based on national origin which could result in a discriminatory working environment.[44]

Examples of negative effects of Official English provisions on employment practices have been cited in California, which has an Official English law. A December 5, 1988 *Time* magazine article reported that, "The manager of an insurance company in Los Angeles ordered Chinese-American staffers to speak only English unless they were dealing with a Chinese-speaking customer."

And in August 1988, *Governing* magazine pointed out that the ACLU of Northern California had been "receiving complaints about work place rules barring employees from speaking their native languages to one another." Ed Chen, staff counsel with the group, was quoted as saying, "You can't help but think that these kinds of policies are finding some sort of support in a law like Proposition 63 (California's Official English provision)."

The use of English-only workplace rules has become prevalent in several states. According to a report by freelance business writer Norman Sklarewitz, "sooner or later every business will have to deal with the issue of using foreign languages in the workplace."[45] Sklarewitz cites cases in California where controversy and legal battles erupt over company policies against workers using their native language in casual conversation.

A "no-Tagalog" [the Filipino language] policy at a Pomona, California hospital received wide media attention in recent years when a Filipina nurse sued the hospital, charging that the policy violated her civil rights by not letting her speak her native language even while on break. In 1991, a federal district court judge ruled that the policy was not discriminatory because it was "little more than management's response to the increasing tension that was dividing the staff nurses. ... However misguided and ineffective the hospital's language restriction may have been, there is simply no basis for concluding that it was motivated by ethnic animosity."[46] The judge determined that if an employer bans only one foreign language at only one specific unit on only one shift, the policy does not qualify as an English-only rule.

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[44]"Declaring English the Official Language: Prejudice Spoken Here," *Harvard Civil Rights Civil Liberties Law Review*, vol.24, no.2, Spring 1989, p.310.

[45]"English-Only on the Job," Norman Sklarewitz, *Across the Board*, January/February 1992, p.19.

[46]*The Los Angeles Times*, October 26, 1991.

Although disappointed by the ruling, civil rights attorneys do not view the decision as precedent-setting because it was at the district court level. In 1993, a settlement was reached by the parties.

Of more concern is a decision by a three-judge panel of the Ninth Circuit Court of Appeals in 1993 which calls the EEOC policy guidelines into question. Garcia, et. al. v. Spun Steak Company concerns a California company's rule requiring English to be spoken in connection with work. Two employees were caught speaking Spanish to one another during work and were separated from each other for two months. They filed suit and in 1991 the court granted summary judgement in their favor. However, the court reversed this decision on appeal, arguing that an English-only rule does not *automatically* create an atmosphere of tension as the EEOC policy suggests. The Court of Appeals also noted that "the Supreme Court has held a plaintiff in a disparate impact case must prove the alleged discriminatory effect before the burden shifts to the employer," whereas the EEOC *presumes* that an English-only rule has a disparate impact.[47] The employees' request to have their case reheard by the full Court was denied. They now have until January 1994 to appeal to the Supreme Court.

Discriminatory side effects

Campaigns to pass Official English measures have been criticized for creating an environment that encourages acts of discrimination. The campaigns themselves have led to a heightened sense of division between English speakers and non-English speakers. And acts of discrimination often have occurred following the passage of state and local Official English measures. Although some of these discriminatory acts have resulted from gross misinterpretations of the measures, often they are examples of how such laws can lead to blatant discrimination.

According to a November 7, 1989 *Wall Street Journal* article, "Last November, the day after Florida passed a referendum making English the state's official language, an Anglo manager in a Miami supermarket suspended a Hispanic cashier for speaking to a co-worker 'in a foreign language'."

A February 20, 1989 *Newsweek* article reported that in California, several Los Angeles

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[47] *EPIC Events*, June/July 1993, p.6. Disparate impact refers to the discriminatory effect of a law or rule on a particular group of people, such as a language minority.

suburbs with large Asian populations have passed ordinances restricting foreign language signs; some teachers have forbidden the use of Spanish among students; and some Los Angeles shelters have refused to accept non-English-speaking homeless people.

On December 5, 1988, *Time* magazine described the following events in California, which has one of the most restrictive official English constitutional amendments: "At a Los Angeles hospital, the head nurse forbade workers to speak anything but English and urged employees to report anyone overheard using another language;" and "The city council in Monterey Park, a suburb of Los Angeles, ousted the trustees of the library for buying foreign-language books and magazines."

Such events are not limited to states or municipalities with Official English provisions. In 1993 a northern Virginia bank circulated memos informing tellers "it was the bank's policy that everyone speak English unless it is absolutely necessary ... to serve customers." The bank's headquarters denied such a policy existed, but several employees maintained that the memos required approval from headquarters and that their circulation was not an "isolated incident" as the bank stated.[48]

The Cuban American National Council has stated:

> Laws that require language conformity ultimately will produce a selection process favoring those who "look American," "sound American," and so "deserve" the opportunities now granted to all. If we accept laws segregating citizens according to language, what group will be next, and under what pretext?[49]

English language proficiency

Official English backers argue that the English language is in jeopardy. They contend that the English language is the main unifying force in our country and that our heritage is endangered because of language differences and ethnic separatism.

Proponents of Official English contend that the bilingual movement is dividing the United States. One of their stated aims is to avoid the battles that have plagued countries such as Canada over official bilingualism. Supporters argue that the United States must counter a trend toward bilingualism and that official English measures will do just that. In statements made introducing his Official English bill, Senator Shelby invoked the "tremendous problems

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[48] *The Washington Post* February 23, 1993.

[49] "America's English Need Not Divide Nor Censor," Cuban American National Council brochure, p.8.

currently facing Canada, Sri Lanka, [and] Yugoslavia" to support his proposal.[50]

The English language, however, does not appear to be under any threat of disappearing or even becoming a secondary language. In fact, such a threat may be more real for Spanish, Chinese and other languages which could be overwhelmed by English in the United States.

Official English advocates argue that the newest immigrants are not assimilating as well as previous groups. Supporters also claim that recent immigrants do not want to assimilate, citing "linguistic ghettos" as examples of immigrants' unwillingness to learn English. They also say that the proliferation of state and federal government use of foreign languages in government services and publications is discouraging acquisition of English.

Census Bureau statistics show, however, that 97 percent of U.S. residents over the age of five speak English "well" or "very well."[51] Recent studies show Hispanics learning English at the same rate as previous immigrants.[52] A 1985 Rand study on language acquisition in California found that 95 percent of first-generation Hispanic immigrants learn English; their children are all fluent in English and half of the children speak *only* English.[53] According to *Newsweek*, a survey of language attitudes in south Florida found that 98.1 percent of Hispanic parents believed it was important for their children to read and write "perfect" English.[54] The Latino National Political Survey, conducted in 1989 and 1990, discovered that most U.S. citizens of Mexican, Puerto Rican and Cuban descent prefer to speak English rather than Spanish, more than 90 percent believed U.S. citizens and residents should learn English, and about 85 percent felt that the purpose of bilingual education was to learn English.[55]

In areas of the country with many non-English-speaking people, English language classes have long waiting lists. According to a December 1, 1988 *American Bar Association Journal* article, "In Los Angeles alone, 40,000 people are on waiting lists to learn English. In New York City, the number exceeds 25,000." In Montgomery County, Maryland, the number of students in adult English classes has grown from fewer than 10,000 in 1986 to

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[50]Congressional Record, February 24, 1993, S.2022.

[51]U.S. Census Bureau, 1990.

[52]*The Arizona Republic*, October 15, 1988.

[53]*Business Week*, November 10, 1986, p.166. See also *American Bar Association Journal*, December 1, 1988, p.35.

[54]*Newsweek*, February 20, 1989.

[55]*The Washington Post*, December 16, 1992.

more than 16,000 in early 1992.[56]

Official English opponents are concerned that laws making English the official language could hamper efforts to ensure that students acquire English proficiency. Norman Cousins, former editor of *The Saturday Review*, summarized this point in his resignation from the Advisory Board of U.S. English: "Not until we provide educational facilities for all who are now standing in line to take lessons in English should we presume to pass judgment on the non-English-speaking people in our midst."[57]

IV. ORGANIZED OPPOSITION TO OFFICIAL ENGLISH MEASURES

Common Cause

To date, three Common Cause state organizations have actively opposed official English legislation in their states.

Common Cause/Arizona joined a coalition of organizations -- including civil rights groups, state legislators, church groups and Hispanic leaders -- to counter an Official English measure on the November 1988 ballot. The initiative passed in Arizona by a narrow margin of 51 percent to 49 percent of the vote.

Common Cause/Colorado became involved by joining a coalition of groups opposing English as the official language when the measure was placed on the ballot in November 1988. The Official English initiative in Colorado won by a vote of 61 percent to 39 percent.

In 1991, Common Cause/Missouri opposed a bill to make English the state's official language. The legislation failed, in a tie vote, in a Senate committee.

English Plus Information Clearing House (EPIC)

A loose coalition of groups has organized in support of English Plus, a concept that promotes working towards a citizenry that is proficient in English *plus* another language. The English Plus Information Clearinghouse (EPIC) was established in 1987 to collect and disseminate information on language rights and language policy and to respond to current efforts to restrict the use of languages other than English. To date, 57 state and national

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[56] *The Washington Post*, April 22, 1992.

[57] "America's English Need Not Divide Nor Censor," Cuban American National Council brochure, p.4.

organizations (see Appendix B) have endorsed EPIC's statement of purpose and goals, which includes the following:

> [T]he national unity and our constitutional values require that language assistance be made available in order to ensure equal access to essential services, education, the electoral process and other rights and opportunities guaranteed to all members of society.

Other Groups

While all of the groups that support English Plus oppose English as the official language, a number of organizations have been particularly active. The Mexican American Legal Defense and Educational Fund (MALDEF) passed a resolution in opposition to Official English and is currently working on a comprehensive plan to oppose English as the official language, including legislative efforts, legal defense issues and grassroots education. Californians United was organized in 1986 to oppose Proposition 63, a constitutional amendment to make English California's official language. (The amendment was subsequently approved.) In 1988, Californians United held a national conference which gave birth to the National Coalition for Language Freedom, a grassroots organization working to oppose Official English laws. Other national groups opposing Official English include the ACLU, the American Psychological Association, the Leadership Conference on Civil Rights (LCCR), the National Education Association (NEA) and People for the American Way.

In addition to opposing the passage of new Official English measures, groups have been monitoring the effects of existing laws. Since the passage of Proposition 63, Californians United has established several task forces to monitor the law's effects. The task forces' activities include tracking incidents of discrimination, proposing legislation to offset the impact of the initiative, looking for possible challenges to the legality of the law, and engaging in public education.

V. COURT RULINGS ON OFFICIAL ENGLISH PROVISIONS

Opponents of Official English were buoyed by two court decisions finding one state and one local Official English measure unconstitutional.

One case involved an Official English amendment to the constitution in Arizona that was ruled unconstitutional on February 6, 1990.[58] A federal district judge in Phoenix, Judge

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[58] Yniguez v. Mofford 730 F. Supp 309 (D. Ariz 1990).

Paul Rosenblatt, declared that Arizona's constitutional amendment making English the only language allowable for "government functions and actions" was a violation of free speech rights guaranteed by the First Amendment to the U.S. Constitution. While this ruling is binding only in Arizona, it is likely to be a factor in lawsuits in other states.

According to the suit, prior to the enactment of Arizona's Official English law, Maria-Kelly Yniguez, a state insurance claims manager since 1984, often spoke Spanish with Spanish-speaking people who were filing medical malpractice claims against the state. After enactment of the law, she stopped speaking Spanish in her job, even when asked to translate, for fear that she would be violating state law and be sanctioned. Two days after the enactment of the Arizona law, Yniguez filed suit.

A second plaintiff in the case, state Senator Jaime Gutierrez (D-Tucson), claimed the law would block him from communicating with his Spanish-speaking constituents. Judge Rosenblatt eliminated Gutierrez as a plaintiff, saying Gutierrez had a "right to communicate in Spanish with his Spanish-speaking constituents."

On February 7, 1990, *The Tempe Daily News Tribune* reported:

> [Judge] Rosenblatt ruled that Arizona's official English law, which prohibits the use of foreign languages in official government action, would "force governmental officers and employees ... to either violate their sworn oaths to obey the state constitution, and thereby subject themselves to potential sanctions and private suits, or to curtail their free speech rights." The measure is "invalid on its face in violation of the First Amendment," Rosenblatt said in his 20-page decision. He also called the law "substantially overbroad."

Former Arizona Governor Rose Mofford, the only person with legal standing to appeal under the district judge's ruling, refused to do so saying, "I'm happy the courts ruled it unconstitutional," and adding that the law was "flawed from the beginning."[59]

However, Arizonans for Official English, an affiliate of U.S. English, successfully appealed to the Ninth Circuit Court of Appeals to be allowed to intervene in the case. They are currently appealing Judge Rosenblatt's ruling.

In another case about the Arizona English-only law, employees and elected officials of the state filed a class action suit in November 1992. Ruiz v. Symington, brought in part by state Senator Armando Ruiz against Governor Fyfe Symington III, argues that the law violates the plaintiffs' First and Fourteenth amendment rights to freedom of speech and equal

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[59] *Tempe Daily News*, February 7, 1990.

protection under the law. Arizonans for Official English also are seeking to intervene in this case because they do not believe that the State would vigorously defend the law.

In July 1989, a federal court struck down a Pomona, California city ordinance that required all commercial signs containing foreign alphabetical characters also to contain at least 50 percent English alphabetical characters. The ordinance was passed in November 1988. In February 1989, the Asian American Business Group filed a lawsuit against the ordinance. Federal Judge Robert Takasugi ruled that the ordinance violated the First and Fourteenth Amendments of the U.S. Constitution.[60]

According to a July 28, 1989 article in *Asian Week*:

> The ordinance reads in part: "On premises signs of commercial or manufacturing establishments which have advertising copy in foreign alphabetical characters shall devote at least one-half of the sign area to advertising copy in English alphabetical characters." But the terminology "advertising copy" was "unconstitutionally vague," wrote Takasugi. ... Vague statutes inhibit a person's exercise of freedom of expression out of fear of breaking the law. They also violate citizens' right to due process. And because the ordinance is directed at sign owners who use foreign alphabetical characters, and the use of foreign languages is directly related to national origin, the ordinance "overtly discriminates on the basis of national origin" and violates the right to equal protection under the 14th Amendment, wrote Takasugi.

An August 1993 Circuit Court ruling upholding the Metro-Dade Commission's repeal of Dade County's municipal English-only law (see page eight) also is encouraging for opponents of Official English seeking to overturn such measures.

In California, a product liability case is testing the limits of that state's Official English provisions. Rosa Rivera sued Plough, Inc. when her son contracted Reye's Syndrome as a result of her not being able to read the English language warning on the label of a bottle of aspirin. The pharmaceutical distributor used California's English-only constitutional provision in its defense. Initially, the Superior Court ruled in favor of Plough, but the decision was reversed on appeal. The Appeals Court argued that "Plough's argument that public policy absolutely precludes liability for failing to warn in a foreign language is seriously undercut by federal regulations." The Federal Drug Administration (FDA) specifically states that its rule requiring Reye's Syndrome warnings does not preclude warnings in other languages and encourages manufacturers to distribute such warnings. In fact, although Plough did not issue warnings in Spanish, it did advertise in the Spanish language media. A trial can now proceed

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[60] *Asian Week*, July 28, 1989, p.4.

to determine whether Plough was negligent.[61]

VI. INNOVATIONS IN MULTILINGUAL REFORM

Recognizing that the United States is becoming more ethnically diverse and multilingual, a number of states and localities have established more inclusive policies pertaining to language.

Four states have enacted laws officially recognizing the importance of learning multiple languages as well as becoming proficient in English. In March 1989, the New Mexico Legislature passed the first English Plus measure in the nation, encouraging "multilingualism as beneficial to the state's continuing economic and cultural vitality, 'whether that proficiency derives from second language study by English speakers or from home language maintenance plus English acquisition by speakers of other languages.'" [62] The measure also reaffirmed the Legislature's "advocacy of the teaching of other languages in the United States and its belief that the position of English is not threatened." (See Appendix C for full text.) Although it passed with strong support, the resolution is nonbinding and contains no guarantee of increased funding for language programs. Nevertheless, the policy has discouraged additional English-only campaigns in New Mexico.

In 1989, Oregon and Washington State also enacted English Plus measures. Washington's law established a policy "to welcome and encourage the presence of diverse cultures and the use of diverse languages in business, government, and private affairs in this state." Oregon's resolution established policy "to welcome, encourage and protect diverse cultures and use of diverse languages in business, government and private affairs."[63]

In May 1992, Rhode Island became the fourth "English Plus" state, enacting legislation that recognizes "English is and will remain the primary language of the United States" and "encourages all citizens to become proficient in English to facilitate full participation in society." The legislation also states:

> [I]t shall be the policy of the state of Rhode Island to welcome and encourage the presence of diverse cultures and the use of diverse languages in business, government, and private affairs in this state.

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[61] *EPIC Events*, February/March 1993, p.5.

[62] Mary Carol Combs, "English Plus: Responding to English Only," in *Language Loyalties*, James Crawford, ed., University of Chicago Press, Chicago, 1992, p.223.

[63] *Ibid.*, p.223.

In Massachusetts, a coalition of educational and community-based organizations, led by Massachusetts English Plus, sponsored an "English Plus Month" in November 1991. While citizens from across the state participated in the activities, the cities of Cambridge and Boston declared November to be English Plus month. The month-long event included a series of activities promoting cultural and language diversity and examining the issue of language rights. Over 200 bilingual education students participated in an art/writing contest focused on the theme of diversity, while adult students of English as a Second Language (ESL) participated in writing projects that were later displayed in their communities. The activities culminated at a Boston festival where hundreds of people shared in the bilingual education contest awards presentation and participated in multicultural performances.

In the Washington, D.C. area, government and private sector policies have been adapting to a wave of immigration in recent years. During the past decade, the area's Hispanic and Asian populations have doubled and immigrants from dozens of other countries have settled in the area, primarily in the suburbs surrounding the capital city.[64] Some bank machines in the area offer instructions in Spanish; political candidates communicate to constituents in Korean; county recycling reports are printed in Cambodian, Laotian, and two Ethiopian languages; all-Spanish radio shows have been added to local stations; county government agencies publish weekly health notices and voting guides in a dozen languages; signs in stores have been added in Vietnamese and Spanish; and the Potomac Electric Power Co. and Chesapeake & Potomac Telephone Co. have established Spanish-speaking hotlines.

Schools in Fairfax and Arlington, northern Virginia suburbs, have adopted voluntary language immersion programs, in which students with a range of language backgrounds spend part of the day in classes where only Spanish, French or Japanese is spoken. The Arlington program was sharply criticized by U.S. English when it was announced.[65] Arlington, whose student population is 28 percent Hispanic, also has established a program with private-sector employers to teach their employees English.[66]

Local leaders laud these efforts. Mara Lopez, acting director of the mayor's office on Latino affairs in the District of Columbia, noted:

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[64] *The Washington Post*, February 11, 1992.

[65] *The Washington Post*, November 20, 1993.

[66] *The Washington Post*, December 2, 1993.

> My general impression is that there is a recognition by politicians, by business people, by anybody providing services, that the demographic fabric of this area has changed, and to stay competitive and do business and to respond to the needs of the community, there is a need to be able to communicate. When you see a sign in Spanish, it says, 'We know you are here. We value your business. We value your input.'

VII. CONCLUSION

Few people would dispute that English is the primary language of our country, that English language skills are necessary to function most effectively in our society, and that advancement in employment in the United States generally requires English proficiency. But it is a long jump from these fundamental statements to the belief that English is endangered and should be made the official language.

Efforts currently underway at the state level to make English the official language would threaten the rights of non-English-speaking residents and would compromise their access to elections, emergency and social services, education and the criminal justice system. By distinguishing between English-speakers and non-English speakers in these areas, Official English measures, in effect, legalize discrimination against people who are not fluent in English. Blocking the Official English Movement's quest to canonize English as the official language is a crucial step to safeguard the rights of non-English-speaking and bilingual people.

Acknowledgement

This paper was prepared by Anna Pegler Gordon, Research Associate for State Issues.

APPENDIX A

Resolution -- English as the Official Language

Common Cause National Governing Board Meeting

November 4, 1989

Resolved, that the National Governing Board authorize state organizations, if they so desire, to oppose the adoption of any English As the Official Language statute or constitutional amendment.

RESOLUTION APPROVED:

38 YES, 5 NO, 5 NOT VOTING

APPENDIX B

Organizations Endorsing the EPIC Statement of Principles

Advocates for Language Learning
American Civil Liberties Union
American Council on the Teaching of Foreign Languages
American Jewish Committee
American Jewish Congress
ASPIRA Association
American Council on the Teaching of Foreign Languages
Asian Pacific American Legal Center of Southern California
Asociacion Politica de Habla Espanol
Californians United
Caribbean Education and Legal Defense Fund
Center for Applied Linguistics
Chinese for Affirmative Action
Christian Church -- Disciples of Christ
Coloradans for Language Freedom
Colorado Women's Agenda
Committee for a Multilingual New York
Conference on College Composition and Communication
El Concilio de El Paso
Greater Miami United
Haitian American Anti-Defamation League
Haitian Refugee Center
Image de Denver
IRATE (Coalition of Massachusetts Trade Unions)
Japanese American Citizens League
Joint National Committee for Languages
League of United Latin American Citizens
Linguistic Society of America
LULAC Foundation
Mexican American Legal Defense and Educational Fund
Michigan English Plus Coalition
Michigan State University, Department of English
Multicultural Education Training and Advocacy Project
National Association for Bilingual Education
National Association for Asian and Pacific American Education
National Association of Latino Elected and Appointed Officials
National Coalition of Advocates for Students
National Council of La Raza
National Council of Teachers of English
National Education Association
National Immigration Project
National Immigration, Refugee and Citizenship Forum

National Lawyers Guild
National Puerto Rican Coalition
New York Association for New Americans
New York State Association of Foreign Language Teachers
New York State Council on Languages
New York State Teachers of English to Speakers of Other Languages
Organization of Chinese Americans
Pacific Northwest Council on Foreign Languages
People for the American Way
Socialist Party USA
Society for the Psychological Study of Social Issues
Southwest Conference on Language Teaching
"Stop English Only" Committee of Hostos Community College (NY)
Teachers of English to Speakers of Other Languages
United States Student Association

APPENDIX C

STATE ENGLISH PLUS MEASURES

New Mexico English Plus Resolution, 1989

WHEREAS the people of New Mexico promote the spirit of diversity-with-harmony represented by the various cultures that make up the fabric of our state and American society; and

WHEREAS the people of New Mexico acknowledge that "English Plus" best serves the national interest since it promotes the concept that all members of our society have full access to opportunities to effectively learn English plus develop proficiency in a second or multiple languages; and

WHEREAS the people of New Mexico recognize that the position of English in the United States needs no official legislation to support it; and

WHEREAS the people of New Mexico recognize that for survival in the twenty-first century our country needs both the preservation of the cultures and languages among us and the fostering of proficiency in other languages on the part of its citizens;

NOW THEREFORE BE IT RESOLVED ... that the First Session of the Thirty-Ninth Legislature of the State of New Mexico hereby reaffirms its advocacy of the teaching of other languages in the United States and its belief that the position of English is not threatened. Proficiency on the part of our citizens in more than one language is to the economic and cultural benefit of our state and the nation, whether that proficiency derives from second language study by English speakers or from home language maintenance plus English acquisition by speakers of other languages. Proficiency in English plus other languages should be encouraged throughout the State.

Rhode Island English Plus Bill (H 8357), 1992

An Act Relating to State Affairs and Government
State Policy in Regards to Diversity of Cultures

Chapter 5.1: Rhode Island Policy and its Diverse Cultures

42-5.1-1. Policy stated.--(1) Diverse ethnic and linguistic communities have contributed to the social and economic prosperity of Rhode Island.

(2) It is the welcomed responsibility and opportunity of Rhode Island to respect and facilitate the efforts of all cultural, ethnic, and linguistic segments of the population to become full participants in Rhode Island communities.

(3) This state's economic well-being depends on foreign trade and international exchange and many jobs are directly linked to foreign trade and international exchange.

(4) If Rhode Island is to prosper in foreign trade and international exchange, it must have citizens that are multilingual and multicultural.

(5) While recognizing the value of a multilingual background, the state also encourages all citizens to become proficient in English to facilitate full participation of all groups in society and to promote cross-communication that currently exists in this state should be promoted to build trust and understanding among all of its citizens.

Therefore, it shall be the policy of the state of Rhode Island to welcome and encourage the presence of diverse cultures and the use of diverse languages in business, government, and private affairs in this state.

(6) The immigration of Hispanics, Portuguese, Southeast Asian and other non-English speaking peoples to Rhode Island continues; and English is already the predominant language of Rhode Island and needs no legislation to support it; and

(7) English is and will remain the primary language of the United States, and all of our society recognize the importance of English to national life, individual accomplishment, and personal enrichment.

(8) The ability to communicate in English and other languages has promoted and can further enhance American economic, political and cultural vitality.

(9) The state both affirms the right of every resident to nurture his or her native language and also encourages all citizens to become proficient in English to facilitate full participation in society and promote cross-cultural communication.

(10) Native language instruction facilitates the development of English proficiency in limited English-proficient children and boosts the overall academic achievement of such children; and

(11) Proficiency in a second or multiple languages can be a major tool for economic growth for our state and help overcome this country's disadvantage in the world economy as we move into the 21st century.

APPENDIX D
PUBLICATIONS ON OFFICIAL ENGLISH

Arington, Michele, "English-Only Laws and Direct Legislation: The Battle in the States over Language Minority Rights," *Journal of Law and Politics*, Winter 1991.

Armsby, Susan, "Krasniy, Blanc and Azul: The English Plus American," Conference on Language Pluralism in the U.S.: Linguistic Minorities and "English Only," Michigan State University, April 13, 1991. Contact People for the American Way, 2000 M St., N.W., Washington, DC 20036. (202) 467-4799.

Califa, Antonio, "The Attack on Minority Language Speakers in the United States." Also, "Declaring English the Official Language: Prejudice Spoken Here," *Harvard Civil Rights Civil Liberties Law Review*, Vol. 24, No. 2, Spring 1989. For both papers, contact the ACLU, 122 Maryland Avenue, N.E., Washington, DC 20002 (202) 544-1681.

Crawford, James, *Hold Your Tongue: Bilingualism and The Politics of "English Only,"* Addison-Wesley Publishing Company, Massachusetts, 1992. This new book provides background on the history of the English-Only movement, the major players, the various arguments, and other topics relating to the English Only/English Plus debate.

Language Loyalties: A Source Book on the Official English Controversy, The University of Chicago Press, Chicago, 1992. This compilation of articles edited by James Crawford provides historical roots of the debate, the arguments for and against, the sociological significance of language conflict, legal precedents on language and civil liberties, implications of language diversity on education, and international perspectives on language politics.

CRS Report for Congress: States Designating English as the Official State Language, Congressional Research Service, The Library of Congress, March 9, 1988 (Revised April 20, 1989 and January 22, 1991).

"English Language Constitutional Amendments," Hearing Report before the Subcommittee on Civil and Constitutional Rights of the Committee on the Judiciary, House of Representatives, May 11, 1988, Serial No. 120. Contact the Superintendent of Documents, Congressional Sales Office, U.S. Government Printing Office, Washington, DC 20402.

English-Only Legislation in Multicultural America: A State and Federal Update, Mexican American Legal Defense and Education Fund, June 1990. Contact the English Plus Information Clearinghouse, c/o National Forum, 220 I Street, N.E., Suite 211, Washington, DC 20002 (202) 544-0005.

EPIC Events; a bimonthly newsletter on official English and related language issues. Contact the English Plus Information Clearinghouse, c/o National Forum, 220 I Street, NE, Suite 211, Washington, DC 20002. (202) 544-0004.

Not Only English: Affirming America's Multilingual Heritage, Harvey A. Daniels, Ed., National Council of Teachers of English, Urbana, Illinois, 1990. Contact the National Council of Teachers of English, 1111 Kenyon Road, Urbana, IL 61801. (217) 328-3870.

Official English/English Only: More Than Meets the Eye, National Education Association, April 1988. Contact the NEA, Human and Civil Rights, 1201-16th Street, N.W., Washington, DC 20036. (202) 822-7700.

APPENDIX E

ORGANIZATIONAL SOURCES OF INFORMATION ON OFFICIAL ENGLISH

American Civil Liberties Union
122 Maryland Avenue, NE
Washington, D.C. 20002
(202) 544-1681.

English Plus Information Clearinghouse
c/o National Forum
220 I Street, NE
Suite 211, Washington, D.C. 20002
(202) 544-0004.

Joint National Committee for Languages
300 I Street, NE, Suite 211
Washington, D.C. 20002
(202) 546-7855.

Mexican American Legal Defense and Educational Fund
1430 K Street, NW, Suite 700
Washington, D.C. 20005
(202) 628-4074.

National Council of Teachers of English
1111 Kenyon Road
Urbana, Illinois 61801
(217) 328-3870.

National Education Association
1201 16th Street, NW
Washington, D.C. 20036
(202) 822-7700.

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