Exploring Barriers and Facilitators to the Use of Qualified Interpreters in Health

Discussion Paper April 2012

Foundation House

The Victorian Foundation for Survivors of Torture

About this Discussion Paper

A number of Australian and Victorian laws, policies and guidelines explicitly or implicitly state that health practitioners should use qualified interpreters when their clients are not proficient in English and they are not able to effectively communicate in another language.

However, clients of the Victorian Foundation for Survivors of Torture (Foundation House) who are not proficient in English regularly report not being provided with a qualified interpreter when accessing health care in Victoria. Reports from other sources indicate that the issue is widespread and longstanding.

The failure to use interpreters invariably leads to flawed communications between health practitioners and their clients which may have a number of undesirable consequences including interventions that are ineffective, time consuming, or even dangerous.

The purpose of the paper is to summarise available evidence regarding the use and failure to use qualified interpreters in various health settings and describe the main barriers and facilitators to the use of qualified interpreters in health settings.

The paper includes:

- a review of existing research and project reports;

- an overview of relevant Commonwealth and Victorian government legislation and policy;

- an analysis of available funding and interpreter usage data;

- an overview of professional standards and codes of conduct;

- a survey of academic institutions that provide training to health practitioners;

- information based on interviews with select stakeholders;

- an overview of potential legal implications relating to failure to use interpreters in health settings.

The next stage of the project will be to develop proposals for possible measures to address identified barriers and facilitate greater use of interpreters in health settings.

For the purposes of this paper, 'client' refers to those people of low English proficiency using the services of health practitioners.

Submissions

Foundation House invites readers to comment on issues covered in this paper and to propose measures to ensure qualified interpreters are available and engaged when necessary in health settings.

The following questions may be useful as a guide:

a) Reflecting on the findings of the paper what opportunities are you aware of to address identified facilitators and barriers? Including policy, practice, standards, reviews, funding, etc.

b) Are there any other specific interventions that you would recommend to improve the use of qualified interpreters by health professionals?

c) Are there any other significant barriers to the use of qualified interpreters that are not described in the paper, or are not sufficiently highlighted?

d) Are there other examples of facilitators of the use of qualified interpreters in Australia or internationally that could be adopted or adapted by health service providers?

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Executive Summary

A range of Australian and Victorian laws, policies and health practitioner codes of conduct explicitly or implicitly state that health practitioners should use qualified interpreters when their clients are not proficient in English and they are not able to effectively communicate in another language. There are compelling reasons for this. In particular, the use of qualified interpreters in health settings:

- improves the quality of care;
- improves client safety;
- promotes access to health care;
- reduces unnecessary health expenditure;
- reduces stress on families; and
- minimises risk of health practitioners incurring legal liability for adverse outcomes.

Both the Victorian and Australian government provide significant funding for health practitioners to be able to access qualified interpreters. The National Translating and Interpreting Service is reportedly the world's only government funded, twenty four hour, seven day a week telephone interpreting service.

However, there are many reports of occasions when health practitioners do not use qualified interpreters while providing services to clients who are not proficient in English, even when fee free interpreting may be available.

The main barriers to the use of qualified interpreters are summarised in Table 1 on the next page. They include clients not being aware that they can request a qualified interpreter and reticence about asking that one be used. This is not to suggest that clients should have the primary responsibility for ensuring that qualified interpreters are used. However, if health practitioners do not provide interpreters as a matter of course, then it is left to clients to request that assistance.

Table 1: Barriers to qualified interpreter use

Overarching Theme	Barriers to qualified interpreter use
Organisational	Need for interpreter not identified at an early stage
	Lack of appropriate telephone equipment
Financial	No Commonwealth funding for qualified interpreters for allied health practitioners in private practice
	Inadequate state funding for qualified interpreters for organisations
Time	Time required to engage interpreters
	Length of consultation
Knowledge	Lack of awareness of interpreter services by health practitioners and other staff
	Inaccurate assessment of English language proficiency
	Professional deferral to presumed client preference
	Health practitioner preference for onsite interpreters
	Lack of understanding of the importance of professional interpreting
Interpreter Service	Interpreters unavailable
Client	Lack of awareness of interpreter services by clients
	Client reticence

A wide variety of factors have been identified as facilitators to the use of qualified interpreters by health practitioners these are summarised in Table 2.

Table 2: Facilitators to qualified interpreter use

Overarching Theme	Facilitators to qualified interpreter use
Health Practitioner	Awareness of interpreter services
	Training
Organisational	Ensuring staff are aware of and trained to access and use interpreters
	Employment of in-house interpreters
	Interpreter equipment technologies
	Service planning and data collection
	Efficient interpreter booking systems
	Block booking interpreters
	Policy and procedure documentation and review
Client	Increasing clients' awareness of interpreter services

Methodology

This discussion paper draws on the following sources of information: a wide range of published documents; a survey of Victorian tertiary institutions that provide training to health practitioners; analysis of data regarding the National Translating and Interpreting Service (TIS); consultations with individuals from government and non-government bodies.

Published Material

Australian published material reviewed included journal articles; books; government reports and policies; statutory authority reports; research projects; program evaluations; budget papers; parliamentary committee reports; parliamentary submissions; quality of care reports; professional codes of conduct; administration law; and court and tribunal rulings.

Abstracting databases used covered Australian health care publications including the Medical Journal of Australia; the Australian Journal of Primary Health; Australian Family Physician; the Australian Health Review; the Australian and New Zealand Journal of Public Health; and the Australian Journal of Rural Health.

International studies were also drawn upon for evidence about reasons to use qualified interpreters and to identify facilitators to interpreter use.

Survey of Tertiary Institutions

Foundation House sent a survey to nine Victorian tertiary institutions that provide training to health practitioners. This sought information about training available in practice ready courses for health practitioners on working with interpreters; cultural competency; and the impact of refugee trauma and torture. Six universities responded regarding thirty-three practice ready courses covering all health disciplines.

Analysis of TIS National Data

The discussion paper reports an analysis of data provided by the Settlement Policy Section of the Department of Immigration and Citizenship regarding the use of the National TIS fee free interpreter service for medical practitioners for the period 2005-06 to 2010-11.

Legal information

Russell Kennedy Pty Ltd.

Consultation

Valuable information and advice was provided by individuals from a number of government and non-government agencies including:

- Australian Government – Department of Immigration and Citizenship (DIAC); and the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA)

- Victorian Government - Department of Health (DH); Department of Education and Early Childhood Development (DEECD); Department of Premier and Cabinet (DPC); and the Department of Justice (DoJ)

- Victorian Public Hospitals – Northern Health; Royal Women's Hospital; Western Health; the Royal Children's Hospital; and Southern Health

- Community Health Centres – Western Region Health Centre; ISIS Primary Care; and Primary Care Connect Community Health Services

- Centre for Culture Ethnicity and Health (CEH)

Scope

The discussion paper focuses specifically on interpreter services. In practice the delivery of interpreter and translation services are closely linked; however translation services are outside the scope of this paper.

List of Acronyms

CEH – Centre for Culture Ethnicity and Health

DEECD – Victorian Department of Education and Early Childhood Development

DH – Victorian Department of Health

DIAC – Australian Department of Immigration and Citizenship

DoJ – Victorian Department of Justice

DPC – Victorian Department of Premier and Cabinet

DPL – Doctors Priority Line

HREOC – Australian Human Rights and Equal Opportunity Commission (now Australian Human Rights Commission)

FaHCSIA – Australian Department of Families, Housing, Community Services and Indigenous Affairs

NAATI – National Accreditation Authority for Translators and Interpreters Ltd

NHMRC – National Health and Medical Research Council

PDRSS - Psychiatric Disability Rehabilitation and Support Services

RACGP – The Royal Australian College of General Practitioners

TCC - Targeted Community Care (Mental Health) Program

TCPU – Transcultural Psychiatry Unit

TIS – Translating and Interpreting Service National

VTPU – Victorian Transcultural Psychiatry Unit

1. INTERPRETER POLICY AND FUNDING OVERVIEW

This chapter provides an overview of the national standards, professional codes of conduct and relevant Australian and Victorian Government policies related to interpreter use. The chapter also outlines the types of interpreter services and the budget allocations (where known) for these services. The issues regarding the provision of interpreter services sit within a human rights framework; this will be explored in the final report.

1.1 National Standards

The Australian Charter of Healthcare Rights was developed by the Australian Commission on Safety and Quality in Healthcare and was adopted by federal and state Health Ministers in July 2008.[1] The Charter provides that clients using government funded healthcare services have the right to a qualified interpreter if they need one and qualified interpreters should be provided at important points during care, such as discussing medical history; treatments; test results; diagnosis; during admission and assessment; and when getting informed consent.[2]

The National Standards for Mental Health Services were endorsed by the Australian Health Ministers Conference in September 2010.[3] The Standards provide that informed consent should be sought in a language understood by the client.[4] The National Standards are accompanied by implementation guidelines for public mental health services and private hospitals; non-government community services; and private office based mental health practices.[5]

1.2 Professional Codes of Conduct

The Medical Board of Australia's Code of Conduct for Doctors in Australia states that doctors should both ensure "arrangements are made to meet patients' specific language, cultural and communication needs" and familiarise themselves with, and use whenever necessary, qualified language interpreters.[6]

The National Health and Medical Research Council's (NHMRC) advice for medical practitioners on communicating with clients is that qualified interpreters should be used when and wherever possible. The NHMRC advice also states it is inappropriate to use family members or friends to interpret and doctors should be aware of and sensitive to situations where clients may prefer family members to interpret.[7]

The Royal Australian College of General Practice (RACGP) standards for general practices require that General Practitioners and staff are aware of TIS for clients not proficient in English. Specific indicators of awareness are that practices have contact details for TIS and staff are able to describe how they communicate with clients who do not speak the same language.[8] General practice accreditation involves an assessment against these RACGP standards.[9]

The use of interpreters would normally be considered within Standard 2.3 'ensuring cultural safety and appropriateness' of the Quality Improvement Council Standards

which form the basis for accreditation for community health centres. There is no specific guideline on use of interpreters; "however, it would be expected as a matter of basic good practice that organisations would use interpreters for clients whose preferred language is not English".[10]

Further information for other health practitioners can be found under the codes of conduct for each National Board.[11]

1.3 Australian Government

1.3.1 Policy

The Australian Government 'Access and Equity Framework' for government services lists 'communication' as one of its four guiding principles. An identified strategy for communication is "recruiting and training staff who have appropriate linguistic and cultural skills or using interpreting services to ensure effective communication with clients as necessary".[12] The Access and Equity framework applies to all government-funded services, whether they are delivered by government agencies, community organisations or commercial enterprises.[13]

In 2009 the Commonwealth Ombudsman published a report on the use of interpreters for the following government services: the Australian Federal Police; the Department of Education Employment and Workplace Relations; Centrelink; and the Department of Immigration and Citizenship (DIAC).[14] The report sets out eight best practice principles for Australian government agencies when using interpreters which cover:

- agency policies;
- promoting interpreter services;
- fair, accessible and responsive services;
- specify who can be used as an interpreter;
- staff training;
- good record keeping;
- accessible complaint handling mechanisms; and
- promoting qualified interpreters.

1.3.2 Funding Interpreter Services

The Australian Government provides the National Translating and Interpreting Service (TIS) through DIAC. "TIS is unique. Australia is the only country in the world with a federally funded translating and interpreting service that provides a national, twenty four hour, seven-days-a-week telephone interpreting service".[15] Since 2000, TIS has priority processing for medical practitioners – the Doctors' Priority Line (DPL).[16 & 17] Free access to TIS is provided to the following health practitioners/services:

- medical practitioners for items claimable under Medicare and pharmacists prescribing PBS medications; and their reception staff working in private practice.[18] Access is unlimited for telephone interpreters, but quotas exist for the number of on-site interpreters available.[19] The 2011-12 DIAC budget for the fee free TIS was $12,030,000.[20] This includes the cost for the free service delivery of TIS not only to medical practitioners but also to non-profit, non-government, community based organisations providing settlement services and case work; members of parliament for constituency services; local government authorities; trade unions; and Emergency Management Australia[21]; and

- services funded to provide the Targeted Community Care (Mental Health) Program (TCC) service streams: Personal Helpers and Mentors; Mental Health Respite; and/or Mental Health Community Based services.[22] The Department of FaHCSIA was unable to provide budget allocation figures for the TIS access but advised there is no limit on the level of TIS services TCC program service providers can access for their clients.[23]

Fee free interpreting is not available to a number of allied and mental health practitioners including:

> "…nurses, radiographers, medical technicians, psychologists, chiropractors, optometrists, pathologists and dieticians.... There is some flexibility for nurses, radiographers and other medical technicians, when assisting a doctor to deliver eligible services working directly under private [medical practitioners], to access fee-free interpreting services, under the doctor's TIS National client code (with that doctor's approval)".[24]

The exclusion of these services is discussed in section 4.2.1.

Further,

> "[a]ll health professionals working in the public health system or otherwise funded by state/commonwealth government are not eligible to access fee-free interpreting services. Non-Medicare procedure consultations including services related to medical-legal work (eg compensation cases or court/tribunal work) and other medical commercial enterprises are also ineligible".[25]

The Australian Government through DIAC also provides funding for the National Accreditation Authority for Translators and Interpreters (NAATI) which facilitates much of the interpreting and translating services in Australia. NAATI is owned jointly by the Commonwealth, State and Territory governments and is governed by a board of five directors, who are appointed by the owners.[26] The base funding for NAATI by DIAC is just over $0.6 million annually.[27] DIAC provided an additional $0.6 million in 2011-12 to supplement this base funding to ensure NAATI can continue to deliver on its objectives, while a review of its future governance and funding arrangements is undertaken.[28]

1.4 Victorian Government

1.4.1 Policy

'Using interpreting services: Victorian Government policies and procedures' states clients who have low English proficiency should "…have access to professional interpreting and translating services: when required to make significant decisions concerning their lives; or when being informed of their rights; or where essential information needs to be communicated to inform decision making, including making informed consent".[29] Furthermore this policy document states, "it is Victorian Government policy that interpreters be accredited at the professional level where possible".[30] The DHS 'Language Services Policy', that covers both DHS and Department of Health services further states: "[p]ersons, including family members, under 18 years of age are not used as interpreters".[31]

Victorian health services are required to develop and implement the 'Victorian cultural responsiveness framework' which has six standards and improvement measures for culturally responsive practice. One is "accredited interpreters are provided to patients who require one".[32] Reporting on the achievements of the 'cultural responsiveness plan' takes place annually through each health services' 'quality of care' report.[33]

The Victorian Government has identified 'improving every Victorian's health status and health experience' as a health service priority for the next decade. An implementation action for this priority in metropolitan Victoria is ensuring interpreters are available where needed.[34]

A number of Victorian laws provide responsibilities and rights relating to interpreters. The Victorian *Mental Health Act 1986* [section 5] requires mental health services to: take into account the language needs of clients who are mentally ill; ensure clients are informed of their legal rights under the Act and relevant provisions of the Act are explained in a language that clients are most likely to understand. The *Health Services Act 1988* [section 9(e)] specifies as an objective to ensure: "users of health services are provided with sufficient information in appropriate forms and languages to make informed decisions about health care". The *Multicultural Victoria Act 2011* [section 26] requires all Victorian Government departments to report annually on the use of interpreting services and communications in languages other than English.

1.4.2 Funding Interpreter Services

The Victorian Government provides funding for interpreter services in support of these policies for the health sector mainly through direct agency funding and credit lines.

a) Direct Agency Funding

Direct agency funding for organisations with a significant volume of interpreter usage for example, public hospitals[35] and large community health services enables them to independently establish formal contracts with an interpreting and translating

service suited to their needs and to employ in-house interpreters.[36] For 2009-2010 the DH reported hospital expenditure on language services as $9,362,218 and direct funding to community health services for language services as $1,678,007.[37] This may be included in global budgets using a complexity funding formula weighted against elements (as is the case for hospitals) or be specific funding for language services (as is the case for community health).[38]

b) Credit-lines

The credit line system is a contract for language services between the relevant department and the interpreting and translating service provider. Each credit line has an annual budget broken down into monthly limits by program areas. Once the available funds for the month have been used for a particular credit line, no more bookings can be made against that credit line.[39]

The DH funded credit lines are available to services or agencies that: deliver DH funded services; do not receive direct funding for language services; and use the language services for metropolitan alcohol and other drug services, metropolitan Psychiatric Disability Rehabilitation and Support Services, metropolitan community health programs, metropolitan disability services and disability staff, metropolitan Victorian College of Optometry services and Royal District Nursing Services. Each rural region has separate access to a credit line and can access the services on the same basis as the metropolitan services.[40] The total expenditure for the Department of Health credit lines for 2009/10 was estimated to be $925,725.[41]

In 2007, the newly established DEECD integrated a number of functions from the Office for Children.[42] As such the Office for Children language services credit line moved to DEECD and is internally regarded as the 'early childhood credit line'.[43] The early childhood credit line enables agencies that deliver services funded by DEECD and who do not receive direct funding for language services to have access to an interpreting service. Eligible health practitioners include those working in Maternal and Child Health Services, Early Childhood Intervention Services and primary and secondary schools as nurses.[44] Expenditure for the early childhood credit line in 2009-10 was $1,100,000.[45]

c) Direct Program Funding

A number of programs delivered by health practitioners also have funded access for the use of interpreter services for clients not proficient in English. These include:

- recurrent funding of $25,000 per equivalent full time refugee health nurse position for the purchase of language services.[46]
- Nurse on call[47];
- Maternal and Child Health Line[48];
- Parent Line[49];
- Gambler's Help[50]; and
- Victims' Assistance and Counselling Program Helpline[51].

d) Direct Project Funding

Funding has been made available to improve access to interpreter services in several other areas:

- for seniors accessing health services in country areas; $400,000 a year ongoing was allocated for marketing strategies and grants as a part of the 2011-12 Victorian budget[52];

- for training health and mental health interpreters in rural and regional Victoria; $100,000 allocation over two years through the annual Budget and Expenditure Review Committee budget process partnered with OMAC/DPC[53]; and

- by increasing the number of quality interpreters and translators and enhancing the use of language services; $2 million was allocated across a number of projects as a part of the 2011-12 Victorian budget.[54]

2. COMMUNICATION APPROACHES BETWEEN HEALTH PRACTITIONERS AND CLIENTS

This chapter describes the four communication means used by health practitioners with clients who are not proficient in English: the health practitioner shares the language other than English in which the client is proficient; an untrained interpreter will be used such as family, friends and bilingual staff; the consultation will proceed in English without assistance; or a qualified interpreter will be engaged. Sometimes the method of communication is the preference of both parties; sometimes it is the preference of one or the other or simply the only method possible in the circumstances. 'Client' refers to those people of low English proficiency using the services of health practitioners.

2.1.1 Health Practitioner shares language other than English

People who are not proficient in English often seek a GP who is 'language concordant' i.e. speaks the same language. According to a study of Bettering the Evaluation of Care and Health (BEACH) program data for general practice activity for 1999-2000, GPs who conduct consultations in a language other than English are more likely to have consultations with those of an English-speaking background (39.5%) than those of an English-speaking background (7.8%).[55] In an analysis of more recent BEACH data it was found that for 2006-2007, 76% of GPs consulted in English only and 2.9% of GPs consulted in a language other than English for more than half there consultations.[56] In two general practice studies, it was found the most common communication strategy was the use of a language concordant GP or nurse.[57 & 58] In two consumer focused studies it was found 60-90% of clients chose to consult a language concordant GP.[59 & 60] Finally, a rural NSW study found in several towns language concordant GPs provided health care for people of refugee backgrounds; however there was confusion about the languages that required interpreting. For example, one practice manager referred Dari speaking refugees to a GP who spoke English and Arabic.[61]

A number of agencies have prepared material to assist clients seeking health practitioners who speak their native language and to assist health service providers to use bilingual health practitioners and other staff.

For example, the Victorian Transcultural Psychiatry Unit (VTPU)[62], the North West Melbourne Division of General Practice[63] and the Victorian branch of the Australian Medical Association[64] have produced directories of health practitioners who provide consultations in languages other than English. The Centre for Ethnicity and Health (CEH) has produced guidelines for recruiting, employing and working with bilingual staff in organisations.[65]

While language concordance between GPs and clients is an ideal communication approach, there is an insufficient number of multilingual GPs to meet language demands. While Australia supplements its GP workforce with overseas trained doctors, they are primarily sourced from the Indian subcontinent, representing

language groups that are not in the top eight languages other than English spoken in Australia.[66]

There has also been activity in Victoria in relation to utilising the language skills of staff for non clinical communication that does not require the use of a qualified interpreter. For example, the 2010 Royal Women's Hospital Language Aide Pilot Project[67] provided training and allowances to a small number of bilingual staff to enable them to provide non-clinical interpretation for clients; this project has not been formally evaluated.[68] Furthermore, a course in language assistance has recently been accredited under the Victorian Qualifications Authority which:

> "enables the development of the additional skills and knowledge needed to use existing language proficiency in English and a language other than English (LOTE) for oral language assistance in the workplace…In order to successfully complete this course intending participants should possess spoken English and second language proficiency to a level that enables low risk information to be conveyed, for example:
>
> - giving directions;
>
> - making or changing appointment times;
>
> - selecting food menu options; and
>
> - identifying forms".[69]

2.1.2 Untrained interpreters

Health practitioners commonly use untrained interpreters such as family, friends and bilingual staff in three way communications, for health consultations; this may be due to their ready availability and the barriers associated with using qualified interpreters discussed in chapter four.

Using untrained interpreters is one of the most common strategies used by GPs.[70 & 71] In general practice surveys it has been reported that untrained interpreters are used: by 80% of practices weekly or more often; by 35% of practices daily; by 35% of GPs 'at every opportunity'; by 11% of GPs 'rarely'; and the most common response for not using qualified interpreters (37%) were that family members were used.[72]

Using untrained interpreters is also reportedly a common strategy used in maternity services and maternal and child health. [73, 74 & 75]

In Australian hospitals, it has been found family or friends are used anywhere from 20%-61.5% of the time. [76, 77, 78 & 79] Clients also report the common practice of using untrained interpreters.[80, 81 & 82]

In a Melbourne hospital, with high usage of qualified interpreters it was found in situations where a qualified interpreter was not available, 71% of health practitioners reported they would use a client's family and friends and 52% would use bilingual staff.[83]

However, using untrained interpreters is often not merely a fall back position when a qualified interpreter cannot be engaged; many health practitioners prefer to use family to interpret.[84, 85, 86 & 87] This is supported by client accounts of many health services actively encouraging them to use family members.[88]

2.1.3 Consultation in English

Many consultations between health practitioners and clients not proficient in English proceed with no assistance.

For dialysis patients at Southern Health, staff used no one for interpreting for 40% of the encounters.[89] In a NSW hospital it was found 7% of consultations where interpreter assistance was required no one was used to interpret.[90]

'Attempting to manage without help' was found in one Melbourne Hospital to be a fall back communication strategy for many health practitioners (46%) when a qualified interpreter is not available.[91]

Finally, a client focused study found: "…newly arrived participants had little or no English speaking networks or no family networks at all. This meant that when language services weren't provided to these participants, these participants often utilised health services without being able to communicate at all".[92]

> When I had a caesarean I did not have an interpreter. I was by myself in the room with the doctor and nurses. I would have liked one there, especially to explain all the anaesthetic things and what was going to happen, actually for many things
>
> Nicolaou, M., (2011), *The pregnancy and birth experience of women from refugee backgrounds living in the Outer East of Melbourne*, EACH Social and Community Health, p 12.

> I went to have some blood tests. The person doing the test was asking me questions but I couldn't understand anything. There was no interpreter. I couldn't ask for one because I don't speak any English. Some days later they called me on the mobile. He was talking in English. I tried to get someone off the street to listen and translate but the doctor just kept talking, talking and then hung up the phone. I don't know how to get the results of my tests.
>
> Brough, C., (2006), *Language Services in Victoria's Health System: Perspectives of Culturally and Linguistically Diverse Consumers*. CEH. p 14.

2.1.4 Qualified interpreters

Private Practice

 Demand for TIS National fee free interpreting services for medical practitioners has almost doubled in the last six years, from 39,905 in 2005/06 to 75,730 in 2010/11. The proportion of total demand in 2010/11 was: 70% GPs (53,389); 29% Specialists (21,928); and 1% Pharmacists (413). Further, in 2010/11 the ratio of specialist total demand for onsite interpreters to telephone interpreters was 3:1; for GPs it was 1:2.[93]

However, in one study, it has been found: 71% of general practices reported using qualified interpreters less than once per year; and 68% and 81% of general practices reported never using telephone and face-to-face interpreters respectively.[94] This is supported by another Australian study which analysed Census, Medicare and TIS datasets finding "[a]fter adjusting for language concordant consultations, we estimated that an interpreter employed by TIS was used in less than one in 100

consultations where the patient had limited proficiency in English".[95] The underutilisation of qualified interpreters by specialist medical practitioners has also been reported. [96, 97 & 98]

Public Hospital - Emergency Department

Most public hospitals employ in-house interpreters and supplement their services with commercial interpreter providers; however evidence suggests there are many occasions when emergency departments do not access the service. Emergency department research of New South Wales and Queensland hospitals indicate qualified interpreters are used as little as 6%-33.3% of the time.[99, 100, 101 & 102] In a Victorian study of client experiences across health settings, only one participant in eighty six said they had ever used a qualified interpreter in an emergency department.[103] The Refugee Council of Australia has reported on the need for emergency departments to use qualified interpreters.[104]

The VTPU has reported staff from Crisis Assessment and Treatment Teams "…acknowledged that they should book interpreters more frequently with…[clients]…who were sometimes admitted involuntarily when staff were uncertain of the clients mental state".[105] There have been recommendations for mandatory standards for engaging qualified interpreters in crisis situations.[106 & 107]

> Failure to engage a qualified interpreter was considered by HREOC to be a contributing factor to the involuntary commitment of a Bosnian refugee with an intellectual disability who was misdiagnosed as having PTSD
>
> HREOC, (2005), *Not for service: experiences of injustice and despair in mental health care in Australia*, p 262

Public Hospital - Inpatient

The use of qualified interpreters in hospitals varies considerably from site to site and in terms of the frequency of use; although qualified interpreters are significantly more likely to be used when the client has a high or moderate clinical complexity.

Research has found qualified interpreters are used as little as 25% in a Victorian renal dialysis unit[108], 31.2% in a Liverpool hospital (NSW) [109] and 58.5% of the time in a Sydney tertiary hospital.[110] Qualified interpreters are not used at all for up to 32% of clients in the renal unit[111] and up to 69% of clients at a tertiary hospital in Sydney.[112] In 2010/11 Melbourne Health reported 39,185 clients required an interpreter, but there were only 32,886 occasions of service.[113]

A 2011 study found ward pharmacists from the Prince of Wales Hospital (NSW) "rarely used interpreters" and nurses used qualified interpreters routinely for consent issues and to identify at risk clients. Further, "[i]nterpreters were not used when patients were interviewed about their medication histories or to explain how they should take their medicines while in hospital".[114]

In 2002 staff at Northern Health were found to use qualified interpreters 90% of the time with individual clients, but much less frequently with groups (27%) and telephone (31%).[115] The Royal Women's Hospital reported for the financial year 2010/11 that on 91% of occasions clients who presented at the hospital and were identified as requiring interpreter services were provided with a qualified interpreter.[116] Variations also exist regarding the number of occasions qualified

interpreters are used for individual clients during their inpatient stay, as it was found to be: once at Liverpool hospital (NSW)[117]; and 21% had an interpreter once, 5.4% twice, 1.9% three times and 2.9% four or more times in a tertiary hospital in Sydney.[118]

VTPU have reported there is a "…lack of interpreting during admission to inpatient facilities up to the point of the mental health review; and lack of engagement of interpreters at critical points in the pathway through care".[119]

Furthermore, it has been found qualified interpreters are significantly more likely to be used when the client has a high or moderate clinical complexity (eg invasive surgery, explanation of major health events, when serious illnesses are diagnosed and treated), indicating a divergence between the policy of universality of interpreter use and the practice of priority setting.[120] Nonetheless, this study also found on a number of occasions clients with moderate to high clinical complexity were not provided with a qualified interpreter.[121]

Finally, in two Sydney based children's hospitals it was found that 28% of the broader culturally and linguistically diverse patient population had problems communicating with doctors and 23% with nurses.[122]

Public Hospital - Outpatient

A small qualitative study undertaken in NSW of physiotherapists found qualified interpreters were not engaged for all consultations, but for initial treatments and subsequent major reassessments, such as every fourth session.[123] Some physiotherapists only engaged a qualified interpreter once all other communication strategies had been exhausted.[124] Furthermore, a Victorian consumer study found many participants had rarely received interpreter services when consulting a specialist in an outpatient setting. A small number of clients said when they had regularly seen the same specialist as an outpatient they had mostly been provided with an interpreter.[125] Similar client reports have been made in Queensland.[126]

Community, Maternal and Child Health

A recent qualitative study completed in Victoria found that

> "on a number of occasions an interpreter was not present at the home visits by domiciliary nurses or maternal child health nurses, despite the needs of the mother…The KPMG evaluation of the Victorian Maternal and Child health services in 2006 found that the program was less accessible for women from CALD backgrounds due to language and cultural barriers".[127]

It has also been found for telephone assistance that "there has been extremely low use of interpreters to assist callers from non-English language backgrounds" for Nurse On Call. The cause is yet to be investigated.[128]

3. SIX REASONS TO USE QUALIFIED INTERPRETERS

Good communication between a health practitioner and a client during a clinical consultation is essential to ensure the safety, quality and effectiveness of care. [129, 130, 131, 132, 133, 134 & 135]

When interpretation is required, qualified interpreters should be used as they are less likely to make errors and any errors made are less likely to be of clinical consequence. [136, 137 & 138] Accredited qualified interpreters operate under a code of professional ethics to ensure their services are impartial, confidential [139] and their level of skill is of a sufficient standard. [140]

> In Victoria, 3.79% of residents (186,759) speak English either 'not well' or 'not at all'.
>
> ABS, (2006), *Proficiency in Spoken English / Language by age for time series*, Cat. No. 2068.0, 2006 Census Tables – Victoria (State).

The use of qualified interpreters in health consultations improves quality of care; improves client safety; promotes access to health care; reduces unnecessary health expenditure; reduces stress on families; and minimises risk of legal complications.

3.1 Quality of Care

When communication barriers exist the quality of care for clients diminishes. [141 & 142] Some consequences are: poor understanding of discharge diagnosis; poor understanding of treatment plans; late presentation of symptoms; and a reduced likelihood of participating in medical decision making. [143, 144 & 145]

> A WA government review recommended the utilisation of interpreter services after finding that "client care was compromised by communication difficulties between clinicians and clients whose primary language was not English".
>
> Government of Western Australia, (2008), *From death we learn*, p 6.

Victorian community services workers "…are aware of multiple incidences where miscommunication within consultation rooms and hospital settings have had negative impacts on clients health outcomes". [146]

Conversely, the use of qualified interpreters has demonstrated improvements in the quality of care for clients through: effective clinical treatment; client satisfaction with treatment; and an increased likelihood of desired health outcomes. [147 & 148]

3.2 Client Safety

Communication barriers increase the risk of medication errors [149, 150, 151]; non-compliance with treatment compliance [152]; and adverse health outcomes. [153, 154 & 155] A study at a Queensland hospital found that that use of interpreter services was associated with a reduced likelihood of an

> A number of preventable adverse events have occurred in Australia where qualified interpreters were not engaged; including a 35 year old Afghan refugee who died and two clients who had procedures undertaken on incorrect body parts.
>
> Bird, S., (2010), *Failure to use an interpreter*, Australian Family Physician, Vol 39 (4), p 241 & Department of Human Services, (2004), *Sentinel event program: annual report 2003-04*, p 24.

adverse pregnancy outcome.[156] Failure to recognise this relationship "...stands as a resident pathogen within the health care system".[157] Good communication facilitated by a qualified interpreter is therefore considered essential to client safety.[158 & 159]

3.3 Access to Health Care

Research demonstrates that communication barriers contribute to less access to health care[160, 161, 162, 163, 164, 165 & 166] including:

- fewer hours of home and community care[167];

- fewer visits to health practitioners[168 & 169];

- lower attendance at antenatal classes[170 & 171];

- a lower likelihood of being referred for a follow up appointment following an emergency department visit[172]; and

- less participation in preventative screening.[173 & 174]

> Concern has been expressed that many elderly clients from a Non English Speaking Background are isolated in their homes and are not accessing services due to both language and service delivery barriers.
>
> HREOC, (2005), *Not for service: experiences of injustice and despair in mental health care in Australia*, p 762.

Qualified interpreters have been found to improve access with increases in: clinical visits; follow up visits; number of prescriptions written and filled; preventative screening services; and the likelihood of referral for mental health care for asylum seekers.[175, 176, 177, 178, 179, 180 & 181] Parents have also identified availability of interpreters would make it easier to access health care for their children.[182]

3.4 Unnecessary Health Expenditure

Communication barriers unnecessarily increase expenditure on health services as they are associated with:

- Higher non-attendance rates at clinics[183];

- increased diagnostic investigations[184];

- higher hospital admission rates[185, 186 & 187];

- increased length of stay in hospital and emergency departments[188, 189 & 190];

- decreased likelihood that clients will seek early treatment at the onset of cardiovascular disease[191]; and

- more frequent intravenous hydration.[192]

The use of qualified interpreters however, has been linked with reduced:

- emergency department return rates[193];

- length of stay in hospital (a reduction of three days over a four year period with interpreter interventions)[194]; and

- failure to attend appointment rates (as the client actually knows about the appointment).[195]

While providing qualified interpreter services increases the use of preventive or early detection services, clients' use of these services may reduce the cost of late-stage disease treatment or emergency visits, reducing the costs in the long run.[196 & 197] Further research is required in Australia to assess the cost benefits associated with the use of qualified interpreters.[198 & 199]

3.5 Stress on Families

When family members are used as interpreters they are emotionally involved and may become privy to sensitive, confidential and potentially distressing information, for example, about the diagnosis of a terminal illness.[200, 201 & 202]

> "I was very embarrassed to be talking about my pregnancy with my son and I could see that he was not very happy or comfortable himself".
>
> Australian Human Rights Commission, (2010), *In our own words African Australians: A review of human rights and social inclusion issues*, p 18.

While not well documented in the literature, there is potential for harm to family members acting as interpreters, as the content of the interpreted consultation may be emotionally burdensome and the family member has not been trained to deal with it.[203 & 204] It has been reported that untrained interpreters in a Californian hospital were unprepared for interpreting in emotionally loaded encounters and felt traumatised by interpreted consultations where bad news had been imparted.[205] One family member has reported that "as the examination progressed and the severity of my father's condition became apparent, I became increasingly uncomfortable with my role…But for my part I had come to fear the role of medical interpreter".[206] A senior project officer at the Health Issues Centre has reported similar levels of anxiety with the role.[207]

> A client of a refugee background was admitted to Melbourne hospital via the ED with breathing difficulties and was isolated with suspected TB. Hospital staff and visitors wore full gown and mask.
> The hospital did not have an interpreter on staff that spoke Kirundi, Swahili or Congolese. Ward staff decided not to use an interpreter as the women's children (aged 13 and 15 years) spoke good English.   A social worker visited the client two days later and arranged a phone interpreter where it was discovered that the client was frightened that she was dying of aids as she had seen a lot of this in Africa.
>
> Consultation with a social worker working in a community based agency in Victoria

Requiring a non-adult child to take on such a potentially stressful role raises significant ethical concerns.[208] In one documented case, a child of 10 years, suffered a severe post traumatic stress reaction that saw her hospitalised for eight months; one of the triggers was being used as an interpreter between her family and medical staff for her younger sibling who died of renal failure at the age of 13 months.[209]

If family members are called on to accompany relatives in order to act as interpreters, this may adversely impact

> If I wanted to go to the doctor, my daughter has to cancel her day from school and then take me.
>
> Henderson, S., & Kendall, E., (2011), *Culturally and linguistically diverse peoples' knowledge of accessibility and utilisation of health services: exploring the need for improvement in health service delivery*, Australian Journal of Primary Health, Vol 17, p 197.

on their other commitments, such as attending school.[210, 211 & 212]

3.6 Risk for Legal Implications

This section has been prepared by Russell Kennedy lawyers. It is intended for general information only and should not be regarded as legal advice. If you have any concerns regarding the use of interpreters you should seek independent legal advice.

Communication is fundamental to the provision of health care. Failure to use an interpreter could result in misdiagnosis, the client misunderstanding the health practitioner's advice or the client being unable to give informed consent to treatment, due to the client not understanding the nature and associated risks of the treatment/procedure.

The requirement for health practitioners[1] to communicate clearly with their patients/clients is underpinned by various legislation[2] and health practitioner codes of conduct.

> In the case of *Medical Board of Australia v Venkataraman* a cosmetic surgery client signed consent forms which were translated to the client by the doctors receptionist. The client's understanding of English was limited and the receptionist was not an accredited or qualified interpreter. Dr Venkataraman admitted that she failed to adequately inform the client of the risks associated with the procedure and thereby failed to obtain informed consent; constituting unprofessional conduct.
>
> Medical Board of Australia v Venkataraman (Occupational and Business Regulation) [2011] VCAT 751 (12 May 2011).

Legal implications may include:

a) Health practitioner disciplinary proceedings

A health practitioner could be disciplined by their respective regulatory board or by the relevant state Tribunal for failing to use an interpreter.

Depending on the facts of a particular case, failure to use an interpreter could constitute unsatisfactory professional performance, unprofessional conduct or, in extreme cases, professional misconduct. A finding of this nature could result in the health practitioner being cautioned or reprimanded. The practitioner's registration could also be suspended, cancelled or made subject to conditions.

b) Civil claim for trespass

Health practitioners may be liable for trespass if they perform or take part in procedures on a client who does not understand the nature of the procedure due to language barriers and therefore is unable to give informed consent. The client must understand 'in broad terms' the nature of the procedure and be able to weigh up the risks and benefits involved.

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[1] The conduct of nurses, doctors, psychologists, dentists, chiropractors, podiatrists, physiotherapists, pharmacists, osteopaths and optometrists is governed by the *Health Practitioner Regulation National Law (Vic) Act* 2009 (Vic) ("**National Law**"). In 2012, medical radiation practitioners, Chinese medicine practitioners, occupational therapists and Aboriginal and Torres Strait Islander health practitioners will also become subject to this Act.

[2] *National Law and the Health Services (Conciliation and review) Act 1987.*

c) Civil claim for negligence

A health practitioner who fails to use an interpreter, where it is would be reasonable to do so, could also be liable in negligence if they carry out a procedure on a client without first obtaining the client's informed consent and the client suffers an adverse outcome.

Vicarious liability

Hospitals and other health care providers may be vicariously liable for the negligent acts of their employees performed during the course of their employment. Therefore, a hospital may also be liable to compensate a client if the client succeeds in an action for negligence against a practitioner.

The extent of any liability will depend on the individual facts of the case.

> In Victoria the failure to obtain informed consent led to a client being dialysed against his wishes resulting in him becoming aggressive towards staff (the situation was later resolved with the assistance of a qualified interpreter).
>
> Zimbudzi. E., Thompson, S., Terrill, B., (2010), *How accessible are interpreter services to dialysis clients of Non-English Speaking Background?,* Australasian Medical Journal, 1, 3, p 208.

Qualified interpreters

Qualified and accredited interpreters should be used.

Health practitioners should familiarise themselves with the policies and procedures for accessing professional interpreter services within their workplace.

> Australia's largest medical defence organisation 'Avant' states "[a]s medical practitioners we have a duty of care to ensure that our patients understand the information provided to them. This can be easily managed by making interpreter services available for patients not confident in speaking or understanding English".
> http://www.avant.org.au/WorkArea/DownloadAsset.aspx?id=2220 accessed on 16/4/2012

Organisations should implement clear policies and procedures regarding use of interpreters and ensure all employees know how to contact a qualified interpreter.

If a qualified interpreter is not available, non-emergency appointments should be rescheduled. As a last resort, it may be acceptable to use an unqualified interpreter to conduct a preliminary consultation to determine if a medical emergency exists.

> Kate Rapsey, the Claims and Operations Manager of Australian-owned medical indemnity underwriting agency 'Invivo' recommends the recording of the interpreter's identification number to manage risk in case of a future dispute.
> http://www.invivo.com.au/newsletter1707_2.html accessed on 16/4/2012

Refusing to treat a client

In general, medical practitioners have the right to refuse to treat a client, where an alternative health care provider is available and the situation is not an emergency.

It is difficult to say with any certainty whether a health practitioner refusing to see a client on the basis that they cannot speak the same language as the practitioner will constitute 'discrimination' within the meaning of state and federal discrimination laws, as there is a lack of relevant Australian cases on this point.

However, given that various professional codes[3] make it clear that health practitioners are expected to use interpreters and should not discriminate against clients, it is likely that health practitioners who refuse to treat clients solely on the basis that they cannot fluently speak the same language may constitute a breach of the practitioner's ethical and professional obligations. However, this will depend on the individual facts and circumstances of each case.

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[3] Code of Professional Conduct for Midwives in Australia (2006) [5] and Code of Professional Conduct for Nurses in Australia (2006) [5]; Medical Practitioners' Board of Australia, Good Medical Practice Code [3 & 5] Chiropractic Board of Australia, Code of Conduct for Chiropractors [4 & 5]; Dental Board of Australia, Code of Conduct for Dentists [4 & 5]; Optometry Board of Australia, Code of Conduct for Optometrists [4 &5]; Osteopathy Board of Australia, Code of Conduct for Registered Health Practitioners [4 & 5]; Pharmacy Board of Australia, Code of Conduct for Registered Health Practitioners [4 &5]; Physiotherapy Board of Australia, Code of Conduct for Registered Health Practitioners [4 & 5] and Podiatry Board of Australia, Code of Conduct for Registered Health Practitioners [4 & 5] and The Australian Psychological Society, Code of Ethics [11].

4. BARRIERS TO THE USE OF QUALIFIED INTERPRETERS

It is critical to understand the reasons why health practitioners may not use qualified interpreters in circumstances where it is desirable to do so, in order to identify measures that can be implemented to encourage and facilitate good practice.

This chapter describes a range of constraints affecting health practitioners and organisations providing health services, identified in the literature and further evidenced with interviews undertaken for this project. These barriers are grouped around five themes: organisational; financial; time; knowledge; and adequacy of interpreter services.

This chapter also describes factors inhibiting clients from requesting that qualified interpreters be engaged. This is not to suggest clients should have the primary responsibility for ensuring qualified interpreters are used. It is important to recognise the unequal power relationship between the providers and clients of health services. As Garrett suggests,

> "(i)nterpreting in health care is a complex communicative interaction between provider, interpreter and patients; parties which have unequal power relations and each of which has their own socially and institutionally mediated values, demands, beliefs, expectations and goals".[213]

If health practitioners do not provide interpreters as a matter of course, then it is left to clients to request a qualified interpreter, we will therefore identify barriers that exist in such circumstances.

4.1 Organisational

4.1.1 Need for interpreter not identified at an early stage

If clients are not identified as requiring an interpreter at the point of initial contact with a service, health practitioners will not be alerted to ensure an interpreter is available when they see clients. In this case, health practitioners may prefer to proceed rather than wait for arrangements to be made, or to abandon and reschedule consultations as a result.

An Australian study of 131 clients attending a hospital emergency department who required an interpreter found that reception staff had recorded this need in only 54 cases.[214] Poor identification of need for an interpreter on patient records was also noted at further three Australian hospitals.[215, 216 & 217] Southern Health recently set up a working group to survey the patient information management system registration screen and

> "There is no automatic system at any public hospital where I have worked to flag that an interpreter will be required, particularly for outpatient bookings. Even when a doctor writes in the notes and specifically asks admin staff for an interpreter to be booked for the next appointment …that request rarely gets transmitted".
>
> Correspondence with a Regional Victorian Paediatrician

audited medical records for compliance with interpreter requests; the working group recommended front of house staff training as a result, suggesting similar issues.[218] Poor documentation can cause interpreter client language mismatch[219 & 220] and can have "…implications on the provision of adequate services such as calculating reliable estimates of interpreter need and utilisation".[221]

It has also been reported that referrals from one service to another do not routinely indicate the client requires an interpreter i.e. GPs referring to specialists and public hospitals referring to community based services.

Further, where referrals do include information regarding the need for an interpreter, they often do not indicate the specific language required. In some cases this may be the result of not being able to record the language as it has been reported that some patient management systems do not have new and emerging languages in the scroll down menus.

> A Victorian hospital referred a client to a Community Health Centre for supported transition back to the community after a lengthy stay at a Community Care Unit (CCU). The community based assessment found that the client had poor English proficiency and the assessment could not proceed unless a qualified interpreter was engaged; there was no mention of the need for an interpreter on the referral or any record of an interpreter ever being used at the CCU.
> Consultation with a Victorian mental health professional

> "One such example involved the process of sending birth notices from the maternity unit to the maternal and child health service. On many occasions, MCHNs [maternal and child health nurses] received the notice identifying that an accredited interpreter was required, however there was no further information regarding the dialect spoken. This then created difficulty in booking an accredited interpreter to be present during the first home visits. Many MCHNs then needed to find other means to aid communication which often meant asking if a partner, family or friend would be present at the time of the visits"[222].

The Auditor General in his review of referral documentation found Bendigo Health referral forms did not require the person completing the form to indicate whether a client needed an interpreter.[223]

4.1.2 Lack of appropriate telephone equipment

The lack of necessary telephone equipment in consultation rooms, or at the patient bedside in hospital settings, is a barrier to using qualified telephone interpreters.[224 & 225] "In the ED phones are often situated in the medical and nursing stations, where use for telephone interpreting with the patient poses its own difficulties in ensuring that patient information remains confidential. It also assumes that the patient or carer can leave the bedside".[226]

> "I try to use speakerphones to make the encounter less clunky and they are not widely enough available in many clinical areas, more so as they need to be in private spaces".
> Correspondence with a Regional Victorian Paediatrician

The quality of the telephone connection has also been reported to be an issue.[227]

4.2 Financial

4.2.1 No Commonwealth funding for qualified interpreters for allied health practitioners in private practice

Allied health practitioners working in private practice providing Medicare funded[228] services do not have funded access to interpreter services.[229 & 230] This exclusion applies to psychologists, social workers, audiologists, dieticians, occupational therapists, optometrists, physiotherapists, radiographers, speech therapists, chiropractors, diabetes educators, exercise physiologists, osteopaths and podiatrists and Aboriginal health workers.[231] The cost of engaging qualified interpreter services in these circumstances must either be met by the allied health practitioner or the client. In practice this means that unless the client can afford to pay for an interpreter, the practitioner is likely to decline the referral, or the client will attend and try to manage on their own, or with the assistance of a friend or family member.
[232, 233 & 234]

4.2.2 Inadequate state funding for qualified interpreters for organisations

Some health organisations that receive funding from the Victorian Government for qualified interpreters are reporting the level of funding is insufficient to meet the demand for interpreter services.[235, 236, 237, 238 & 239] Organisations report they deal with the shortfall in funding by topping up the budget for interpreter services from other sources[240 & 241]; rationing existing resources by for example using quotas/waiting lists; or using in house interpreters for similar languages.[242 & 243]

In the hospital setting, anecdotally some hospitals have reported not being able to employ the required number of in-house interpreters due to budgetary constraints. This may be in part a reflection of the budget priorities within the hospital, within a context of overall budget considerations, however it is also in part a reflection of inadequate state funding.

> "…I really feel that the number of interpreters we have does not cope with the expanding need of interpreter use we are currently faced with".
>
> Zimbudzi. E., Thompson, S., Terrill, B., (2010), *How accessible are interpreter services to dialysis patients of Non-English Speaking Background?*, Australasian Medical Journal, 1(3), p 207.

In relation to community health, the funding for interpreter services may be inadequate in terms of direct funding or inadequate credit line funding.

In relation to direct funding for example, the Western Region Health Centre reported in 2008/2009 that funding received for interpreter services ($167, 127) only covered 50% of their total expenditure ($339,298) on language services.[244] More recently WRHC reported funding for interpreter services only covers 33% of their total expenditure on language services.[245] ISIS Primary Care reported that in 2010/2011 that funding received for interpreter services ($120,000) only covered 20% of their total expenditure ($600,000) on language services.[246]

Anecdotally, it appears for some credit lines, available funds are being exhausted prior to the end of the month resulting in no more bookings being be made against that credit line. This issue is longstanding as Allen Consulting back in 2002 found credit line "…funding may be exhausted prior to a booked appointment taking place".[247]

Increasing demand for interpreter services as a result of Victoria's ageing migrant population[248], will impact on the cost of purchasing interpreter services.

Furthermore, the cost of purchasing interpreter services is expected to increase significantly following the recent decision of the Federal Court of Australia in *On Call Interpreters and Translators Agency Pty Ltd v Commissioner of Taxation.*[249] The court determined that the qualified interpreters used by On Call were employees within the meaning of the *Superannuation Guarantee (Administration) Act 1992 (Cth)* instead of what On Call regarded as self-employed independent contractors. On Call was therefore deemed to be liable for the superannuation guarantee charges for these interpreters.[250] This ruling will impact other organisations as the Australian Taxation Office has said it will continue to apply the superannuation guarantee ruling, by 'distinction or organisation test'; that contractors are common law employees if they are operating in the business of the payer rather than operating on his or her account. [251 & 252]

4.3 Time

4.3.1 Time required to engage interpreters

The time required to arrange a qualified interpreter is considered to be a barrier for many health practitioners.[253, 254, 255, 256 & 257] Arranging a qualified onsite interpreter can be time consuming, especially where an individual is attempting to co-ordinate an appointment that suits the individual schedules of the interpreter, client/s and the health practitioner.[258]

Furthermore, it has been reported Refugee Health Nurses are spending a lot of time advocating for their clients to ensure that other health practitioners use interpreter services during consultations with their clients.[259] Anecdotally Foundation House staff are reporting similar levels of advocacy.

> A client of refugee background was booked into an antenatal clinic at a Victorian Hospital. The client attended two antenatal appointments that could not proceed because the language of the interpreter was incorrect (Burmese & Haka). This occurred despite the Refugee Health nurse ringing ahead of each appointment to inform front of house staff that that a Chin interpreter needed to be booked.
>
> Consultation with a Victorian Refugee Health Nurse

The task of booking onsite interpreters being delegated to reception or front of house staff can be effective as it frees up clinical time for health practitioners. A study of physiotherapists found they did not consider the time required to book interpreters for appointments as an issue and concluded: "this may be explained by the fact that receptionists, not physiotherapists, organised and coordinated physiotherapy appointments with interpreters".[260] Furthermore, the NHMRC advises

that guidelines for reception staff who are making appointments should include enquiring whether the patient requires access to a qualified interpreter.[261]

Placing the responsibility on reception staff to engage interpreters requires explicit direction and policies to ensure it occurs routinely. This is suggested by a study of general practices which found 30% of front of house staff would not contact an interpreter if asked by a client.[262] This has been found to be a result of front of house staff considering the decision regarding accessing interpreter services to be the responsibility of the GP. These staff gave a number of reasons for this: the process of engaging a qualified interpreter is a medical decision; accessing an interpreter was felt to be so cumbersome that they would not initiate contacting an interpreter without express direction of the GP; and respect for professional hierarchies.[263]

However, this may not always be practical in those settings where health practitioners need to book interpreters in order to manage their own diaries, or for engaging telephone interpreters.

> "The big disincentive is the number of steps that it takes to be put though to a telephone interpreter. I can't just ring the interpreting service myself. I have to ring the nursing co-ordinator (or equivalent) at the hospital – which takes time…".
>
> Correspondence with a Regional Victorian Pediatrician

4.3.2 Length of consultation

Many health practitioners believe using a qualified interpreter during a consultation takes extra time,[264, 265, 266, 267, 268 & 269] anywhere up to twice as long.[270 & 271] In one study, 54% of GPs believed the extra time needed to use phone interpreters was too long to be practical in general practice.[272] This is exacerbated if the interpreter is running late, as appointments will either be rescheduled, or appointments will run over time leading to delays for other appointments.[273]

For consultations with qualified interpreters a GP can claim a longer consultation (MBS item number 36) which is for at least 20 minutes and has a schedule fee of $69.00.[274]

We are not aware of Australian research on the length of time of clinical consultations using qualified interpreters. Studies of the length of time of consultations using interpreters have been conducted in other countries but the findings cannot be directly applied to Australia because of the varied definitions of interpreters, including: specialist medical interpreters; hospital interpreters; bilingual health practitioners; relatives; and friends.[275, 276 & 277]

A pilot study at the New York University School of Medicine (NYUSM) found when remote interpreters are used, the simultaneous method of interpretation (RSMI) is much quicker than traditional consecutive interpreting. RSMI enables almost word for word interpretation like a voice over, whereas traditional consecutive interpreting requires the interpreter to listen as the primary speaker speaks, and then interpret only once the primary speaker has finished.[278] The use of RSMI technology at the NYUSM has been reported to have many other benefits.[279]

4.4 Knowledge

4.4.1 Lack of awareness of interpreter services by health practitioners and other staff

Many health practitioners and other staff working in various health settings may not know about the availability of interpreter services at all, or are unfamiliar with important aspects of how the services operate.

Studies of Australian doctors and other personnel in general practices in 2008 and 2009 found that 36% to 39% of those surveyed were unaware of the TIS Doctors Priority Line.[280 & 281]

Health practitioners and front of house staff who are aware may have misconceptions about the types of services provided. A number of studies reported confusion about the cost of TIS services among practitioners who have free access[282 283 & 284] and telephone interpreters can be utilised[285] and accessed on demand[286 & 287] and after hours.[288] One rural study found even practices geared toward refugee health misunderstood the TIS service, asking refugees to arrange their own interpreters, meaning refugees would have to pay for a service that is free for the doctor to access.[289]

Similar gaps in knowledge have been identified in other settings. It has been found hospital ward pharmacists and community nurses were unaware of telephone interpreting services.[290] Furthermore, at a Melbourne hospital it was found 17% of health practitioners from a variety of disciplines were unfamiliar with the available interpreter services. This unfamiliarity directly correlated with: a lack of qualified interpreter use; an increased use of family or friends as interpreters; and reporting a lack of protocols and guidelines for interpreter use negatively affected their use of qualified interpreters.[291] It has also been reported mental health practitioners are often unaware of the processes in which to use interpreter services when they are available.[292] Knowledge gaps have been reported in Victorian community health and Queensland also.[293 & 294]

4.4.2 Inaccurate assessment of English language proficiency

Health practitioners may decide not to engage an interpreter in situations where they believe clients have sufficient command of English; to communicate and to comprehend what may be quite complex information about the clients' physical and mental well-being, options for treatment, medication and other important matters. The assessment of clients' linguistic proficiency may be mistaken.

A New Zealand study of interpreter use by health practitioners found one of the reasons health practitioners reported not using interpreters was a misjudgement of their clients' language ability.[295] In rural NSWs, it was found health practitioners

> "The receptionist advised that despite the clients expressed need for an interpreter, the psychiatrist had cancelled the interpreter, believing that the client's English was good enough…"
>
> *Queensland Accessing Interpreters Working Party, (2008), A Matter for interpretation: the case for access to high quality accredited interpreting and translating services and cultural competence in Queensland services working with culturally and linguistically diverse people, p 9.*

who used no interpreter assessed the clients as 'spoke English' without first checking their comprehension level or asking them if they wanted an interpreter.[296]

In a Victorian study, 37% of GPs reported they did not use a qualified interpreter because there was no need, but the accuracy of their assessment is questionable as 9% of the population in the catchment area where the GPs worked had poor proficiency in English.[297] Clients have reported doctors have told them they do not need an interpreter. [298]

Clients may also be prone to mistakenly believing their proficiency in English is adequate for certain situations. In NSW, for example, a number of clients attending a hospital emergency department declined the offer to use a qualified interpreter because they considered their language skills to be adequate, but found they were not able to properly understand the consultation.[299] In another NSW study, "there were many situations observed by researchers and accounts given by staff, of family members who believed they spoke English 'well' but in reality faced significant challenges in understanding the information provided and expressing their views clearly".[300]

> "The first time I was asked if I wanted an interpreter but thought because I have a little English I should say no. I did not realise that a lot of information I did not understand and then I felt embarrassed and did not ask for one after that, but it would have been good".
>
> Nicolaou, M., (2011), *The pregnancy and birth experience of women from refugee backgrounds living in the Outer East of Melbourne*, EACH Social and Community Health, p 12.

Even when clients use every day English, their language skills may be insufficient for complex communication in the health setting as a result of: their capacity to express themselves; their understanding of technical medical language and explanations, which may compromise understanding of the medical assessment, diagnosis, treatment and care. [301 & 302] For example, it was found in two Sydney based hospitals that 47% of the CALD clients had a problem understanding medical words.[303]

4.4.3 Professional deferral to presumed client preference

Health practitioners often believe clients prefer having family or friends interpreting in health consultations.[304 & 305] GPs have also expressed concern that engaging a qualified interpreter may undermine the clients' family support.[306 & 307]

Research suggests the majority of clients prefer qualified interpreters be used as they "…ensure both basic and thorough understanding; ensure essential information wasn't missed; reduce anxiety; enable privacy and full understanding and to reduce embarrassment around private or serious health issues".[308 & 309]

For the clients who prefer using family members; the preference may be

> A client of refugee background from a new language group, with a sexual and reproductive health issue attended two appointments to see a specialist physician at a community health centre that did not proceed because an interpreter (telephone or onsite) could not attend (both were pre-booked but not confirmed). The same thing happened to her twice more at the specialist outpatient clinic at the hospital. On the second occasion the specialist went ahead with the appointment using family to interpret. As a result of the sensitive nature of the consultation, the client was not honest when asked questions by the specialist.
>
> Consultation with a Victorian Refugee Health Nurse

situational rather than general. Particular circumstances where clients have reportedly declined an offer made by a health practitioner to engage a qualified interpreter are where: sensitive matters are to be discussed i.e. mental, sexual, reproductive health or domestic violence; the client uses a new and emerging language; and the interpreter is of the opposite gender.

In an Australian study of 51 Iranian women, almost all the women said they would refuse access to a qualified interpreter when discussing sexual matters.[310] Some GPs have also expressed difficulty in dealing with sensitive issues such as mental, sexual and reproductive health.[311 & 312]

While embarrassment was noted as a factor in the study of Iranian women, the underlying fear of discussing sensitive matters in front of a qualified interpreter was caused by concern that the interpreter would be known to their small community and their confidential information would therefore be divulged.[313] Concerns regarding breaches of confidentiality particularly for clients from small communities with new and emerging languages or rural communities have been echoed elsewhere.[314, 315, 316 & 317] Further it has been reported mental health practitioners share client concerns about the ability of interpreters to maintain confidentiality within smaller communities.[318] The Australian Institute of Interpreters and Translators code of ethics requires interpreters to respect their clients' rights to privacy and confidentiality.[319]

In another Australian study, focus group discussions with 100 clients from nine different ethnic groups, found clients not proficient in English preferred using family for everyday health consultations. In contrast, they preferred qualified interpreters for sensitive issues (which may be related to some being from established ethnic communities), for emergency situations or where complex medical issues needed to be addressed.[320]

As such, the need for gender specific interpreters, the anonymity afforded by the telephone modality and the repeated stressing of confidentiality are considered indispensable strategies when discussing private and sensitive issues[321, 322, 323, 324, 325, 326 & 327] Utilising interpreters from another state or country of birth, if available, may also address issues regarding confidentiality.

4.4.4 Health practitioner preference for onsite interpreter

Health practitioners prefer onsite interpreting over telephone interpreting. [328, 329 & 330]

In certain situations, a preference for onsite interpreters is based on an assessment of the clinical situation. For example Foundation House prefers the use of onsite interpreters to establish rapport in psychotherapy and the same interpreter for multiple appointments to promote continuity.

However, if the preference for an onsite interpreter is based on the health practitioner's level of comfort this can lead to extra costs and unnecessary and potentially dangerous deferral of treatment.

Telephone interpreting provides the easiest access to qualified interpreters and it is more cost effective than face to face interpreters[331], unless the consultation is lengthy in duration. For example, in February 2012 TIS connected to an interpreter in a major community language within 3 minutes on 99% of occasions.[332]

As highlighted in the previous barrier the telephone modality also provides the greatest level of anonymity and privacy as interpreters can be sourced from other states, which is especially important for clients in rural and regional communities and those who speak new and emerging languages. Specifically, "…patient confidence in the confidentiality of the consultation may be higher when the interpreter is not present, especially if physically present interpreters would otherwise be recruited from the patient's local community".[333] In one rural study, a number of participants in focus group discussions stated that they preferred the anonymity of the telephone service.[334] Furthermore, at Companion House it has been found that:

> "on ten occasions during the last five years, patients have declined to have the interpreter after these prepatory narrative discussions, citing concerns about confidentiality or lack of trust of the interpreter because of his her background. These instances of rejecting a remote interpreter are very small compared with the number who have requested one in preference to an on-site interpreter for the same reasons".[335]

Furthermore, the mode of service delivery has no bearing on the training or qualifications of the interpreter.

Finally, in the United States it was found that the proportion of clients utilising telephone interpreters who were satisfied with their clinic visit was identical to that of language concordant clients.[336]

A Ukrainian student was brought to the emergency department of a small regional hospital, where it was found that he required surgery. The staff decided to keep him comfortable overnight by giving him pain relief and deferred getting consent for the operation until the morning staff came on, when they knew there was an overseas trained doctor who spoke Ukrainian. The staff expressed some concern about not knowing if he was allergic to morphine, but decided to go ahead and give it to him.

"The patient was denied information about his treatment for seven hours, and given medication without knowing it was safe for him. This potentially risky situation could have been avoided by contacting a telephone interpreter".

Phillips, C., (2010), *Using interpreters a guide for GPs*, Australian Family Physician vol 39(4).

4.4.5 Lack of understanding of the importance of qualified interpreting

A number of Australian and overseas studies indicate many health practitioners consider interpreting needs can be met adequately and appropriately by family members and untrained bilingual staff[337, 338 & 339] this was also reported in Western Australia.[340] In one study it was found 20% of GPs didn't believe using a qualified interpreter was needed to gain informed consent.[341] In another study it was found 46% of doctors required interpreters to have no qualifications and only 23% required NAATI professional accreditation and only 30% believed interpreters should be university trained.[342]

4.5 Interpreter Service

4.5.1 Interpreters unavailable

Health practitioners and clients alike regularly report having difficulties in accessing interpreters in a timely manner.[343, 344, 345, 346, 347, 348 & 349]

Accessing qualified interpreters onsite in a timely manner during business hours for common languages can be an issue.[350 & 351] When a health practitioner requests an on-site interpreter, TIS will confirm the job within three days of the request in 85% of the cases.[352] Ensuring qualified interpreters are available in a timely manner is more difficult in certain circumstances, such as:

- qualified interpreter not pre-booked - including unplanned and emergency presentations[353, 354, 355, 356, 357 & 358];

- after hours - including weekends and public holidays[359 & 360];

- rural or regional location[361, 362, 363, 364, 365];

- rare or emerging language required[366, 367, 368, 369, 370, 371 & 372];

- high demand languages i.e. Italian and Greek;

- health or mental health experience required[373]; or

- gender requirements.

> A client of a refugee background presented as an emergency at a dental clinic with severe pain and bleeding gums. After a couple of hours, the client was seen and then told that, because an interpreter was not booked (and a telephone interpreter was unavailable) she would have to come back when the clinic could book an interpreter. The relative with her was not permitted to interpret, as the clinic had recently been advised that only a dentist and a professional interpreter could interpret, provide treatment advice and follow up options. The clinic sent the patient home. It was not until a worker from VFST followed up the issue that the patient understood there had been a problem regarding interpreter access and that she needed to return later to the clinic.
>
> Davidson, N., Skull, S., Calache, H., Chesters, D., Chalmers, J. (2007), *Equitable access to dental care for an at risk group: a review of services for Australian refugees*, Australian and New Zealand Journal of Public Health, Vol 31(1), p 73.

Delays in securing interpreter services cause delays in appointments. In a study of nine Victorian liver clinics it was found that CALD clients experienced the longest waiting times for clinics due to limited access to interpreter services, the worst waiting times were reported to be at the hospital liver clinic where "they don't have interpreters".[374] The Australian College of Optometry places Victorians of a refugee background on a waiting list for interpreter services and notes that these waiting lists are longer.[375] Clients have commented if they do not identify as needing an interpreter they will be given an earlier appointment.[376] Faced with delayed appointments, clients may prefer to use family and friends to interpret, make do in English, not receive assistance, or not request assistance. [377, 378, 379 & 380]

> "…booking for an interpreter was not always easy due to long waiting times. Therefore some women had to rely on their partners or family members to interpret for them. As reported in the interview results, some women relied on their husbands for interpreting but once again they were faced with another obstacle as husbands could not come with them to all the routine check-ups and antenatal visits due to work or study commitments".
>
> Hoang, Ha., (2008), *Language and cultural barriers of Asian migrants in accessing maternal care in Australia*, The International Journal of Language Society and Culture, Issue 26, p 58.

The main reason for being unable to access interpreters in a timely manner is insufficient interpreters are available; this will be addressed below. Other reasons cited for being unable to access interpreters in a timely manner include interpreters running late[381] (which causes appointment delays in the health setting); and a lack of co-ordination between health and interpreter services.[382]

Insufficient interpreters being available at the time of the job reportedly occurs across all private interpreter services, TIS and in-house interpreter services.

Insufficient interpreters are available at the time of the job

For the 2010/2011 financial year unmet demand for TIS National fee free interpreting services by 'medical practitioners' (general practitioners, specialists and pharmacists) was 6% for telephone interpreting and 27% for onsite interpreting. The average levels of unmet demand over the last six years (2005/06-2010/11) for medical practitioners have been 7% for telephone and 29% for onsite interpreting.[383] One study found that GPs reported satisfactory experiences with accessing the DPL.[384]

The primary reason for unmet demand for telephone interpreters for 'medical practitioners' over the past six years have been that no interpreters were available at the time of job which is a result of TIS National not being able to source an interpreter in the requested language; see graph one.[385]

Graph 1: Reasons for unmet demand for medical practitioners' accessing TIS fee free interpreting services – telephone (FY 2005/06 -2010/11)
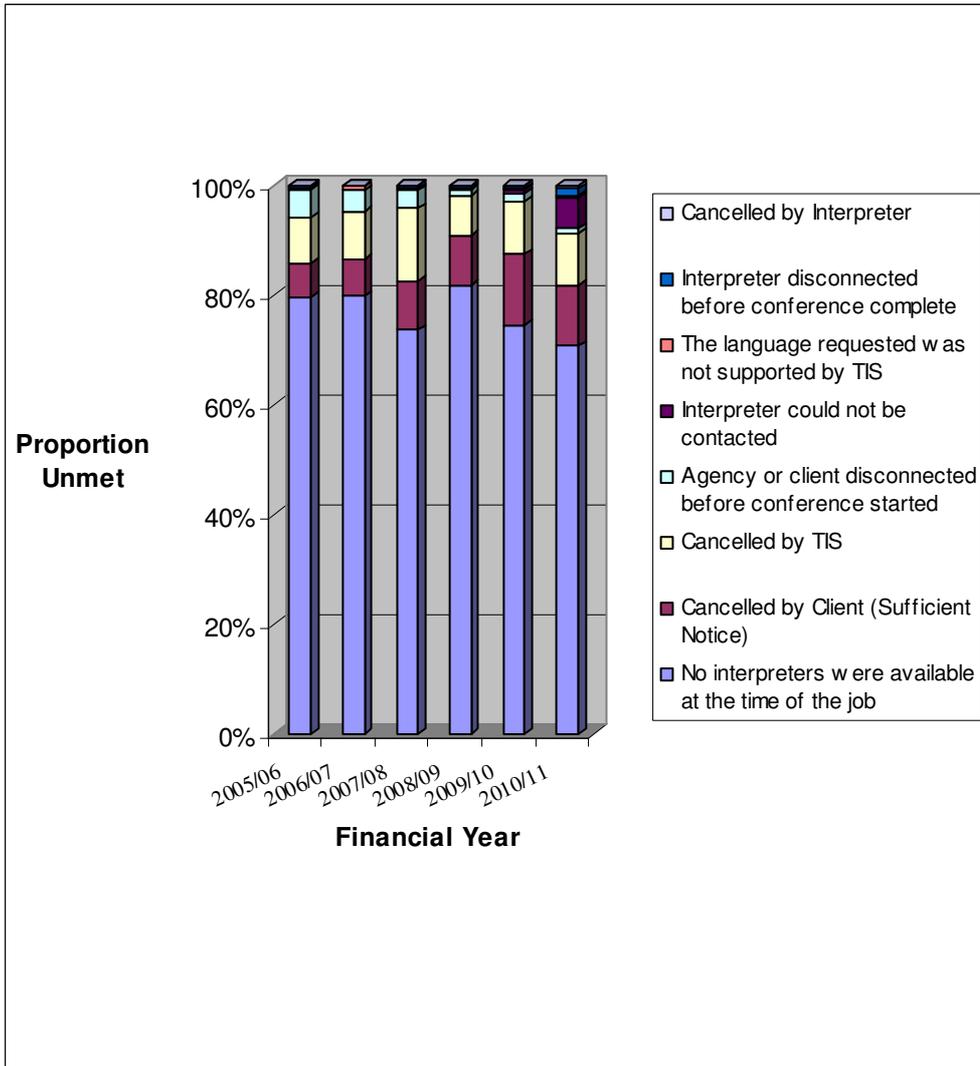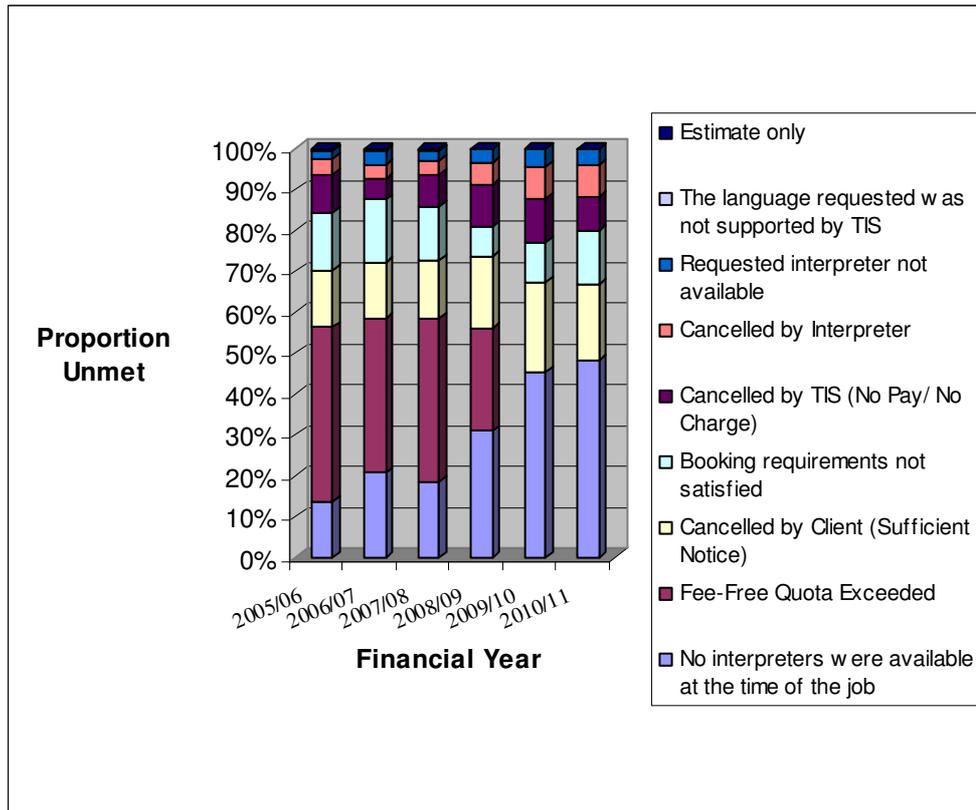

Source: Data set provided by the Settlement Policy Section of the Department of Immigration and Citizenship on 8/12/2011

Note: *The data cannot be disaggregated into pre-booked and on-demand or language group of request not met.

For onsite interpreters no interpreters being available at the time of the job is also the main reason for unmet demand; see graph two. The fee free quota being exceeded was also a significant reason for 2005/06 – 2008/09; however it has not been reported as a reason for unmet demand since. [386]

Graph 2: Reasons for unmet demand for medical practitioners' accessing TIS fee free interpreting services – onsite (FY 2005/06 -2010/11)

Source: Source: Data set provided by the Settlement Policy Section of the Department of Immigration and Citizenship on 8/12/2011

Note: *The data cannot be disaggregated into pre-booked and on-demand or language group of request not met. **Further expanded reasons: (1) Cancelled by Interpreter i.e. an interpreter has accepted a telephone assignment, but has had to cancel for some reason and there is insufficient time to allocate another interpreter to the booking (2) Cancelled by TIS (No Pay/ No Charge), describes a situation where a job is cancelled as a result of being a duplicate booking or an administrative error (3) Booking requirements not satisfied i.e. insufficient information provided for the booking, such as an incomplete booking form.

TIS National is the only interpreter provider service we are aware of collecting data on unmet demand. The only available estimate of unmet demand located for Victoria was published by Allen Consulting in 2002, where unmet demand was estimated to be 3% of bookings; it is not stated how the estimate was calculated.[387] New reporting requirements for quality of care reports[388 & 389] will assist in determining the number of instances when an interpreter was required but not provided. However, this data will not capture the reasons why an interpreter was not provided; including that the language service provider was unable to meet the request.

Interpreter Workforce

In Victoria and elsewhere in Australia, the size of the qualified interpreter workforce is less than the requirement for services. There are particular shortages of female interpreters and of interpreters in both new and emerging languages and a number of established community languages i.e. Greek, Italian, Vietnamese and Cantonese. The arrival of migrants and humanitarian entrants from new language groups is a further challenge in meeting service requirements.

A number of issues have been identified as affecting the supply of qualified interpreters, including;

- Retention - Interpreters are leaving the profession at higher rates than those entering the profession. This may in part be due to:

  a) an ageing workforce;
  b) a highly casualised working environment, resulting in fluctuating work and no certainty of income or job security;
  c) poor remuneration, marked by a declining income in real terms; and
  d) poor working conditions, including excessive travel which incurs out of pocket expenses and represents a loss of income earning potential and on the job stress i.e. mental health consultations.

- Recognition - Limited in terms of career paths and professional development opportunities i.e. lack of specialised training in medical and mental health terminology.

- Recruitment – New immigrants may not be aware of employment opportunities and interpreter courses do not cater for rare and emerging languages i.e. Karen and Swahili.

The quality of interpreting has also been identified as an issue of concern.- Factors identified here include declining levels of accreditation due to limited incentives to upgrade, high cost of accreditation and high failure rates for accreditation testing. Other quality issues include punctuality. [390 & 391]

The Western Australian Government in its review of language services also found "interpreter pay rates are considered low and many interpreters can earn a higher income working in business and industry".[392]

An investigation into the adequacy and quality of the interpreter workforce is outside the scope of this project, except to acknowledge investments are being made by the Australian and Victorian Governments.

For example, the Victorian Government has identified as a priority strategy under the multicultural policy the development of a workforce strategy to improve the supply of interpreters when using government services, including the better use of technology.[393] The Victorian Government has also invested directly in projects, some of which are outlined in section 1.4.2 of this paper.

An Australian Government example is the 'new interpreters project' which is administered by the National Accreditation Authority for Translators and Interpreters Ltd on behalf of the DIAC.[394]

Training and Accreditation Standards

In Victoria tertiary training for interpreters is provided by Monash and RMIT; a basic interpreter skills course is available in regional Victoria. The Victorian Government Office of Multicultural Affairs and Citizenship, offers scholarships to applicants of targeted language groups, enrolled in the Diploma of Interpreting at RMIT University worth $2,000.[395]

According to a Monash University report 'Pathways to Interpreting and Translating' there are issues associated with prospective interpreters in emerging languages being able to meet entry requirements for interpreting courses and a lack of pathways once they have been 'recognised' by NAATI, to obtain a higher level of accreditation.[396] This means private interpreter services are "often obliged to send out non-accredited interpreters or paraprofessional interpreters (in place of professional interpreters).[397]

In relation to the Accreditation Framework the Monash University report found:

> "The current accreditation framework in Australia is not reflective of workplace practice. There is a high failure rate of candidates sitting the accreditation exam and delays in movement from recruitment/training to successful accreditation. A testing system that accredits so few practitioners creates disillusionment and dissatisfaction among candidates, stops 'new blood' from entering the profession and encourages translators and interpreters to work without accreditation. It is counterproductive to both the individual and the industry to focus solely on creating ways to attract potential practitioners from new and emerging languages (at the recruitment stage) without addressing some of the reasons behind the large failure rate of NAATI accreditation candidates".[398]

NAATI is in the first stage of 'improvements to NAATI testing project' which will "review language translator and interpreter testing literatures as well as review government language/interpreter policies. This will be followed by reviews of testing instruments, marking systems and accreditation/certification systems leading to development and definition of standards and initial consultations with stakeholders". The aim is to have recommendations for consultation and feedback by July and it is "expected the proposed conceptual overview for new NAATI standards, testing and assessment would be finalised by the end of 2012".[399]

4.6 Client

4.6.1 Lack of awareness of interpreter services by clients

Studies in a number of states have found many clients are unaware of the availability of qualified interpreters in health settings. For example, in a study of the carers of paediatric emergency department patients at a NSW hospital it was found 29% were unaware of the hospital interpreter service and some of the carers only chose to use an ad hoc interpreter because they were not aware of other options.[400] Client studies in Victoria[401] and Western Australia[402] have found clients are unaware of qualified

interpreter services in the health sector more broadly. The Queensland 'accessing interpreters working group' found the confusing array of services made it "hard for those who need interpreters to know what to expect or what their entitlements or rights are". [403] Hospital health practitioners have also reported some clients are unfamiliar with interpreter services and therefore do not request qualified interpreters.[404]

4.6.2 Client Reticence

Even if clients are aware interpreters are available they may be reticent to ask for a number of reasons including:

- felt embarrassed or uncomfortable[405]; and

- not wanting to appear as a drain on government resources.[406]

 DIAC has reported "[a]lthough the Humanitarian Settlement Services (HSS) program promotes appropriate use of interpreters, visits conducted with clients exiting HSS repeatedly show many clients lack the ability and confidence to request interpreting services. Similar interviews conducted in Victoria with Complex Case Support clients found this trend persists even after a period of intensive case management".[407]

Often clients report when they have requested interpreters health practitioners have refused to provide them[408, 409, 410, 411, 412 & 413] insisting the client communicate without assistance or uses family to interpret.[414] The main reasons given to clients were:

- interpreter services are not available in a particular setting[415];

- their English was considered 'good enough'[416]; or

- the health practitioner does not work with interpreters.[417]

The experience of clients is confirmed by a study of GP practices which found 30% of practices would not arrange a qualified interpreter if requested.[418] As the Human Rights and Equal Opportunity Commission highlighted, this

> "suggests a failure of service providers to understand the repercussions of the refusal to engage interpreters to treat refugees…many refugees are socially isolated and lack the necessary family and social supports to assist them through their illness. Also, language barriers and cultural barriers may also impede help seeking behaviour. For this particularly vulnerable group of consumers, to have overcome all these issues and then be turned away could result in no further attempts being made to access alternate service providers or receiving inadequate care".[419]

There is concern clients may be unaware they have a right to an interpreter[420, 421, 422 & 423] and how to make a complaint if things go wrong.[424] One study found a lack of complaints mechanisms related to a poor use of interpreter services.[425] Clients have said they require information about complaints mechanisms.[426]

5. FACILITATORS TO THE USE OF QUALIFIED INTERPRETERS

It is important to understand the factors that encourage health practitioners to use qualified interpreters as a means to disseminate successful strategies others may adopt and to promote the routine use of qualified interpreters in day to day practice.

This chapter describes the facilitators to the use of qualified interpreters in health settings identified in studies and discussions. The assorted measures relate variously to health practitioners and other staff, to the organisations in which they work and to clients themselves.

5.1 Health Practitioner

5.1.1 Awareness of interpreter services

Increasing health practitioners' awareness of interpreter services and how to access them makes it more likely they will use the services.[427] As discussed in section 1.2 on professional codes of conduct and guidance documents the RACGP accreditation standards for general practices require that GPs and staff are aware of TIS for clients not proficient in English. The requirement to use interpreters when necessary was included in the first edition of the RACGP Standards for general practices published in 1996.[428]

Since late 2007, TIS National has promoted the DPL with activities including:

* a medical practitioner welcome pack, including a brochure on the fee-free service that is sent to newly registered doctors;

* technology enabled strategies to encourage registration, such as a readily accessible medical practitioner registration form on the TIS National website; and

* community outreach projects where presentations about services were provided to members of local area health care networks.[429]

RACGP accreditation standards and TIS National promotional activities may be contributing factors to a major increase in GP registrations for TIS National and smaller though still marked increases in total demand for TIS services (see Table three below).

Table 3: TIS National GP Registrations and GP service requests (2005-06 - 2010-11)

Year	GP Registrations	Increase in GP registrations	Total GP requests for TIS service	Increase in GP requests for TIS service
2005-06	300		25684	
2006-07	438	46%	30612	19%
2007-08	608	39%	33317	9%
2008-09	1275	109%	36356	9%
2009-10	2229	75%	43975	21%
2010-11	2399	8%	53389	21%

Source: Data set provided directly by the Settlement Policy Section of the Department of Immigration and Citizenship on 8/12/2011

5.1.2 Training

Health practitioners who have been trained to use qualified interpreters are more aware of the need to work with qualified interpreters and are more likely to use them.[430, 431, 432, 433, 434 & 435] As such, the provision of training on qualified interpreter use is considered to be best practice [436, 437, 438, 439, 440, 441 & 442] Training is necessary not only to make practitioners aware of the availability of interpreter services and how to access them (addressed above) but should also include issues such as:

- understanding the importance of using qualified interpreters[443];
- assessing whether clients are adequately proficient in English for the clinical situation;
  when to engage an interpreter: "focusing on the 4Cs: consent, crisis, complex instructions and competence (is the client competent to give consent or manage their own care?) might be a useful way of stressing when failure to use an interpreter is likely to result in disaster"[444];
- practical advice on how to work effectively with interpreters[445 & 446];
- cultural competence[447, 448 & 449]; and
- particular considerations for use of interpreters when working with refugees and asylum seekers taking into account the impact of refugee trauma and torture.[450]

A Cochrane review is currently underway which aims to "assess the effects of cultural competence education interventions for health practitioners on patient-related outcomes, health practitioner outcomes, and healthcare organisation outcomes".[451]

a) Pre-service training

Pre-service training as a part of practice ready health practitioner TAFE and tertiary courses is essential to reach health practitioners before they start to practice.[452]

A small voluntary interpreter training case study of first year medical students at the University of Western Sydney had low participation rates, which may indicate a lack of interest by students, and the need to ensure that training is compulsory.[453] Ideally, students studying to become health practitioners should be trained on the use of interpreters as a compulsory component of their course.

TAFE

The 'work effectively with culturally diverse clients and co-workers'[454] is a unit of competency which forms a compulsory part of the health training package for all TAFE students studying nursing and pathology.[455] The unit directly covers compliance with duty of care policies of the organisation and communication through an "an interpreter or other person".[456]

University

At the end of 2011, Foundation House sent a survey to 9 Victorian tertiary institutions; regarding training in practice ready courses for health practitioners. The survey enquired whether the institutions courses covered: working with interpreters; cultural competency; and the impact of refugee trauma and torture. Six universities responded regarding 33 practice ready courses covering all health disciplines.

Table 4: Foundation House Survey of Victorian Tertiary Health Courses

Course	Do you teach students to use interpreters or as a minimum address associated issues within the course?				Do you provide education in cultural competency?			Do you teach students about the impact of refugee trauma/torture and how to deal with this in the health consultation?		
	Teach students to use intepreters	Address associated issues with use of interpreters	Do not teach students on using intepreters or issues associated with intepreter use	Total	Yes	No	Total	Yes	No	Total
Nursing & Midwifery	3	2	2	**7**	6	1	**7**	5	2	**7**
Health Sciences (including oral/dental)	3	0	1	**4**	4	0	**4**	2	2	**4**
Human Services	1	0	0	**1**	1	0	**1**	1	0	**1**
Nutrition & Dietetics	1	0	1	**2**	2	0	**2**	2	0	**2**
Physiotherapy	1	0	1	**2**	2	0	**2**	2	0	**2**
Occupational Therapy	2	1	0	**3**	3	0	**3**	3	0	**3**
Psychology & Social Work	1	3	3	**7**	7	0	**7**	3	4	**7**
Pharmacy	1	0	0	**1**	1	0	**1**	1	0	**1**
Speech Pathology	1	0	0	**1**	1	0	**1**	0	1	**1**
Ambulance and Paramedics	1	0	0	**1**	1	0	**1**	1	0	**1**
Radiography and Medical Imaging	0	0	2	**2**	2	0	**2**	0	2	**2**
Medicine	2	0	0	**2**	2	0	**2**	2	0	**2**
TOTAL	**17**	**6**	**10**	**33**	**32**	**1**	**33**	**22**	**11**	**33**
PERCENT	51%	19%	30%	100%	97%	3%	100%	67%	33%	100%

In summary the respondents indicated that:

- over half (51%) of the courses have components to teach students how to work with interpreters, several universities indicated that the components were elective – we do not know the status of the others. The most comprehensive components were in one institution's physiotherapy and occupational therapy courses where students attended either a three hour or an all day seminar with interpreting and translating students where issues pertaining to using interpreters are explored and simulated interactions with interpreters are practiced.

- a further 19% of courses explored issues pertaining to the use of interpreters such as informed consent, but did not teach students how to work with interpreters.

- thirty percent of courses do not cover either working with interpreters or the issues associated with using interpreters. One course co-ordinator explained that teaching about interpreter use is not included as it is unusual for clients not to have a family member interpreting for them.

b) Professional development

Training in the use of qualified interpreters should be provided to practising health professionals to equip those who have not received any training pre or post service and to refresh and develop the skills of those who have. It has been widely reported there are a number of health practitioners who require formalised training on interpreter use.[457, 458, 459, 460, 461 & 462]

A study attributed low participation rates to a lack of interest in interpreting by medical practitioners[463] and it has been proposed that training should feature compulsorily as a component of annual staff performance reviews[464 & 465] or be connected to professional development points to increase the likelihood of participation.[466] Some organisations have developed on-line training to increase participation for health practitioners with limited available time.[467, 468 & 469] Staff at all levels in health organisations should be provided with interpreter training[470], including front of house staff as they are often a key access point to interpreter services.[471 & 472]

In Victoria training is delivered on interpreter use by a variety of bodies including:

- commercial language service providers - for example: ONCALL[473];

- The Centre for Ethnicity and Health (CEH)[474];

- community dental services[475]; and

- directly by hospitals - for example: St Vincent's hospital[476].

In 2007, the CEH piloted a TIS (DPL) Training Module for General Practices 'working effectively with professional interpreters in private general practice' which was accredited by the RACGP and attracted professional development points to

address the gap in training for GPs.[477] In a written questionnaire completed by 46 GPs, 21% indicated they would like training in effectively using an interpreter.[478]

5.2 Organisational

The commitment of the organisations that provide health services to the use of qualified interpreters is a critical facilitator of good practice. This is the case in organisations of all types and scales, from small GP practices to major hospitals.[479] Organisational commitment may be manifested in the following ways, some of which may be pertinent to all organisations and others to only some.

5.2.1 Ensuring staff are aware of and trained to access and use interpreters

The preceding section described the importance of health practitioners and other staff being aware of interpreter services and how to access them and – particularly in the case of clinicians – how to work with qualified interpreters. Organisations need to indicate to pertinent staff that they are expected to have or acquire the necessary knowledge and skills and allocate the time and funding to permit them to attend training.[480] Staff members who are committed to culturally competent practice can if supported, drive organisational improvements in the use of interpreters.[481]

5.2.2 Employment of in-house interpreters

Health practitioners are more likely to use interpreters when the interpreters are employed by their organisation than those provided by external agencies. In one study, health practitioners gave the services of an in-house interpreter a 100% positive rating and none stated there was a better alternative. The positive rating was felt to be the result of: the established rapport, trust and continuity between the in-house interpreter and the clients; high level of training and ethical standards; professionalism; and competence.[482] The health care experience, in terms of cultural issues and medical terminology are other notable strengths of in-house interpreters.[483] Western Health has similarly reported in house interpreters provide continuity of care, accessibility at short notice, cost effectiveness and service efficiencies.[484]

In 2002 it was found at Northern Health health practitioners who worked from the campus with the on-site interpreter co-ordination service were less likely than their colleagues from other campuses to prefer the use of ad-hoc or unqualified interpreters, to use an ad-hoc interpreter or manage without assistance when a qualified interpreter was unavailable; and to report that their use of interpreters was negatively affected by the length of time involved in organising an interpreter.[485]

Northern Health has since increased the number of in–house interpreters from 4 FTE in 2007 to 15.1 FTE in 2011. There was a 3 fold increase in requests for interpreters for the same period and the level of unmet demand fell from over 5% in 2008 to 3.4% in 2011. It should be noted the increase in staff was also complemented by a substantial increase in the number of training sessions; from 30 in 2008 to 92 in 2011.[486]

Western Region Health Centre has reported the need to clearly document the role and expectations of interpreters in their position descriptions, for example whether or not client advocacy is to form a part of the duties of the interpreter.[487]

5.2.3 Interpreter equipment technologies

Telephone

Utilising technology that supports quality telephone interpreting will address barriers to using telephone interpreters. Some examples are described below.

Dual Handset Phones
In the USA and UK, commercial organisation 'Language Line'[488] uses dual handset phones enabling sensitive information to be shared confidentially without using a speakerphone. The health practitioner and the client have their own handset which means there is no need to pass a handset back and forth between the health practitioner and the non-English speaker. The dual hand set phone also has speaker phone capabilities to enable hands free consultations where confidentiality is not an issue and directly links to the commercial provider.[489 & 490] It has been reported that "the ease with which the technology can be used is reflected in the increase of telephone interpreting as a widely used model by many health providers. Additionally and equally important is its cost effectiveness in many health encounters which would otherwise cost double for a face-to-face encounter".[491]

Wireless Speaker Phones
The Polycom® SoundStation2W™ is a wireless conference phone that enables cordless roaming from the base station, allowing the phone to be used in rooms without phone lines.[492] A single unit is in operation at Primary Care Connect Community Health Services where the base station is docked in the reception area. Staff book the cordless unit on Microsoft outlook and collect it prior to the scheduled health consultation requiring telephone interpreting. The voice quality, loudness and microphone sensitivity are reported to be very good as the phone is successfully used to provide cordless speaker phone interpreting sessions between health practitioners and whole families.[493]

Mobile Phones
Primary Care Connect Community Health Services purchased i-phones to be used in conjunction with speaker docks to successfully enable hands free off-site interpreting. Mobile call charges were not considered to be prohibitive under the organisation's telecommunication contract[494], but that may not be so for organisations with other contracts.

Video Medical Interpreter Technology

Video Medical Interpreter (VMI) technology links a remote qualified interpreter to a client and a health practitioner via a video link so they can see and hear each other.[495] The systems range from elaborate wireless freestanding equipment on trolleys to wheel to the point of care[496] to web cameras in existing computers.[497]

In 2003, the Holy Name Hospital in New Jersey implemented VMI. An evaluation of the VMI found: it was more expensive than using telephone interpreters but much less expensive than using on-site interpreters; patients were comfortable with the system; there were fewer delays for interpreters; all important visual clues and body language which can be important in a health setting were able to be identified; and it could be easily replicated in other settings with the assistance of organisations' information technology staff.[498]

In 2005, the Rancho Los Amigos National Rehabilitation Center implemented VMI.[499] The VMI was reported to have increased access to qualified telephone interpreters by 18%, which was a six fold increase in the total number of patient encounters served by remote qualified interpreters.[500] Rancho has used VMI technology to participate as a member of the Health Care Interpreter Network discussed below.[501]

Examples of Victorian health service organisations utilising VMI include Northern Health[502], Sunraysia Community Health Services[503] and Southern Health who report benefits of faster access to qualified interpreters and cost effectiveness.[504]

The use of technology such as VMI, could assist rural communities because of the limited pool of onsite interpreters.[505] Specialists, consultant physicians or consultant psychiatrists who implement VMI technology may be able to take advantage of the telehealth start up and quarterly financial incentives as well as MBS item numbers, if they also use VMI in consultations with clients in eligible telehealth areas.[506]

Network of shared interpreter services

VMI technology has facilitated the establishment of the Health Care Interpreter Network (HCIN), a not for profit cooperative of Californian public hospitals sharing interpreter services.[507] The network operates via a mobile video unit that is wheeled to the point of care at the time of need which enables both telephone and video interpreting. The interpreter request is initiated automatically when the health practitioner pushes a button. Requests are first routed to in-house interpreters. If they are unavailable the request is then routed to the network of participating hospitals and subsequently to a commercial interpreter provider.[508] Hospitals when they joined the network had start up costs for the necessary equipment; and pay annual fees to participate in the network (hospitals that provide more services pay less than those hospitals that provide fewer services).[509] Funding support came from multiple sources, including US government, philanthropic foundations and consumer organisations.[510] There are at least four other interpreter networks across the US: Illinois Video Interpreter Network; Kaiser Permanente Interpreter Network; University of New Mexico Hospitals; MedStar Interpreter Network.[511 & 512]

The HCIN network acts as a facilitator in accessing qualified interpreters as: there was a large uptake in the use of interpreter services after the implementation of the network; it increased the interpreted hours provided (as interpreters are not required to change locations); it lowered costs; and it increased access to new and emerging languages.[513] It has further been reported the HCIN has the capacity to designate high priority for a call, so that an emergency call can jump to the top of the queue. Furthermore, interpreter requests are answered in less than 3 minutes, with an average connection time of 22 seconds.[514] However, it was found face-to-face interpreters may still be preferable to both physicians and clients and there were additional costs associated with training health practitioners on how to use the equipment.[515]

5.2.4 Service planning and data collection

Identification of anticipated requirement for interpreting

Health service providers with good systems for recording the needs of clients who are not proficient in English at initial presentation are well placed to ensure interpreting is available: during the consultation; as frequently as required for inpatients; and for subsequent appointments[516, 517 & 518] Primary Care Connect Community Health Services use a central intake system to enable an initial needs assessment that flags when an interpreter is required and the appropriate language.[519] Eastern Health uses an interpreter alert sticker on the records of those patients who require interpreter assistance.[520]

A NSW study found patients requiring complex interventions and therefore requiring frequent use of qualified interpreters during their hospital stay could be flagged at presentation, as their model of interpreter use and clinical complexity had potentially good predictive powers. To measure clinical complexity a communication complexity score was constructed comprising eight variables: admission status; urgency of admission; triage category; medical emergences/events; HDU/ICU admission; numbers of medications; invasiveness of procedures; and diagnosis.[521]

Using demographic data for service planning

Demographic data from bodies such as the Australian Bureau of Statistics (e.g. the census for proficiency in spoken English) and the Department of Immigration and Citizenship (e.g. settlement database: http://www.immi.gov.au/settlement/) can be accessed to assist health services to plan to meet the language needs of clients in their catchment areas who are not proficient in English. The data can indicate the presence of substantial numbers of people who may require language assistance and also the languages.[522] This data can be used to compare the demand for and use of interpreters by clients - the subject of the next section – to assist in assessing whether services are effectively accessible to the populations they serve and whether they serve them equitably.[523 & 524]

Monitoring demand for and use of interpreters

The collection and analysis of data about the demand for and provision of interpreters provides organisations with a tool to monitor issues such as whether staff are engaging interpreters at critical moments in care, whether there is unmet demand

and whether action to improve interpreter access is working.[525 & 526] Projecting demand is especially important in budgeting for interpreter services. The Victorian Government has standards for data collection on interpreting and translating for funded agencies which cover client demographics, expenditure, in house-staff and services provided by language service providers.[527] New reporting requirements for quality of care reports[528], will assist service providers in monitoring demand for and use of interpreters. Collection of data is important not only systemically but also to monitor the quality and safety of treatment of individual clients, for example those in acute care requiring complex interventions.[529] GPs do not routinely collect data on: Country of Birth, interpreter required, or preferred language.

5.2.5 Efficient interpreter booking systems

Complex or inefficient booking systems can impact upon the engagement of interpreter services.[530] The lack of service coordination in relation to booking interpreters can also be a source of frustration.[531] It follows that "[g]ood practice in language services delivery in the health and community sector is characterised by established and efficient interpreter booking systems".[532]

Improved efficiencies in booking and using interpreters have been brought about both by organisational arrangements and technology.

Designating a specific staff member with responsibility for the organisational operation of the interpreter service is regarded as an example of best practice,[533] for example Northern Health, the Royal Women's Hospital and Western Health.[534] Recently, the Dental Hospital changed the way it makes bookings for interpreters, with the new system all bookings are made via an interpreter bookings officer. It is reported "[i]nterpreters, patients and staff like the new system because they know who to contact and where to go for any interpreter issues. It saves everyone time and money".[535]

Western Health recently introduced the 'dr. notes' system specifically tailored for their needs. The 'dr. notes' system replaced a manual system where paper based requests would be entered into Excel and then forward onto in-house or agency interpreters. The 'dr. notes' system is reportedly working well; no bookings have been lost since its introduction. Other reported benefits include:
- it is easy for staff to use;
- there are fewer errors;
- it has the capacity to generate reports; and
- it is more efficient.[536]

5.2.6 Block booking interpreters

A number of health services that have high demand for particular languages book on site interpreters in those languages for regular sessions of time, for example ISIS Primary Care block book the same Chin Burmese interpreter for one day each week.[537] Further,

> "[t]wo block booked interpreters are used at Greater Dandenong Community Health Service (Southern Health), a Burmese interpreter for the MY Health Clinic and a Cambodian interpreter for the Well Women's Clinic. For September, October and November 2011, the use of these block booked interpreters was tracked to ascertain usage. Usage of these interpreters was high over this period. When comparing the cost of block booked interpreters to the cost of booking individual interpreters instead to provide the same service, using block booked interpreters facilitated a significant saving of $8,308.50 over the period".[538]

Organisations also opportunistically block book, for example Primary Care Connect Community Health Services used colour coding in Outlook (e.g. Arabic - green, Dari – blue) when they book interpreters, so that other staff can synchronise appointments that arise for those language groups with the scheduled interpreter appointments.[539]

Block booking is more efficient in time as it minimises travel for the interpreter providing more interpreted hours and less travel time. It is also more cost effective for the organisation as each onsite booking is charged for 90 minutes irrespective of the consultation length, therefore if consultations typically take 30 minutes, the interpreter can see three clients for the cost of one on-site booking. Furthermore, it enhances access to the health service when community members become aware an interpreter in their language is regularly available on a dedicated day. [540, 541, 542 & 543]

5.2.7 Policy and procedure documentation and review

Policies and procedures

The development and adoption of policies and procedures on the use of qualified interpreters are important elements of organisational commitment. [544 & 545] "(T)he promotion and uptake of the policies and procedures by staff throughout the organisation is just as critical"[546] the research confirms that staff awareness of organisational policies increases the use of qualified interpreters.[547]

Policies and procedures should encompass the organisation's values and expectations, complaints mechanisms, government policy where applicable, as well as detailed procedural guidelines, for example, booking procedure, guidelines on use of onsite or telephone interpreters. These should be referenced in cultural responsiveness or quality improvement plans.

Internal Reviews

Many organisations have initiated internal reviews of language service use which have facilitated either the review of policies and procedures, the mapping of interpreter use, the identification of opportunities for improvement to current procedures or optimised budgetary efficiencies. For example Primary Care Connect Community Health Services in 2008 heavily utilised the 'Language Services Toolkit'[548] in a move towards implementing procedures for best practice.[549] In 2010, ISIS Primary Care also had an internal review that culminated in improved efficiencies and a review of policies.[550] In 2010, WRHC also had an internal review which identified areas for improvement within the organisation.[551] The Royal Women's Hospital has recently set up a taskforce focused on language service delivery which will seek to improve budget efficiencies and address identified barriers to the use of interpreters.[552]

5.3 Client

5.3.1 Increasing clients' awareness of interpreter services

Some health practitioners may not initiate the use of interpreters but will do so if requested by clients. Findings from a GP survey found that 24% of respondents believed the client needs to trigger interpreter use; responding to a question on what would encourage interpreter use in their practice. Furthermore it was found 68% of practices said they would arrange a qualified interpreter if a patient requested one.[553] While we do not consider the onus should be on clients not proficient in English to ensure qualified interpreters are used, it can facilitate access if clients know that such a service is available and they are entitled to ask for it.

The CEH has run two 'social marketing' campaigns to Italian[554] and Vietnamese background clients[555] after feedback that clients not proficient in English were expected by many health practitioners to request a qualified interpreter. The CEH Vietnamese social marketing campaign culminated in a five-week period of radio announcements and the placement of a newspaper advertisement.[556] Participants in focus groups indicated that the campaigns had increased awareness of the right to request an interpreter and how to do so, but it was unknown whether this directly translated into client requests.[557]

The DEECD conducted a similar campaign for Chinese and Arabic language users of the maternal and child health service, in combination with cultural competency training for MCH nurses regarding interpreter use. This was successful, as there was found to be a 6-9% increase in demand for interpreter services, which was inclusive of noted increases in usage of qualified interpreter services for the targeted communities.[558]

Eastern Health disseminated a brochure in community languages providing information on available interpreting services and there was 41% increase in interpreter usage in the first year of the publication's release, which was sustained in subsequent years.[559] Increases in demand following client awareness campaigns have been noted elsewhere.[560]

The National Interpreter Symbol

The National Interpreter Symbol provides a simple way of indicating where people with limited English proficiency can ask for interpreter assistance when using government services.[561] The symbol was designed in accordance with Australian Standard 2342 'development, testing and implementation of information and safety symbols and symbolic signs' and was tested in Victoria, Queensland, Western Australia and New South Wales with over 580 people from a diverse cultural and linguistic backgrounds.[562] Small scale print runs of the national interpreter symbol may be expensive, challenges may also exist in locating suppliers of adhesive or metal signage.[563]
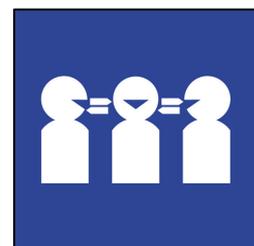
The Victorian Interpreter Card

Victoria[564], Queensland[565] and Western Australia have cards which clients not proficient in English can present to request interpreter assistance in the correct language. There has not been a formal evaluation of the effectiveness of the card in Victoria. Victorian cards were available from Centrelink and AMES offices and some local councils, migrant resource centres, public hospitals, schools and community agencies.[566] Presently, the card is available for download in 32 languages.[567] A WA study found the interpreter card had "gradually disappeared from ethnic communities and government institutions" even though it was still promoted through a website. Less than 5% of participants surveyed were aware of the card and none had used it. Further, 60% of health service staff had heard of the card but only 13% had ever seen one.[568]
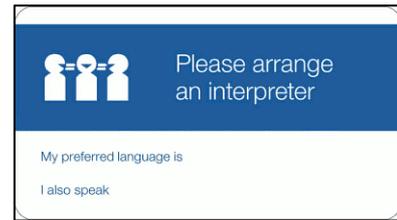
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