Review

Interpretation and Translation-Mediated Telemental Health Services for Adults With Limited Language Proficiency: Scoping Review

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Abstract

Background: Individuals with limited English proficiency (LEP) or limited host-language proficiency (LLP) represent a growing, medically underserved population at disproportionate risk for poor mental health outcomes. Most mental and behavioral health services provided to individuals with LEP or LLP are delivered by providers who do not speak the patient's preferred language, due to a shortage of bilingual mental health professionals. Since the onset of the COVID-19 pandemic, the number of telehealth-delivered outpatient mental health (telemental) visits has increased, yet little is understood about the provision of interpretation and/or translation-facilitated telemental health care in populations with LEP and LLP.

Objective: This study is a scoping review that aimed to characterize the existing evidence on interpretation- and translation-mediated telemental health services for adults with LEP or LLP. We examined study characteristics, populations, and settings represented, telemental health modalities used, reported barriers and facilitators, and the methodological quality and gaps within the current evidence base.

Methods: Included studies focused on adults receiving interpreter and/or translation-mediated telemental health services. All studies were published in the English language, which may limit generalizability. Studies with bilingual providers, nonbehavioral health care, mobile health (mHealth) applications, or deaf or hard-of-hearing populations were excluded. Online databases were used to identify papers published through May 2026, from which we selected 15 publications from 137 full-text articles retrieved for full-text screening.

Results: A total of 60% (9/15) of publications reported qualitative or mixed method designs, while 40% (6/15) were quantitative. Most were conducted with Spanish-speaking populations. Of the 15 studies, 12 achieved >4 out of 5 using the Mixed Methods Appraisal Tool (MMAT). Thematic analysis yielded the following four themes across the articles reviewed: (1) facilitators of access, (2) barriers to access, (3) therapeutic process considerations, and (4) recommendations to improve quality of and access to interpreter- or translation-mediated telemental health care in LEP and LLP populations.

Conclusions: As previous reviews focused primarily on in-person mental health care, this scoping review is among the first to synthesize evidence specifically on interpreter and translation-mediated telemental health for individuals with LEP or LLP. In addition, its inclusion of literature published after COVID-19 allowed for an examination of how the literature has evolved from the prepandemic period to the post-2020 telemental health expansion. Findings underscored the following needs: (1) address access barriers to telemental health care in populations with LEP and LLP, which persist following the postpandemic increase in telemental health adoption; (2) standardize training for clinicians and interpreters; and (3) update clinical guidelines in the context of rapid telehealth uptake in behavioral health care. It also highlighted the potential impact of

emerging AI technologies for real-time translation in mental health care, calling for further research on their ethical and clinical implications.

JMIR Ment Health 2026;13:e81632; doi: 10.2196/81632

Keywords: limited English proficiency; telemedicine; ethnic and racial minorities; mental health; health services accessibility

Introduction

Records Management

More than 67 million people in the United States speak a language other than English at home, and more than 26 million (8% of the population) have limited English proficiency (LEP), defined as individuals aged 5 years or older who self-identify as speaking English less than "very well" according to the US Census [1]. While most people with LEP are immigrants, nearly 19% were born in the United States, most to immigrant parents [1]. People with LEP are anticipated to reach 19% of the US population by 2050 [2]. This fast-growing segment of the US population is at disproportionate risk for poor mental health outcomes. One study using population-based data from the California Health Interview Survey found that among Latino and Asian immigrants aged 60 and older, those with LEP tended to have poorer self-rated health and higher psychological distress than their English-proficient (EP) counterparts [3]. Similar patterns are observed in other high-immigration countries. A systematic review of 41 studies reporting prevalence of psychiatric symptoms or disorders among migrants found that limited host-language proficiency (LLP) was consistently associated with higher prevalence and severity of psychotic, mood, anxiety, and posttraumatic stress disorder (PTSD) [4]. In Norway, immigrants with limited Norwegian proficiency had higher odds of self-reported mental health problems than those with good proficiency [5], and in Australia and Canada, LEP among immigrants has been linked to poorer self-rated health, lower subjective mental health, and higher depression and anxiety symptoms [6,7].

Yet individuals with LEP or LLP are less likely to access needed mental health care [8-10] due to financial, cultural, and linguistic barriers to access and navigation. For example, they may delay seeking care to avoid communication difficulties with clinicians who do not share their language or cultural background [11,12]; or, in a US context, out of concern about the costs of behavioral health care, coverage of which has not reached parity with physical health care [13]; or because they doubt their needs will be adequately addressed by mental health care providers [14-16].

Given these barriers, professionals who speak the client's preferred language represent the gold standard for delivering health services to individuals with LEP or LLP; patients prefer bilingual providers, and language concordant care has been shown to improve health outcomes among patients with LEP or LLP [17-20]. Despite the benefits of preferred language delivery, however, the vast majority of mental health treatment for individuals with LEP or LLP is provided by providers who cannot speak the patient's preferred language, due to a shortage of bilingual mental health professionals [21]. To bridge language and cultural gaps between mental health professionals and individuals with LEP or LLP, guidelines for language access have recommended the use of trained interpreters [22]. Research has shown that using professional interpreters in health care visits for individuals with LEP or LLP improves patient satisfaction and the quality of health care provided while reducing medical and communication errors and costs [18,23-26]. Providing high-quality medical interpretation in patients' preferred languages is a crucial component of culturally responsive care, particularly in mental health care, which primarily relies on verbal communication (as opposed to laboratory tests) to obtain reports of patients' psychiatric history, symptoms, experiences, and emotions to yield accurate psychiatric diagnoses and to deliver effective interventions [10,27,28].

During and following COVID-19, the provision of mental health care was rapidly transformed. Before the onset of the global pandemic, psychologists performed approximately 7% of their clinical work with telehealth [29]. According to a survey undertaken by the American Psychological Association, by 2020, this increased 12-fold to 86% during the pandemic, and was projected to decrease to 35% after the pandemic [29]. Adoption of telehealth delivery during and post pandemic has been even greater in safety-net settings, where a disproportionate number of individuals with LEP receive care; a 2023 secret shopper study of California safety-net clinics found that 86% of simulated patients with LEP were offered telebehavioral health visits and that 22% of safety-net clinics did not offer in-person care [30]. Yet, as the use of telehealth expanded, individuals with LEP encountered significant barriers to telehealth access compared to their EP counterparts [31]. For instance, a study using data from the National Health Interview Survey (July 2020-December 2021) found that, after controlling for predisposing (eg, age, sex, and race or ethnicity), enabling (eg, education, family income, health insurance, and having a usual place of care), and need (eg, health status, disability, and presence of multiple chronic conditions) factors, adults with LEP still had 20% lower odds of having a telemedicine visit than adults with EP (P=.02) [32]. Additionally, patients with LEP were 43% less likely to use video-based telehealth during the COVID-19 pandemic compared with EP patients [33]. Given this "digital divide," it is important to determine factors that affect the quality of and access to interpretation and/or translation-mediated telemental health care for individuals with LEP or LLP.

In this paper, we distinguish between interpreting (the oral rendering of spoken language from one language to another) and translation (the conversion of written text from one language to another). While both are essential components of language access in health care, our primary

emphasis is on interpreting, particularly as it pertains to mediated patient-provider communication in behavioral and mental health contexts. However, given that some studies use the terms interchangeably or examine both, we include relevant findings involving translation when appropriate—for example, studies that use asynchronous translation of telemental health care encounters by a human translator or via AI.

Despite the vital role that interpreting and translation play in the delivery of telemental health services to people with LEP or LLP, research on this topic is scarce. The vast majority of reviews examining interpreting's role in the provision of mental health services for individuals with LEP or LLP were published before the rapid adoption of telehealth delivery for outpatient mental health services [18,22,26-28,34,35]. These reviews therefore do not address key questions raised since the rapid uptake of these innovations, including how the therapeutic alliance is affected in phone vs videoconferencing-based, interpreter-mediated telemental health encounters [36] or how AI-based translation may be effectively deployed to meet the needs of patients with LEP or LLP in behavioral and mental health care settings [37,38].

Accordingly, the aim of this study was to characterize the existing evidence on interpreter- and/or translator-mediated telemental health care, including the populations studied, delivery modalities examined, reported barriers and facilitators, and methodological strengths and limitations of the available literature. By mapping this emerging field, we sought to identify evidence gaps and future directions for research.

Rationale and Objectives

Because our study's aim was to produce an overall map of the literature concerning remotely delivered, interpretation- and translation-mediated mental health services for immigrants with LEP or LLP, a scoping review was the most suitable method. Scoping reviews are an effective approach for assessing the breadth, volume, and key areas of focus of research literature on a specific topic. In contrast to a systematic review approach in which specific study designs are selected to answer a highly focused research question, a scoping review seeks to identify all relevant publications to summarize and disseminate research findings on a given topic and characterize research gaps in the existing literature [39].

The objectives of our scoping review were to address the following research questions:

1. First, what are the characteristics of the existing evidence on interpreter- and translation-mediated telemental health care for adults with LEP or LLP, including the populations studied, care settings, delivery modalities, study designs, and reported outcomes?
2. Second, what are the methodological strengths and limitations of the existing literature on interpreter- and translation-mediated telemental health care for adults with LEP or LLP, and what key evidence gaps remain?

Methods

Protocol and Registration

Our scoping review protocol was preregistered on the Open Science Framework (OSF), maintained by the Center for Open Science.

Eligibility Criteria

Inclusion and exclusion criteria were guided by the population, concept, and context (PCC) framework developed by the Joanna Briggs Institute (JBI) [40].

Population

We included studies focused on adults receiving remotely delivered mental health care services via interpreters and/or translators. Because we wished to focus on populations with LEP or LLP (who, in the United States, are protected against language discrimination in Title VI of the Civil Rights Act of 1964), studies that focused on deaf or hard of hearing populations (whose communication needs are protected under the Americans with Disabilities Act) were excluded.

Concept

The key concept in our review was remotely delivered interpreter and/or translation-mediated behavioral and mental health care. We therefore included studies investigating a broad range of interpreting and/or translation modalities, including consecutive interpretation (ie, the process of interpreting after the speaker has completed one or more ideas in the original or source language), simultaneous interpretation (the process of interpreting into the new/target language at the same time as the original or source language is being delivered), as well as asynchronous translation of behavioral or mental health care encounters by a human translator or via AI. We excluded studies investigating telemental health services provided by bilingual providers, as well as studies of mobile health (mHealth) applications in participants' preferred languages, because we wished to focus on interpretation and/or translation-mediated care. We also excluded studies that investigated nonbehavioral and mental health care.

Context

The context is the provision of remotely delivered or telemental health care. We wished to focus on this context because of the rapid and continued uptake of telehealth following the outbreak of the COVID-19 pandemic—particularly in outpatient mental health settings [30]—in the context of the "digital divide" among populations with LEP and LLP [31]. We therefore included various remote modes of interpreter and/or translation-mediated communication including teleconferencing, virtual consultations, telephone, mobile app, and internet-delivered care. Studies that focused on only in-person delivery were excluded.

Publication Type, Study Design, Language, and Dates

The article had to be an original research paper published in a scientific journal. We included empirical research using both qualitative and quantitative designs and clinical case studies but excluded best practice guidelines and editorials or commentaries. Records were screened at the title and abstract stage based on the topic and concepts discussed, subject matter, research design, and alignment with the PCC framework. Records that appeared to meet the PCC criteria were included for full-text screening. We included articles written in English only. We included all studies published since the inception of the bibliographic databases (refer to Information Sources and Search section) through May 8, 2026.

Information Sources and Methods

To identify potentially relevant articles, the following bibliographic databases were searched: PubMed (PubMed), Embase (Elsevier), Cochrane CENTRAL Register of Controlled Trials (Wiley), CINAHL (EBSCO), PsycINFO (Ovid), and Web of Science (Clarivate). We did not search study registries. We additionally performed citation searching by browsing reference lists of relevant articles and conducted a hand search of these citations.

Search Strategies

Guided by the study protocol along with the PRISMA-S (Preferred Reporting Items for Systematic Reviews and Meta-Analyses literature search extension) extension [41], the search strategies were created by a medical research informationist and coauthor (LB), using a combination of database-specific controlled vocabulary terms and keyword searching in titles and abstracts (Multimedia Appendix 1). The most recent search was executed on May 8, 2026.

Managing Records

The final results were imported into Covidence (Veritas Health Innovation) [42], and duplicates were automatically removed. The total number of records identified from each database can be found in the study flow diagram, which depicts the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) flow diagram.

Selection of Sources of Evidence (Peer Review)

The review team included 6 reviewers (FL, CZ, CQ, RYC, RJ, and FC) experienced in health disparities research. Using the review platform Covidence [42], a reviewer pair independently reviewed the titles, abstracts, and then full texts of all publications identified by our searches for potentially relevant publications to be included in the review. We resolved disagreements on study selection through discussion between the 2 reviewers or, if needed, in consensus meetings with the larger reviewer team (FL, CZ, CQ, RYC, RJ, and FC) and advisors and coauthors with expertise in synthesis (FG, AE, CR, LD, JG, and JL).

Data Charting Process

The primary author (FL) developed a data-charting form to determine which variables to extract, which was reviewed by the senior author (JL). The data extraction team included 5 coders (FL, CZ, CQ, RYC, and RJ). Moreover, 2 coders independently charted data, with any disagreements resolved through discussion or in consensus meetings as described above.

Data Items

We abstracted data on study aims, study design (eg, qualitative, randomized controlled trials, quantitative nonrandomized, quantitative descriptive, and mixed methods), data collection periods, population and setting (ie, the clinical setting, country, and context), telemental health and interpreting modalities, participant characteristics (eg, age, gender, race or ethnicity, preferred language, LEP and LLP status, country of origin, and clinical characteristics), and main findings.

Critical Appraisal of Individual Sources of Evidence

As interpreter- and/or translation-mediated remotely delivered mental health service provision for individuals with LEP or LLP is an emerging area of study, we aimed to explore the methodological quality of existing research studies on this topic to (1) identify strengths and limitations of the available evidence to guide interpretation of findings and (2) highlight gaps in study design or execution to inform future research priorities and methodological improvements. Studies were assessed for quality using the Mixed Methods Appraisal Tool (MMAT), a critical appraisal tool that is designed for reviews that include qualitative, quantitative, and mixed methods studies. The tool comprises 2 parts, part 1 comprising a 5-item checklist specific to the following five different study designs: (1) qualitative, (2) quantitative randomized controlled trials, (3) quantitative nonrandomized, (4) quantitative descriptive, and (5) mixed methods studies; and part 2 comprising a definition of the 5 predetermined criteria for each study type (each criterion can be rated as "Yes," "No," or "Can't tell"). Pairs of reviewers (FL, CZ, CQ, RYC, and RJ) independently assessed the articles. A third reviewer (FL, CZ, CQ, RYC, and RJ) resolved any discrepancy.

Synthesis of Results

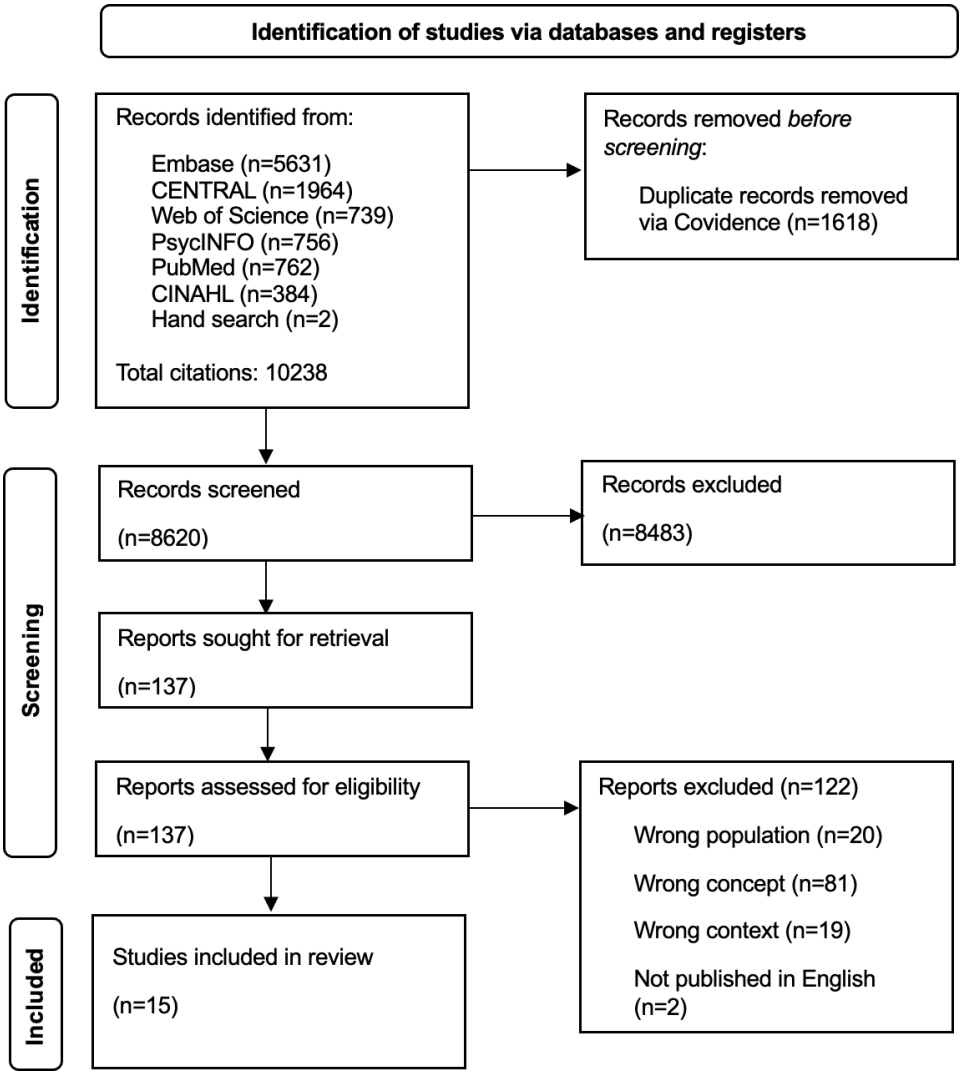
We summarized the studies by aims, design, population and setting, participant characteristics, and main findings. Pairs of coders (FL, CZ, CQ, RYC, and RJ) read through each article independently and identified themes that emerged via coding of each study included in the review. We then discussed, compared, and developed our thematic analysis.

Results

Selection, Characteristics, and Critical Appraisal of Included Studies

After duplicates were removed, a total of 8620 citations were identified from searches of electronic databases and review article references. Based on the title and abstract, 8483 were excluded, with 137 full text articles retrieved for full text screening. Following full text screening, 122 reports were excluded due to their focus on the wrong populations, concepts, or contexts. The remaining 15 studies were considered eligible for this review [43-57] (Figure 1).

Figure 1. PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) flow diagram.



The studies' aims, design, types of settings, populations, methods, and main findings are presented in Table 1. MMAT ratings for each study are presented in Multimedia Appendix 2 [43-57]. Multimedia Appendix 3 provides a visual summary of key study characteristics, including population focus, telehealth modality, publication period (pre- vs post–COVID-19), study design, and disciplinary representation.

Table 1. Scoping review of remotely delivered interpretation and translation-mediated mental health services for limited language proficient individuals (n=15).

Study	Study aims	Study design and telehealth or interpreting modality	Population and setting	Participants	Main findings
Cheung et al [43]	To assess patient and provider characteristics (eg, LEP[a]) associated with barriers and facilitators of satisfactory consultation-liaison telepsychiatry encounters	• Cross-sectional survey collected from March to June 2020 with 11 attendings and log review of their telepsychiatry encounters with n=223 patients • Phone or audio only and videoconference, via remote interpretation (consecutive vs simultaneous not specified)	Patients receiving telepsychiatry services from consultation-liaison psychiatrists at an academic medical center in New York City, United States	Patient characteristics (n=223): • Sex (female: n=82, 36.77%; male: n=123, 55.16%; and other: n=18, 8.07%) • Age (mean 51.6, SD 16.6 y) • Preferred language (Chinese: n=2, 0.9%; English: n=164, 73.54%; German: n=7, 3.14%; Greek: n=2, 0.9%; Spanish: n=48, 21.52%) • Language proficiency: not defined; study categorized patients by their preferred language: English-preferring patients or non-English–preferring patients (n=59, 26.46%)	For patients who preferred a non-English language, in spite of professional interpretation, authors found a significantly higher number of unresolvable user issues (OR[b] 9.059, 95% CI 3.397-27.027; *P*<.001) and decreased rapport (OR 0.189, 95% CI 0.060-0.528; *P*=.001). Patients with LEP were also significantly more likely to have audio-only interactions.
Disney et al [44]	To understand how mental health clinicians and case workers at a refugee-serving mental health clinic are shifting their face-to-face practice to telemental health, the obstacles they encounter, and what resources they have found to be helpful	• Surveys and interviews collected in May 2020 with refugee mental health providers (n=17) • Phone or audio only and videoconference, via remote interpretation (consecutive vs simultaneous not specified)	Practitioners at a refugee-serving outpatient mental health clinic in a large refugee resettlement area in the United States	Provider characteristics (n=17): • Sex (female=87%) • Age (mean 37, range 27-65 y) • Race (White 47%; African American 33%; Asian 7%) • Job title (Therapist 46%; Case manager 29%; Psychologist 6%; Advanced practice registered nurse 6%) • Language proficiency: LEP referred to refugees who do not speak English and required interpreters	Overall, practitioners shared they felt equipped to provide telemental health services and that telemental health delivery increased access to care in refugee communities. However, practitioners reported several language-related barriers to care, including "trickier" nature of incorporating 3 parties (interpreter, client, and therapist) in the visit; difficulties securing remote interpreters for clients; and difficulty hearing and understanding individuals in the telehealth setting, even with an interpreter present.
Ekblad et al [45]	To assess the feasibility, acceptability, and outcomes of a brief online trauma-focused group intervention on perceived trust, anxiety or stress, and perceived health.	• Mixed methods pilot study (n=136; October 2023-March 2024). • Online trauma-focused group intervention via Microsoft Teams (Zoom for deaf participants) with mobile phone follow-up. Remote interpretation (online or telephone) in Ukrainian, Russian, and Swedish; sign-language interpretation available. Consecutive vs	Adult Ukrainian refugees residing in 5 Swedish municipalities under the European Union Temporary Protection Directive. Participants were Ukrainian-, Russian-, and Russian sign language–speaking refugees, including a subgroup of deaf participants.	Participant characteristics (n=136): • Age (mean 44.7, SD 12.3; range 18-75 y) • Sex (female: n=103, 75.7%; male: n=33, 24.3%) • Marital status (married: n=65, 47.8%; unmarried: n=23, 23.2%; divorced: n=15, 11%; widowed: n=9, 6.6%) • Country of birth (Ukraine: n=121, 90%; Russia or former Union of Soviet Socialist Republics: n=15, 11%)	Quantitative results showed significant reductions in anxiety or stress and significant improvements in perceived health post intervention. Qualitative findings indicated improved coping strategies (eg, breathing techniques and cognitive tools), increased knowledge about Swedish systems, and enhanced perceived trust, alongside challenges related to online group dynamics, communication barriers, and limited interaction.

Study	Study aims	Study design and telehealth or interpreting modality	Population and setting	Participants	Main findings
		simultaneous interpretation not specified.		• Primary language (Ukrainian: n=95, 69.8%; Ukrainian and Russian: n=20, 14.7%; Russian: n=18, 13.2%) • Deaf participants: n=12 • Time in Sweden (mean 19 months) • Employment status (unemployed: n=95, 69.9%; employed: n=41, 30.9%) • Refugee status: Temporary Protection Directive (Sweden) • Language proficiency: not defined; participants were primarily Ukrainian- and Russian-speaking refugees and received interpreter support and translated study materials throughout the intervention.	
Gallegos-Rejas et al [46]	To describe telehealth usage within a major health service and identify sociodemographic factors (eg, requiring interpreter services) that may contribute to limited telehealth access	• Cross-sectional study using service activity data from January 2021 to December 2021 from 4 metropolitan hospitals in Queensland, Australia (n=153,427) • Phone or audio only and videoconference, via remote interpretation (consecutive vs simultaneous not specified)	Patients who had an outpatient appointment within 10 specialty services that used videoconference most frequently (including psychology) from hospitals within the Metro South Health (MSH) region, the most culturally diverse area in Queensland	Patient or visit characteristics (n=153,427): • Age (mean 52.52, SD 17.61 y) • Sex (female: n=76,977, 50.17%; male: n=76,406, 49.8%) • Clinical service (Psychology: n=10,608, 6.91%; Neuropsychology: n=1693, 1.1%; Other: n=141,126, 91.98%) • Use of English (English: n=132,772, 88.42%; Non-English: n=17,393, 11.58%) • Use of interpreter (yes: n=9163, 6.09%; no: n=141,348, 93.91%) • Language proficiency: LEP defined as people not using English as a first language or requiring interpreter services	People who required interpreter services were 66% less likely to use telehealth services (adjusted OR 0.33, 95% CI 0.31-0.36; $P<.05$) than English-speaking people. Among those using telehealth, people requiring interpreter services were 13% less likely to use videoconference than phone (adjusted OR 0.97, 95% CI 0.77-0.98; $P<.05$). The study highlights significant disparities in telehealth access among culturally and linguistically diverse patients, particularly non-English speakers.
Hilty et al [47]	To assess the need for culturally competent telepsychiatric services for patients with LEP at rural telemedicine sites in California	• Cross-sectional survey of providers and staff at 39 telemedicine sites in rural California (n=62). Data collection period not reported. • Phone or audio only and videoconference, via on-site interpretation (consecutive vs simultaneous not specified)	Rural clinics in 33 counties in Northern and Eastern California, including 4 IHS[c] clinics, serving culturally diverse populations with a high number of Hispanic and Vietnamese patients	Patient characteristics: Rural northern sites (n=842) • Age (18-30 y: 27.9%; 31-45 y: 29.5%; 46-65 y: 36.9%; 65 y and older: 4.1%) • Ethnicity (Caucasian: 96.7%; American Indian: 0.8%; Latino: 0.8%; African American: 1.6%; Asian: 0%) • Sex (male: 41.8%) IHS sites (n=145)	Providers and staff rated access to culturally competent telepsychiatric services as very limited, particularly for patients with LEP. Average care for patients with LEP was 1.3, and care for Spanish-speakers was 1.8 on a 1- to 7-point Likert scale, that is, “very hard to come by.” Untrained staff or family members were often used as interpreters;

Study	Study aims	Study design and telehealth or interpreting modality	Population and setting	Participants	Main findings
				• Age (18-30 y: 35.5%; 31-45 y: 37%; 46-65 y: 20%; 65 y and older: 6.6%) • Ethnicity (Caucasian: 17.8%; American Indian: 80%; Latino: 2.2%; African American: 0%; Asian: 0%) • Sex (male: 66.7%) • Language proficiency: LEP defined as patients who experience language barriers and require interpreter services	specifically, these included local site staff without the correct language (2.7%), a trained interpreter from the academic health center (3.7%), local site trained translator (8.2%), local site provider who spoke the patient's language (although technically untrained to translate; 17.2%), local site family translator (18.8%), and local site staff (technically untrained; 31.4%).
Iturralde et al [48]	To examine factors associated with perinatal depression treatment engagement by race or ethnicity among insured patients in a health care system	• Qualitative study using focus groups conducted from July 2018 to September 2018 with pregnant and postpartum women (8 groups, 2-7 participants per group, n=30) and clinician interviews (n=9) • Telemedicine and interpretation modality not specified	Kaiser Permanente Northern California, a large integrated health care system with medical facilities in 14 counties	Patient characteristics (n=30): • Age (mean 34, SD 5 y) • Ethnicity (Asian: n=10, 33%; Black: n=5, 17%; Latina: n=6, 20%; White: n=9, 30%) • Sex (female: n=30, 100%) • Pregnant: n=10, 33% • Postpartum: n=20, 67% • College graduate or more: n=13, 43% • Medicaid: n=5, 17% • Treatment type (psychotherapy only: n=8, 38%; medication only: n=3, 4%; combination: n=10, 48%) Clinician characteristics (n=9): • Specialty (OB-GYN[d]: n=6; internal medicine: n=1; psychologist: n=1; LCSW[e]: n=1) • Race or ethnicity (Asian: n=2; Black: n=1; White: n=6) • Years in practice: median 18, range 8-30 y) • Language proficiency: not defined or assessed; ethnic or racial minority perinatal women were the primary population of focus	Treatment barriers included social stigma, difficulties recognizing one's own depression, low understanding of treatment options, and lack of time for treatment. Distinct factors emerged for non-White women including culturally specific messages discouraging treatment, low social support, trauma history, and difficulty taking time off work for treatment. Participants recommended greater treatment convenience (eg, telemedicine). Lack of English proficiency posed additional barriers, according to clinicians. Patients might avoid disclosing depressive symptoms in front of medical interpreters, especially men.
Kreienbrinck et al [49]	To identify barriers and resources in providing mental healthcare to migrants using translation technologies (eg, machine translation, online dictionaries, and	• Qualitative study using 175 semistructured interviews conducted from November 2023 to December 2024 • Phone or audio only and videoconference, via on-site	Psychosocial health care providers, interpreters, service users with self-reported language barriers, supporters (eg, caregivers), and stakeholders (policymakers and CBOs[f]) in Germany, South Africa,	Participant characteristics (n=175): • Age (mean 40.2, SD 12.7 y) • Stakeholder type (health care personnel: n=27, 15%; service users: n=54, 31%; supporters: n=38, 22%; interpreters: n=32, 18%; stakeholders: n=24, 14%)	Thematic analysis yielded six themes, each with several subthemes: (1) perceived effectiveness and limitations of technological tools (limited effectiveness; context-specific suitability); (2) cultural, linguistic, and social fit (cultural and

Study	Study aims	Study design and telehealth or interpreting modality	Population and setting	Participants	Main findings
	pretranslated fixed phrase applications)	interpretation (consecutive vs simultaneous not specified)	Romania, the Netherlands, and China	• Country: (Germany: n=46, 26%; South Africa: n=49, 28%; Romania: n=34, 19%; Netherlands: n=23, 13%; China: n=23, 13%) • Language proficiency: not defined or reported; service user sub-sample (n=54, 31%) were users of interpreter services	contextual suitability; digital literacy and generational divide); (3) human aspects of communication and care (empathy and emotional connection; trust and relational dynamics); (4) ethical and attitudinal dimensions (user-based reflections and perspectives; ethical considerations); (5) implementation and improvement pathways (technical improvements; integration into existing workflows; policy, training, and institutional support); and (6) access barriers (infrastructure; practical constraints to tool use).
Lui et al [50]	To assess the feasibility and acceptability of telehealth-delivered psycho-oncology counseling sessions via different interpreting modalities for cancer patients with LEP, and exploring the impact on communication and treatment outcomes	• Mixed methods, 3-arm pilot randomized control trial of 45 Mandarin-speaking cancer patients with LEP, enrollment began March 2024 • Participants received 6 videoconferencing (Zoom)-delivered psychotherapy sessions via Remote Simultaneous Medical Interpreting (RSMI), Remote Consecutive Medical Interpreting (RCMI), or via a bilingual counselor	Mandarin-speaking Chinese American cancer patients with LEP recruited at a cancer center in the Northeast residing in New York or New Jersey	Patient characteristics: • Language proficiency: LEP defined as speaks English less than "very well" • Eligibility criteria (study protocol without reported participant characteristics): of Chinese descent, prefers to speak in Mandarin Chinese, stage III or IV cancer, >18 years old; resides in New York or New Jersey	This is a study protocol; results are pending. The study aims to determine feasibility and acceptability of RSMI and RCMI vs the "gold standard" of a bilingual counselor for delivering psycho-oncology counseling to cancer patients with LEP. Secondary outcomes include therapeutic alliance, content comprehension, and clinically significant interpreting errors between RSMI and RCMI.
Mishori et al [51]	To pilot remote asylum mental health evaluations for clients in a migrant encampment in Mexico	• Thematic analysis of post-evaluation surveys conducted from December 2019 to March 2020 with n=12 US-based clinicians who conducted 25 remote mental health evaluations with clients in Mexico • Phone or audio only and videoconference, via remote interpretation (consecutive vs simultaneous not specified)	Migrant encampment in Matamoros, across the US-Mexico border from Brownsville, Texas, since the Migrant Protection Protocols (MPP) policy requiring asylum seekers to wait in Mexico for US immigration court dates	Clinician specialty (n=12): • Psychiatrist: n=5, internal medicine: n=1, pediatrician: n=1, psychologist: n=3, clinical psychologist: n=2 • Language proficiency: Not defined or reported; almost all evaluations (24/25, 96%) required an interpreter	5 domains were identified: rapport building, achieving overall goal, comparison of in-person vs remote, technical issues, and coordination. Clinicians observed a decreased ability to establish rapport with the clients, technical difficulties, and diagnostic challenges being unable to virtually assess reactions. They also stated the importance of coordination and interpretation. Nearly uniformly, clinicians noted that despite difficulties, they were able to achieve the goals of the evaluation.

Study	Study aims	Study design and telehealth or interpreting modality	Population and setting	Participants	Main findings
Olavarrieta and Benuto [52]	Case study of a refugee patient with PTSD[g] treated using 18 phone sessions of narrative exposure therapy	• Qualitative case study of a case during the COVID-19 pandemic, 8 months after the client immigrated to the United States (n=1) • Phone or audio only via remote interpretation (consecutive vs simultaneous not specified)	Farsi-speaking client referred by an international center to a specialized clinic for victims of crime in an urban city in the mountain West of the United States	Patient characteristics (n=1): • Age: 26 years old • Race or Ethnicity: Afghani or Iranian • Language: Dari or Farsi (LEP) • Sex: Female • Immigrated to the United States 8 months prior to initial intake • Language proficiency: not defined or reported; case study focused on a patient who used Dari or Farsi interpretation services	This case explored the use of NET[h] via a phone interpreter. Recommendations included: using one consistent interpreter to increase rapport; debriefings between clinician and interpreter to review psychological and NET-specific terms, PTSD symptoms, and allowing for any clarifying questions to be asked by the interpreter.
Phimphasone-Brady et al [53]	To assess the telehealth implementation experiences of ambulatory personnel in different disciplines (including psychiatry) and their perspectives on potential telehealth disparities (including for patients with LEP served via remote consecutive interpretation)	• Convergent parallel mixed methods design (quantitative survey and qualitative responses to open-ended questions) collected from June 2020 to July 2020 with n=147 clinicians and staff from geriatric medicine, internal medicine, and psychiatry • Phone or audio only and videoconference, via remote interpretation (consecutive vs simultaneous not specified)	Clinicians and staff working in 3 ambulatory care disciplines (geriatric medicine, internal medicine, and psychiatry), at an academic medical center in Colorado, United States, during the COVID-19 pandemic	Clinician or staff demographics (n=147): • Sex (female: n=98, 66.7%; male: n=46, 31.3%; nonbinary: n=3, 2%) • Age (18-34 y: n=55, 37.4%; 35-54 y: n=68, 46.2%; older than 55 y: n=24, 16.3%) • Race (White: n=107, 72.8%; Black or African American: n=8, 5.4%; Asian: n=8, 5.4%; American Indian or Alaskan: n=1, 0.7%; other or multiple races: n=13, 8.9%; chose not to disclose: n=12, 8.2%) • Clinic role or position (attending faculty: n=51, 34.7%; resident or fellow: n=28, 19%; medical assistant or licensed practical nurse: n=28, 19%; registered nurse or other clinical specialist: n=11, 7.5%; administrative support: n=15, 9.5%; mental health provider: n=9, 6.1%; other: n=6, 4.1%) • Language proficiency: not formally assessed or reported	Prior to 2020, 77% of clinicians had never delivered telehealth services. By Spring 2020, 78% reported conducting more than half of clinic visits by telehealth. Among clinicians, 52% agreed or strongly agreed that rapid telehealth implementation exacerbated disparities among those needing interpretation services. Clinicians noted difficulty accessing and arranging interpreter services for virtual visits. Notably, there was a trend (P=.076) for geriatrics and internal medicine clinicians to perceive greater disparity rates than psychiatry clinicians.
Pogue et al [54]	To assess clinician perspectives and experiences conducting remote asylum evaluations	• Cross-sectional survey collected from September 2020 to October 2020 with clinicians performing asylum evaluations (n=155) • Phone or audio only and videoconference, via remote interpretation (consecutive vs simultaneous not specified)	Clinicians identified and recruited through the Physicians for Human Rights Asylum Network	Clinician characteristics (n=155): • Age (mean 53.4 y) • Sex (female: 121/153, 79.1%; male: 32/153, 20.9%) • Specialty (psychologist: 28/154, 18.2%; psychiatrist: 27/154, 17.5%; social worker: 26/154, 16.9%; family medicine: 19/154, 12.3%; internal medicine: 18/154, 11.7%;	155 clinicians responded to the survey, 104 of whom had received referrals for remote evaluations, 75 of whom had completed at least one of those referrals. The vast majority of clinicians performing remote asylum evaluations had positive experiences, although many experienced challenges related to performing physical

Study	Study aims	Study design and telehealth or interpreting modality	Population and setting	Participants	Main findings
				emergency medicine: 9/154, 5.8%; pediatrics: 9/154, 5.8%; OB-GYN: 3/154, 1.9%; other: 15/154, 9.7%) • Years of experience with asylum evals: mean 7.1 y • No formal explicit LEP definition, there is an implicit operation definition where LEP referred to asylum seekers requiring interpretation services for effective communication during asylum evaluations	evaluations. The vast majority reported that remote interpretation was effective (85%, 51/60), and clinicians reported wanting to continue doing remote evaluations even after the pandemic.
Tougas et al [55]	To measure the frequency and accuracy of the translation of figurative language devices and patient word count per minute in telepsychiatric assessment with Spanish-speaking patients with LEP with human interpreter vs asynchronous AI translation	• Cross-sectional analysis of transcripts of 2 methods of telepsychiatric assessment conducted in 2021 with n=6 Spanish-speaking patients with LEP • Method A: in-person assessment via human interpreter (consecutive vs simultaneous not specified) • Method B: "asynchronous telepsychiatry"; interview in Spanish, translated via AI, then shared with an English-speaking psychiatrist for diagnosis and treatment planning	Hispanic individuals with significant LEP from mental health and primary care clinics, and screened to likely to have a nonurgent psychiatric disorder or chronic medical condition	Patient characteristics (n=6): • Sex (female: n=4, 67%; male: n=2, 33%) • Age (mean 53, range 42-71 y) • Country of birth (Mexico: n=4, 67%; Costa Rica: n=1, 17%; Guatemala: n=1, 17%) • Spanish-speaking: n=6, 100% • LEP: n=6, 100% • Language proficiency: LEP defined as reduced ability to speak, write, or read English	Study compared the number of FLDs[i], the translation accuracy of figurative language, and the patient word counts were compared as proxies for interview complexity and volume. The authors found in the AI interpretation model that word counts were greater, and FLDs were more common but less accurately translated than in the human interpreter model.
Weith et al [56]	To examine sociocultural and structural barriers that may impact telemental health services received by resettled refugees via remote consecutive interpretation during the COVID-19 pandemic	• Cross-sectional survey collected in August 2020 from 85 mental health providers serving refugee and non-refugee clients in the United States • Phone or audio only and videoconference, via remote interpretation (consecutive vs simultaneous not specified)	Mental health providers enrolled in 2 listservs—NCTTP[j] and APTC[k]—to capture providers who treat refugee vs non-refugee clients (NCTTP and APTC, respectively)	Provider characteristics (n=85): • Clinician focus (refugee clients: n=50, 58.8%; nonrefugee clients: n=35, (41.2%) • Role (Clinician: 54.12%; Supervisor: 49.41%; Student therapist: 7.06%) • Experience with age groups (adult: 97.65%; children: 45.88%; adolescents: 59.82%; older adults: 60%) • Language proficiency: not formally assessed or reported; discussed LEP as a social determinant of health and a structural barrier to accessing mental health services	Providers described the following barriers: lack of privacy due to space constraints, technology challenges, and difficulty contacting clients or setting up appointments. Benefits included fewer cancelations and transportation problems; better access to childcare; and more opportunities to observe clients' circumstances in "home" visits. Recommendations include increasing access to technology, providing culturally sensitive

Study	Study aims	Study design and telehealth or interpreting modality	Population and setting	Participants	Main findings
					clinician training, and funding programs to reduce stigma.
Yellowlees et al [57]	To examine the feasibility and diagnostic reliability of asynchronous telepsychiatry (ATP) consultations in Spanish vs in Spanish-to-English translation	• Cross-sectional analysis of 2 assessment methods of 24 interviews conducted from 2008-2009 of Spanish-speaking patients using the Structured Clinical Interview for DSM-IV[l] Axis I Disorders (SCID-I[m]) • Method 1: in-person clinical interview in Spanish followed by assessment by Spanish-speaking psychiatrists reading the Spanish-language transcripts • Method 2: in-person clinical interview in Spanish translated into English, then assessed by English-speaking psychiatrists reading the translated transcripts	Spanish-speaking patients referred by their PCP[n] for a psychiatric consultation from 3 primary care centers in Tulare County, California	Patient characteristics (n=24): • Age (mean 47.9, SD 13.4 y) • Sex (female: n=15, 63%; male: n=9, 38%) • Education (less than high-school: n=10, 59%; high-school: n=5, 29%; college: n=2, 12%) • Currently employed (yes: n=7, 30%; no: n=16, 70%) • Religion (yes: n=20, 83%; no: n=4, 17%) • Children (mean 3.9, SD 3.1) • Diagnoses (mood: n=13, 54%; anxiety: n=4, 17%; substance use: n=1, 4%; mood and anxiety: n=3, 13%; mood and substance: n=1, 4%; psychotic: n=1, 4%; no diagnosis: n=1, 4%) • LEP: n=24, 100% (LEP explicitly defined as limited English proficiency and individuals experiencing restricted access to health care and mental health services due to language barriers)	Study demonstrates that asynchronous telepsychiatry across languages is a feasible clinical process that can avoid the need for real-time interpreters. Kappa values for agreement with the expert psychiatrist were 0.52 or above (moderate-very good) across all raters and categories (percentage agreement 79% and higher). The highest agreements with the expert psychiatrist were in the substance abuse 0.63-1.00 (92%-100%) and psychotic disorder 1.00 (100%) categories. Moderate to very good agreement was found in the anxiety 0.55-0.90 (79%-96%) and mood disorder 0.52-0.78 (83%-92%) categories.

[a]LEP: limited English proficiency.
[b]OR: odds ratio.
[c]IHS: Indian Health Service.
[d]OB-GYN: obstetrics and gynecology.
[e]LCSW: licensed clinical social worker.
[f]CBO: community-based organization.
[g]PTSD: posttraumatic stress disorder.
[h]NET: narrative exposure therapy.
[i]FLD: figurative language device.
[j]NCTTP: National Consortium of Torture Treatment Programs.
[k]APTC: Association of Psychological Training Clinics.
[l]DSM-IV: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.
[m]SCID-I: Structured Clinical Interview for DSM-IV Axis I Disorders.
[n]PCP: primary care provider.

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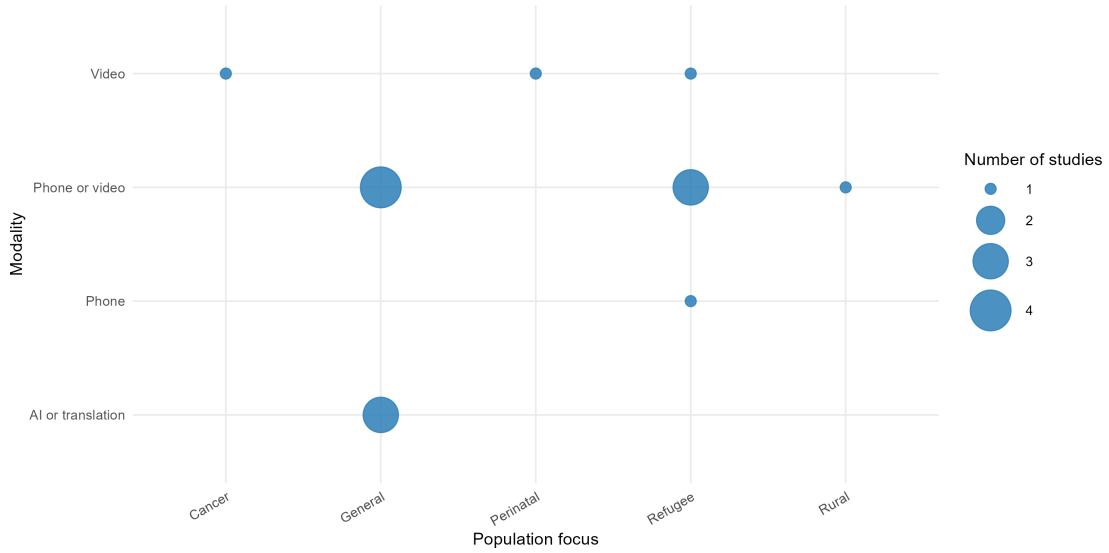
Synthesis of Results

The studies were undertaken in 8 different countries (United States, Mexico, Australia, Germany, South Africa, Romania, the Netherlands, and China), with the majority focused on Spanish-speaking populations. Of the 15 studies, 10 used data collected during the COVID-19 pandemic as mental health services underwent a rapid transition to telemedicine [43,44,46,48,51-56], and 13 of the 15 articles were published during or after the pandemic (ie, 2020 or later) [43-46,48-56]. Special populations of focus included refugees or asylees (6/15 studies) [44,45,51,52,54,56], rural populations (3/16 studies) [47,55,57], and perinatal women (1/16 studies) [48]. The majority of studies (8/12) discussed both phone or audio-only and videoconference telemental health modalities [43-47,49,51,53,54,56], 1 used videoconference only modality [50], 1 used phone or audio-only modality [52], 2 used asynchronous modalities (ie, in-person structured clinical interview in the patient's preferred language conducted by a bilingual research assistant, which was translated into English, followed by an assessment by a psychiatrist reading the translated interview) [55,57], 1 focused on translation technologies (ie, machine translation applications such as Google Translate) [49], and 1 did not specify telemental health modality [48]. Of the 13 studies that discussed synchronously delivered telemental health services to individuals with LEP [43-49,51-54,56,58], only 1 distinguished between consecutive vs simultaneous interpretation [50], and another focused on use of machine translation applications [49] (Table 1). Studies used many different research methods and were generally of acceptable quality, with 5 of the 15 studies [44,47,49,56,57] receiving a MMAT score of 5/5, 7 studies [43,46,48,51-53,55] receiving a MMAT score of 4/5, 1 study [54] receiving a MMAT score of 3/5, and 2 studies [45,50] receiving a MMAT score of 2 or below; 1 [50] was a protocol paper and the majority of items were not applicable (Multimedia Appendix 2; refer to Multimedia Appendix 1 for justifications of study ratings). Studies included a wide range of disciplines, including social work, psychology, public health, and psychiatry. A thematic synthesis of the studies follows. Figure 2 presents an evidence gap map illustrating the distribution of studies across population groups and telemental health modalities.

Figure 2. Evidence gap map of interpreter- and/or translation-mediated telemental health care.



Key Themes

Overview

We identified 4 broad themes across the 15 studies included in the review: (1) access facilitators; (2) barriers to access; (3) therapeutic process considerations; and (4) recommendations to optimize interpreter- and/or translation-mediated telemental health care to LEP/LLP individuals.

Access Facilitators

Facilitation of Mental Health Care Access for Individuals With LEP Amid Pandemics

Of the 15 articles, 10 under review were published using data collected during the COVID-19 pandemic [43,44,46,48,51-56], highlighting the ability to continue offering mental health services to patients with LEP and LLP amid the pandemic as a benefit of interpretation and/or translation-mediated telemental health. Despite the learning curve associated with the sudden uptake of telemental health delivery, studies largely highlighted clinicians' adaptability and resourcefulness in providing care to individuals with LEP and LLP in the context of an emerging global pandemic. For example, in a study by Disney et al [44] assessing mental health clinicians' perspectives on shifting to telemental health delivery at a refugee-serving mental health clinic, the authors noted providers' flexibility and self-directed engagement in telemental health learning and skill acquisition, through supervision and/or "check-in" meetings with colleagues with telemental health experience and resources available on the internet (articles, webinars, etc). Similarly, in the study by Phimphasone-Brady et al [53], while the majority of providers (53%) did not feel equipped to use telemental

health before COVID-19, all reported feeling equipped to use it by the end of the study.

Potential for Greater Access to Mental or Behavioral Health Care for Individuals With LEP and LLP Due to a Reduction in Transportation and Time Burden

Of the 15 articles, 7 discussed the ways in which interpretation and/or translation-mediated telemental health care had potential to increase access to care due to a reduction in access barriers related to transportation and time burden [46,48,50,51,53,54,56]. Although these benefits existed before the pandemic, several papers noted that COVID-19 accelerated telehealth adoption, creating the potential to either benefit—or fail to benefit—individuals with LLP and LEP. For example, the study by Phimphasone-Brady et al [53] of telehealth implementation in 3 ambulatory care services (including psychiatry) during the COVID-19 pandemic found that telepsychiatry reduced transportation barriers, which disproportionately affect patients with LEP. However, this benefit was not fully realized because telehealth platforms were not multilingual nor equipped to integrate foreign language interpreters into visits [53]. In contrast, a postpandemic study by Weith et al [56] examining practitioners' perspectives on barriers to and benefits of telemental health services for resettled refugees and asylees in the United States found that most providers identified transportation challenges (eg, unreliable transportation, long commutes, lack of a driver's license, and travel costs) as among the most significant barriers to in-person care for individuals with LEP. Accordingly, they viewed the elimination of transportation requirements as one of the primary benefits of telemental health and noted improved session attendance [56], likely reflecting that refugee-serving providers had already integrated interpreters into their telemental health care workflows.

Reductions in time burden were also observed for clinicians and administrators in both pre- and postpandemic studies. In a pilot study of remote asylum mental health evaluations for clients in a migrant encampment in Mexico by Mishori et al [51], which was conducted before the COVID-19 pandemic, the authors observed that in-person asylum evaluations were often conducted in detention facilities in remote locations, requiring clinicians to travel several hours to perform exams that are themselves several hours long, reducing feasibility. By contrast, the option to conduct the evaluations remotely increased their feasibility for clinicians, thereby increasing access to asylees who otherwise would not have received an evaluation [51]. Similarly, in the study by Pogue et al [54], assessing clinician perspectives and experiences conducting remote asylum (primarily psychiatric) evaluations during the COVID-19 pandemic, more than 60% of respondents said conducting remote evaluations was a "time saver" and more than half agreed they would like to continue doing asylum evaluations remotely even after the COVID-19 pandemic. Time savings for clinicians were observed in the ambulatory psychiatry setting as well. In the study by Phimphasone-Brady et al [53], conducted during the pandemic, several clinician and staff members noted "great efficiencies with clinic operations" due to fewer delays associated with late patients and check-ins.

Increased Access to Linguistically Appropriate Care, Especially for Hard-to-Reach Populations

Another consistent subtheme was how interpreter- and translation-mediated telemental health delivery can expand access to language concordant care, especially for medically underserved populations and contexts such as rural populations [47], refugees or asylum seekers [43,51-53,56], patients with advanced cancer with symptom burden [50], perinatal women [48], and individuals in countries with limited language diffusion (eg, South Africa, which has 12 official national languages, and where more than 80% of medical consultations occur in the presence of language barriers) [49]. Notably, several of these studies examined telemental health pilots conducted before the pandemic [47,51,57], suggesting that underserved settings were early adopters of interpreter- and translation-mediated telemental health care. In the study by Hilty et al [47] assessing the psychiatric needs of patients with LEP at rural telemedicine sites in California, for example, providers and staff rated obtaining in-person psychiatric consultations for patients with LEP and Spanish-speakers as "very hard to come by." Providers noted that untrained staff or family members were often used as interpreters and observed that telemental health delivery could facilitate linguistically appropriate care because a trained interpreter could join remotely (as opposed to requiring an in-person interpreter) [47]. Similarly, studies that focused on the needs of refugees and asylum-seekers highlighted the promise of interpreter-mediated telemental health to increase reach and access for this population, despite technological and logistical challenges associated with telehealth delivery [44,51,52,54]. In the study by Mishori et al [51]—also conducted before the pandemic—clinicians explicitly framed their experience conducting remote asylum mental health evaluations as a set of tradeoffs whereby interpreter-mediated remote delivery could increase reach and access for detained asylum seekers without compromising accuracy, even if the process involved challenges (eg, loss of verbal and physical connection, technical difficulties, and increased complexity—particularly in the asylee population—refer to the "Greater complexity of care" section); "Even though it isn't ideal, it's an acceptable way for asylum seekers to get the help they need," and "It allows us to reach many more folks" [51].

While the majority of articles under review discussed telemental health delivery in the context of synchronous (ie, real-time) language interpretation, 2 articles specifically noted the potential for asynchronous telepsychiatry (ATP) to meet service gaps for patients with LEP and LLP [55,57]. In ATP, a primary care provider or other nonspecialist conducts a clinical interview in the patient's preferred language. The interview is then translated (by a professional human translator or AI) into the preferred language of the psychiatric specialist who would be evaluating it, obviating the need for a

real-time interpreter [55,57]. For example, in a pilot study by Yellowlees et al [57] examining the feasibility and diagnostic reliability of ATP consultations in Spanish, conducted in a rural county in central California, the authors note ATP's potential to increase access to psychiatric assessment and medication management among difficult-to-access groups, such as incarcerated individuals and the military.

"Fit" Between Mental Health Services and Telehealth Delivery

Another access facilitator identified through thematic coding was perceived compatibility ("fit") between mental health services and telehealth delivery. Notably, this subtheme appeared more frequently in postpandemic publications, suggesting increased openness to telemental health approaches following the pandemic. For example, in a study by Pogue et al [54] assessing clinicians' experiences conducting remote asylum psychiatric evaluations during the COVID-19 pandemic, the majority of clinician-evaluators reported they were easily able to assess mental status and affect via interpreter-mediated videoconference calls, that the psychological examination was easy to conduct, and that there was no significant difference in their ability to obtain the history compared with an in-person evaluation. Similarly, the study by Phimphasone-Brady et al [53], which examined telehealth implementation data across 3 ambulatory care services during the Covid-19 pandemic, highlighted "better suitability" for telehealth delivery for the services provided by the psychiatric clinic (eg, psychotherapy, medication management, and consultation) compared with services offered by internists and geriatricians, because psychiatrists may have less of a need to complete a physical exam beyond what can be seen via video.

Access Barriers

Greater Complexity of Care

Of the 15 articles, 5 under review identified greater complexity of care for refugees or asylees with LEP or LLP as a potential barrier to telemental health access [44,51,52,54,56]. This subtheme was present in both pre- and postpandemic articles discussing remotely conducted mental health asylum evaluations, which are highly specialized medicolegal encounters to collect physical and/or mental health evidence for use in immigration proceedings [51,54]; as well as in studies concerning asylees and refugees more generally [44,52,56], because this population is more likely to experience trauma, displacement, and housing instability. For instance, Mishori et al [51] described the need to involve multidisciplinary team members to coordinate care in their pilot project conducting remote asylum mental health evaluations for clients in a migrant encampment in Mexico. Similarly, the case study by Olavarrieta and Benuto [52] on conducting remote narrative exposure therapy (NET) with a Farsi-speaking refugee client emphasized the importance of close collaboration between the clinician and interpreter, particularly in trauma work. Specifically, they observed that switching between different interpreters could impact the patient's sense of security and comfort, and that it would therefore be beneficial to rapport-building to coordinate and schedule the same interpreter throughout the therapy [52]. In their case, they were fortunate to find an interpreter who was willing and available to attend all their sessions with the client, but this is not possible in many health settings, and their example illustrates how needing to coordinate interpreters could act as an access barrier and contribute to the complexity of care for patients with LEP and trauma histories.

Studies focused on the general population with LEP and LLP (as opposed refugees and asylees) described complexity of care challenges associated with use of technology [43,49,53] (refer to Technology-Related Barriers section).

Technology-Related Barriers

Technology-related barriers to interpretation and translation-mediated telemental health care featured in 7 of the 15 articles under review, and this theme appeared in both prepandemic studies and those published after the COVID-19 pandemic [43,46,49,51,53,54,56]. In the qualitative study by Kreienbrinck [49] exploring the experiences, attitudes, and needs of stakeholders in 5 countries (Germany, South Africa, Romania, the Netherlands, and China) regarding use of translation technologies (eg, Google Translate and ChatGPT [OpenAI]) in mental health care, participants described infrastructure-related barriers that limited use of translation technologies, including unstable electricity and poor internet connectivity; these were particularly pronounced in the South African subsample [49]. Cheung et al [43] observed that patients with LEP were significantly more likely to face unresolvable user issues and preferred audio-only interactions, possibly because interpreters were available only via audio, even when clinicians were seen via video. Similarly, Gallegos-Rejas et al [46] found that users of interpreter services were 13% less likely to use video and 40% less likely to use telehealth services than patients who did not require interpreter services. Phimphasone-Brady [53] observed that people with lower socioeconomic status—individuals with LEP are more likely to be low-income—were disproportionately affected by the switch to telehealth during the COVID-19 pandemic due to lack of stable broadband access, limited data, and/or inadequate access to electronic devices. Mishori et al [51] and Weith et al [56] presented similar findings, showing that technology-related challenges were particularly prominent among asylees and refugees with LEP, who are more likely to reside in temporary living conditions without stable broadband access (refer to Systemic Barriers section).

Lack of Linguistically-Responsive Resources to Support Language Concordant Telemental Health Care

Another pivotal subtheme was barriers related to subpar resources available to support language concordant telemental health care, which were discussed in 6 of the 15 studies under review [46,47,49,50,53,56]. Although this theme appears in both pre- and postpandemic studies, earlier research emphasized interpreter shortages, while later studies highlighted gaps in linguistically responsive telehealth

platforms—likely reflecting evolving needs following the rapid expansion of telehealth. In the prepandemic study by Hilty et al [47], surveyed providers rated care for patients with LEP as "hard to come by" because sites lacked trained medical interpreters. In contrast, the postpandemic study by Gallegos-Rejas et al [46] found that patients requiring interpreters had 66% lower telehealth uptake compared with their EP counterparts, potentially due to English-language patient portals for non-EP patients. Weith et al [56] similarly noted how telehealth delivery could exacerbate resource barriers, because additional resources would need to be devoted to technology troubleshooting and to the development of linguistically appropriate telehealth platforms. For example, providers observed that some video platforms lack interpreter integration features. Even when such functionality was available, many providers reported difficulties in reaching interpreters, leading to increased administrative effort to secure an interpreter and reducing the time available for clinical care [56]. In the postpandemic study by Kreienbrinck et al [49], which examined stakeholders' perspectives on translation technologies, stakeholders observed that these tools are imperfect and often insufficient for conveying the nuances of mental health communication (refer to "The medium is the message" below). As a result, they were typically used only when human interpreters were unavailable and were viewed as a supplement that should be incorporated into broader language access strategies [49].

Systemic Barriers

Systemic barriers—that is, institutionalized policies, practices, and norms that create obstacles to access for certain groups—were also discussed in 6 of the 15 studies under review [44,46,47,49,53,56]. For example, Gallegos-Rejas et al [46] found that patients with LEP were more often referred for in-person clinical appointments instead of telehealth services, which systematically decreased access to telehealth for patients with LEP—a potential partial explanation for the disproportionately low uptake of telehealth services among patients with LEP compared with their EP counterparts. Studies concerning refugees and asylees observed that this population was more likely to face resource barriers, including lack of access to electronic devices, reliable Wi-Fi signals, and a confidential space for their sessions [44,56].

Although these barriers were observed in both pre- and postpandemic studies, 1 prepandemic barrier—inequities in billing across telemental health vs in-person services—proved to be more adaptable during the pandemic. The prepandemic study by Hilty et al [47] highlighted that emerging telemental health modalities, such as translation-mediated ATP, were not yet incorporated into existing billing frameworks. While this issue has not been fully resolved—the consulting psychiatrist in an ATP encounter would be considered an external consultant and therefore unable to access federal funding streams at federally qualified health centers—the rapid adjustments to billing policies during the pandemic (ie, telehealth and in-person parity) demonstrate that such structural barriers are modifiable.

Therapeutic Process Considerations in Telemental Health With Populations With LEP

Rapport-Building in the Context of Telemental Health Delivery

All 15 of the articles under review discussed rapport-building (ie, building a harmonious and collaborative alliance between the provider and patient) as a key factor to consider in interpreter and/or translation-assisted telemental health delivery in populations with LEP [43-49,51-58]. This theme appeared consistently in both pre- and postpandemic literature, indicating that it remained a central concern even after the widespread adoption of telehealth during the pandemic. In the cross-sectional study by Cheung et al [43] assessing patient and provider characteristics associated with barriers to and facilitators of satisfactory consultation-liaison telepsychiatry encounters, the authors found that patients who preferred any language other than English were significantly less likely to have participated in an encounter with a positive assessment of rapport, suggesting significant challenges in this domain [43]. A number of qualitative studies—most of which focused on the asylee or refugee population—yielded further insights regarding barriers to building rapport with patients via telemental health, highlighting challenges posed by the absence or limited nature of nonverbal communication [44,48,51,52]. For example, refugee mental health providers shared that they had an especially difficult time building rapport and assessing mood when meeting via telehealth for an initial evaluation, stating they preferred initial meetings to be in-person [44], and clinicians conducting remote asylum mental health evaluations noted that building rapport was especially challenging in the asylee population, as clinicians needed to collect "very sensitive and painful" information [51]. Relatedly, the authors of a case study of a telephone-delivered psychotherapy intervention with a patient with LEP and PTSD noted that observing body language and facial expressions would have been especially beneficial in conducting cross-cultural psychotherapy with a traumatized individual, given the language barrier between therapist and patient [52].

On the other hand, providers in the study by Weith et al [56] highlighted unexpected benefits to rapport due to telemental health delivery. Specifically, therapists observed that the lack of the "physical presence of the therapist" could at times allow clients with LEP to reveal "more vulnerable aspects of their experience" that they might not have felt comfortable sharing in person [56]. Moreover, providers reported that they gained a deeper understanding of their clients' context by directly observing their stressors (eg, familial stressors, linguistic barriers to care, economic hardship, and exposure to violence and discrimination), because the interpreter-mediated telemental health sessions took place in clients' homes. This firsthand view enabled them to conduct more in-vivo interventions "in real time," suggesting that the telehealth modality improved rapport by enhancing their understanding of clients' social determinants of health [56].

Notably, only 1 article under review specified whether synchronous remote interpretation was conducted consecutively vs simultaneously—a published protocol of a mixed methods pilot randomized controlled trial examining the feasibility and acceptability of telehealth-delivered psycho-oncology counseling delivered through different interpreting modalities for patients with cancer having LEP [50]. This gap limits our ability to determine how interpretation modality may influence rapport.

Another study examined emerging translation technologies such as ChatGPT, reflecting growing postpandemic interest in new technological approaches to linguistically appropriate telemental health care. Additionally, 2 studies focusing on asynchronous translation methods suggested that the type of modality used (ie, AI vs human interpreter) [55,57] may shape patient-provider interactions in ways that could affect rapport-building (refer to "The medium is the message" below).

"The medium is the message": the modality itself (ie, AI vs human interpreter, phone vs videoconferencing) may change the nature of the interaction.

One notable subtheme concerned how the modality or "medium" of telemental health services can itself change the nature of the interaction. As communication theorist, Marshall McLuhan argued, "the medium is the message": technological changes—such as the presence or absence of a human interpreter (eg, when using AI or translation tools), or the use of telephone versus videoconferencing—can shape both the therapeutic process and the "scale and form" of interactions between provider and patient. Although this theme appears in both pre- and postpandemic literature, the specific modalities examined—and their perceived effects on care—reflect the technologies available at the time.

For example, studies involving human interpreters emphasized interpersonal and procedural factors, such as the interpreter's gender [48], and proposed strategies to reduce friction in triadic encounters, including clinician-interpreter debriefings before and after sessions [52]. More recent work extends this line of inquiry by explicitly testing how different remote interpreting modalities shape the clinical interaction; for instance, a proposed trial comparing remote simultaneous medical interpreting with remote consecutive medical interpreting evaluates whether these approaches differ in rates of clinically significant interpreting errors, the patient's level of content comprehension, and strength of the therapeutic alliance [50].

A pandemic-era study by Tougas et al [55] leveraged a natural experiment to compare 2 telepsychiatric assessment approaches amid a shift to videoconferencing; midway through data collection, interviews moved from in-person to Zoom (Zoom Communications) due to the pandemic. In method A, an English-speaking psychiatrist interviewed Spanish-speaking patients with the assistance of a human interpreter. In method B, a Spanish-speaking interviewer conducted the assessment, which was then recorded, translated, and transcribed using AI, then reviewed by an English-speaking psychiatrist. The authors found that both the method of interpretation and the communication medium influenced the clinical encounter and potentially the evaluator's understanding of the patient's psychopathology. AI-mediated interviews produced higher word counts and more figurative language, suggesting that patient speech may be simplified and truncated when mediated by a human interpreter, potentially limiting the comprehensiveness of the psychiatric assessment [55]. Additionally, after the transition to Zoom, participants used shorter phrases and exhibited longer pauses, indicating that videoconferencing itself may further shape patient-provider interactions [55].

Challenges in Phone and Audio-Only Delivery

Another prominent subtheme was specific challenges raised by phone and audio-only delivery, which limited clinicians' ability to see facial expressions and other nonverbal cues. This issue was particularly prominent in postpandemic studies, where videoconferencing options were generally available but remained inaccessible for some patients with LEP due to limited digital literacy or barriers to access. In addition to the challenges audio-only encounters could pose to building rapport, providers described logistical difficulties delivering mental health interventions that were developed assuming in-person delivery. For example, practitioners in the study by Weith et al [56] observed that interactive interventions that incorporated photos or modeling, and trauma interventions including NET, felt "impossible to do over the phone." On the other hand, the clinician in the case study by Olavarietta and Benuto [52] used NET in phone sessions by incorporating adaptations for audio-only delivery, that is, offering feedback regarding other nonverbal observations (eg, on how the client's voice sounded while retelling certain details)—notably, an intervention possible only with consecutive vs simultaneous interpretation—and asking clients to visualize and verbally describe objects and memories. Providers in the study by Disney et al [44] similarly described modulating their interventions for phone delivery, including compensating for the lack of nonverbal interaction by demonstrating "increased attention to verbal validation of feelings."

Recommendations to Improve Quality of and Access to Care

Train and Educate Stakeholders

The most common recommendation made to improve access to telemental health care in populations with LEP was to train and educate stakeholders, including patients, providers, and administrative staff. This subtheme was especially pronounced in postpandemic literature, as mass adoption made clear inequities in digital literacy among populations with LLP and LEP. In the study by Disney et al [44], clinicians recommended seeking out various resources for skill development in telemental health practice (eg, webinars, meetings with supervisors and colleagues, and clinic-sponsored trainings). Phimphasone-Brady et al [53] and Pogue et al [54] also emphasized the need for additional targeted training and resource provision for both patients and clinicians related to virtual platforms, including patient-facing

how-to guides and instructions for clearer guidance on video visits and trainings to increase familiarity with technology, to help clinicians feel more confident and work more efficiently with telehealth delivery. Gallegos-Rejas et al [46] also discussed the importance of promoting education and training for both patients and providers on digital tools needed for telehealth (eg, Zoom, MyChart, and Doximity). Weith et al [56] similarly recommended specific training on communication between providers and interpreters to establish collaborative relationships in the telemental health context, especially in light of the lack of standardized professional guidelines for this. Kreienbrinck et al [49] also noted the need for institutional guidelines and training regarding the use of translation technologies in mental health. These strategies have the potential to help bridge digital divides, more effectively address language barriers, and ultimately improve the quality of telemental health care provided to patients with LEP.

Improve Infrastructure

Another key recommendation for improvement that emerged was to make infrastructure improvements at the institutional or governmental level to reduce barriers to access. This subtheme was largely absent from prepandemic literature, likely because such recommendations were less relevant before the widespread adoption of telemental health delivery. Phimphasone-Brady et al [53] suggested enhancing access to devices, technologies, and free Wi-Fi, and recommended increased funding for telemedicine-specific language and interpreter services (ie, telehealth platforms with improved interpreter integration features that would support the synchronous use of multiple families and translators). These changes would potentially address both technology and interpretation-related barriers. Weith et al [56] proposed collaborating with local community-based organizations (CBOs) to provide safe and private spaces for patients with LEP who might lack them. One notable exception to the limited discussion of this theme in the prepandemic literature is the study by Mishori et al [51], which provides a practical example of this approach. In this case, a local, refugee-serving CBO provided private rooms and wireless internet access for videoconferencing to clients living in a migrant encampment and helped coordinate the multiple parties involved in remote asylum evaluations (ie, interpreters, legal advocates, and clinicians). This partnership likely contributed to clinicians' positive assessment of the feasibility and acceptability of remote asylum evaluations [51].

The cross-country qualitative study by Kreienbrinck et al [49] similarly underscores that adequate infrastructure—such as unreliable internet connectivity, limited access to devices, and poor integration of translation tools into clinical systems—remains a critical barrier to effective use of translation technologies in telemental health care. Their findings highlight the need for system-level investment in accessible, secure, and well-integrated translation technologies, as well as institutional policies and training to support their consistent and equitable use (refer to "Train and educate stakeholders" section).

Finally, institutions may need to reshape their workspaces to adapt to telemental health delivery, as suggested by the findings of Disney et al [44] that clinicians reported needing to physically change their space to accommodate remote sessions with clients. For example, providing funding for home office upgrades, upgrading videoconferencing technology, and implementing hoteling and office reservation systems could better accommodate hybrid schedules for clinicians who treat patients with LEP both in-person and via telehealth at home.

Discussion

Summary of Evidence

The aim of this scoping review was to summarize the available research evidence on interpreter and/or translator-mediated telemental health care for individuals with LEP.

Our review identified studies that represented a range of disciplines (ie, social work [44], psychology [45,48,50,52,53,56], public health [46,49,51,54], and psychiatry [43,47,55,57]), contexts (eg, academic medical centers [48,50,53], migrant encampments and refugee-serving clinics [44,45,51,56], and rural clinics [47,55,57]), and research methods (eg, qualitative [44,48,49,51,52], quantitative [43,46,47,54,55,57], and mixed methods [45,50,53,56]). These studies largely examined the process of delivering interpretation and/or translation-mediated telemental health care to populations with LEP and LLP [44,45,49,51,52,54], provider and patient factors associated with interpretation and/or translation-mediated telemental health care quality and/or access [43,46-48,51,53,54,56], and comparisons of different interpretation and translation modalities (eg, AI-translated ATP vs a synchronous psychiatric encounter facilitated by a human interpreter [55,57], simultaneous vs consecutive interpreting [50]). Notably, the number of studies that met our eligibility criteria was smaller than the number identified by prior reviews that focused primarily on in-person mental health services delivered to populations with LEP [18,22,26-28,34,35], pointing to the need for further research in this area, especially as telemental health delivery and use of AI-enabled translation technologies grows increasingly common [41]. Most studies did not explicitly define or assess LEP and LLP [43-45,48,49,51-54], suggesting a need for improved reporting standards, and few directly captured patient experiences, highlighting the importance of more patient-centered research in this area.

Studies discussed how a reduction in transportation and time barriers afforded by interpretation and translation-mediated remote delivery could increase access to linguistically appropriate mental health care [46,48,50,51,53,54,56], especially for hard-to-reach populations (eg, rural populations, patients with advanced cancer, and refugees or asylum seekers) [43,47,49-53,56]. Facilitation of mental health care access amid global pandemics was a prominent subtheme, likely a reflection of the timing of these publications; most included articles were published using data collected during the COVID-19 pandemic [43,44,46,48,51-56].

However, some of the findings regarding access barriers [44] were already outdated due to the pandemic's acceleration of telemental health uptake. For example, telehealth-friendly clinical offices and telehealth platforms that accommodate more than 2 parties (including interpreters) have been widely adopted [59]. This highlights the need for updated, postpandemic research to identify current barriers to and facilitators of interpretation and translation-mediated telemental health care access, as well as for state and federal policymakers to adopt regulations (eg, regarding controlled substance prescribing via telehealth, interstate practice restrictions, and CMS reimbursement for language services) [60] to ensure individuals with LEP or LLP can meaningfully access these services.

Findings concerning factors that could impact the therapeutic process when delivering interpretation and/or translation-mediated telemental health care to populations with LEP and LLP demonstrated how telemental health modalities themselves (eg, the presence or absence of a human vs AI interpreter, phone vs videoconferencing technology) [50,55] shaped the therapeutic process, as exemplified by a study that showed patients use more simplistic language in the presence of a human interpreter when compared with the AI-interpretation model [55]. These results align with others in the literature suggesting less psychoemotional contact is conveyed in interpreter-mediated encounters [61], potentially impacting therapeutic alliance. However, only 1 study examined use of AI interpretation or translation technologies [49], despite widespread integration of AI into the language services industry. As AI's language translation and interpretation abilities continue to evolve [41], further studies on its application in mental health care settings are needed to determine its readiness for use in telemental health and its potential effects on the therapeutic process.

Limitations

Our review was limited by several factors. Because we restricted the scope of our review to telemental health care, there could be articles on translation and/or interpretation-mediated health encounters pertinent to the behavioral health needs of patients with LEP that span nonbehavioral health care. Most studies in our review were conducted in the United States and therefore, findings are not generalizable to other countries. Few studies examined patient perspectives, particularly those with LEP or LLP, limiting our ability to characterize patient-centered barriers and facilitators in interpreter- and translation-mediated telemental health care. Our search was conducted in English only, so we may have missed other relevant international studies published in non-English language scientific journals.

Conclusions

By focusing on interpreter- and translation-mediated telemental health for populations with LEP and LLP—an area largely absent from earlier reviews focused on in-person care—this scoping review fills an important gap in the literature. Moreover, by incorporating post–COVID-19 publications, our review captures how scholarship has shifted alongside the rapid expansion of telemental health after 2020. Findings underscore the need for interpreter- and translation-mediated telemental health services to address the needs of individuals with LLP or LEP as its adoption continues to expand. Beyond improving access to technology, the literature also highlights the need to prioritize equitable, linguistically appropriate care through investments in digital infrastructure, telehealth-friendly language services, and updated institutional guidelines and stakeholder training. At the same time, important gaps in the evidence base remain, including limited direct examination of patient experiences with interpreter- and translation-mediated telemental health care, which constrains understanding of how these services are perceived and used in real-world settings. Research on emerging technologies—particularly AI-enabled translation—also remains sparse, highlighting the need for rigorous evaluation of their safety, effectiveness, and impact on therapeutic alliance. Addressing these gaps will be critical to informing policy, guiding best practices, and ensuring telemental health delivery does not exacerbate existing disparities, but instead advances more equitable models of care.

Generative AI Use

Generative AI tools were not used in the preparation of this manuscript.

Funding

This work was supported by the grants from National Cancer Institute (U54CA137788), CCNY-MSK Partnership for Cancer Research, Training, and Community Outreach (U54CA132378), and Cancer Center Support Grant (P30 CA008748). This work was also supported in part by the American Cancer Society Cancer Research Institutional Grant (DICRIDG-22-1012253-02-DICRIDG). Clinician Scientist Sub-award was given to FL from the American Cancer Society.

Data Availability

The datasets generated or analyzed during this study are available from the corresponding author on reasonable request.

Authors' Contributions

Conceptualization: FL, FG, AE, JL
Data curation: LB
Formal analysis: FL, CZ, ZG, CQ, RYC, RJ, FC
Funding acquisition: FL, FG, AE, CR
Investigation: FL, CZ, ZG, CQ, RYC, RJ, FC, LB
Methodology: FL, LB

Project administration: CZ, FC
Supervision: FG, AE, JL
Visualization: ZG
Writing – Original Draft: FL, CZ, ZG, CQ, RYC, RJ, LB
Writing – Review and Editing: FL, FG, AE, CR, LD, LD, JL

Conflicts of Interest

None declared.

Multimedia Appendix 1

Search strategies used in this study.
[DOCX File (Microsoft Word File), 33 KB-Multimedia Appendix 1]

Multimedia Appendix 2

MMAT (Mixed Methods Appraisal Tool) critical appraisal ratings by study design.
[DOCX File (Microsoft Word File), 15 KB-Multimedia Appendix 2]

Multimedia Appendix 3

Key study characteristics.
[PNG File (Portable Network Graphics File), 140 KB-Multimedia Appendix 3]

Checklist 1

PRISMA-ScR checklist.
[PDF File (Adobe File), 251 KB-Checklist 1]

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Abbreviations

ATP: asynchronous telepsychiatry
CBO: community-based organization
EP: English-proficient
JBI: Joanna Briggs Institute
LEP: limited English proficiency
LLP: limited host-language proficiency
mHealth: mobile health
MMAT: Mixed Methods Appraisal Tool
NET: narrative exposure therapy
OSF: Open Science Framework
PCC: population, concept, and context
PRISMA: Preferred Reporting Items for Systematic Reviews and Meta-Analyses
PRISMA-S: Preferred Reporting Items for Systematic Reviews and Meta-Analyses literature search extension
PTSD: posttraumatic stress disorder

Edited by John Torous; peer-reviewed by Kenneth Drude, Loretta Hsueh; submitted 04.Aug.2025; initial comments to author 30.Apr.2026; final revised version received 14.Jul.2026; accepted 15.Jul.2026; published 25.Nov.2026

Please cite as:
Lui F, Gany F, Espinosa A, Riobó C, Zhao C, Gao Z, Qi C, Chen RY, Jiang R, Chang F, Boyce L, Diamond L, Gonzalez J, Leng J
Interpretation and Translation-Mediated Telemental Health Services for Adults With Limited Language Proficiency: Scoping Review
JMIR Ment Health 2026;13:e81632
URL: https://mental.jmir.org/2026/1/e81632
doi: 10.2196/81632

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