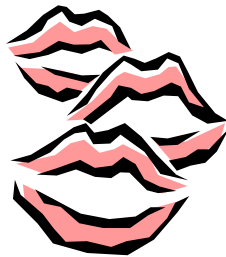




*Community Health Action  
Group (CHAG)*

# Lost in Translation



A Discussion Paper on  
Interpreting Issues in Health  
Care Settings in Queensland

*March 2004*

**CHAG is the advocacy arm of the Multicultural Health Network.  
Convened by the Multicultural Development Association.**

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The views expressed in this report are the views of the Community Health Action Group, and not necessarily the views of the Multicultural Development Association. The Community Health Action Group wishes to acknowledge that the case studies contained in the Discussion Paper have not been formally presented to any Queensland government body.

## **Terms**

The following terms are used interchangeably throughout the paper – People from culturally and linguistically diverse (CALD) backgrounds, migrants and refugees, non-English speaking background (NESB).

## **Acronyms**

TIS	Translating and Interpreting Service
DIMIA	Department of Immigration and Multicultural and Indigenous Affairs
NAATI	National Accreditation Association for Translators and Interpreters
AUSIT	Australian Institute of Interpreters and Translators
MAQ	Multicultural Affairs Queensland
CHAG	Community Health Action Group

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# Lost in Translation: A Discussion Paper on Interpreting Issues in Health Care Settings in Queensland

## EXECUTIVE SUMMARY

This Discussion Paper has been initiated and prepared by members of the Community Health Action Group (CHAG), the advocacy arm of the Multicultural Health Network, which is convened through Multicultural Development Association Inc. It is a response to interpreting and translating issues within a health care context, which have been of on-going concern to community based workers and many non-English speaking background people in Queensland.

The consequences of not using accredited interpreters can be extremely serious as the following shows:

“Through misinterpretation of the doctor’s directions, the contraceptive pill was taken by the husband and the woman became pregnant.” (*Report on the Ethnic Health Policy Consultation Process*)

“A Hmong child was used as an interpreter. The doctor said the medication was for her mother’s ear. As a result of misunderstanding, the patient crushed up the tablet and put it in her ear instead of swallowing it.” (*Report on the Ethnic Health Policy Consultation Process*)

The information for this paper has been collected from community based workers, interpreters, ethnic based agencies, community representatives, as well as formal research findings.

The main issues relating to interpreting within the health care setting in Queensland expressed by workers and clients are:

- Insufficient use of interpreters by the health care profession and a general lack of awareness and inaccurate information about the Translating and Interpreting Service (TIS);
- Confusion and misunderstandings by community workers regarding coverage of TIS and the exemption process for fee free services;
- Continued usage of non-professional ‘interpreters’ (e.g. relatives/ children/ bilingual staff) in important health situations;
- Cost, access and other issues with TIS
  - TIS operational and policy issues
  - Gender and cultural considerations;
- Lack of a resource or guide which comprehensively presents all the necessary information for both workers and service providers (or which directs them to existing resources);
- Lack of community / consumer education on how to pursue the right to request an interpreter, when faced with a reluctant service provider;
- Interpreting issues in rural and regional areas;
- Professional standards and training for interpreters and translators and;
- Impacts of the restrictive eligibility criteria for translation services.

The policy framework is in place with the Queensland Government Language Services Policy (which reflects a whole of government commitment to the development of communication strategies to inform eligible clients of services and their entitlements and how they can obtain them) and the Queensland Health Language Services Policy Statement. This policy specifies that the engagement of professional interpreters paid for by the government is a key method of fulfilling that commitment. The resource material is also in place with detailed information available on Queensland Health's website.

The challenge is to achieve full implementation of the policy. With awareness, resources and a commitment to accessible, quality services, use of interpreters and translators can become a standard part of the delivery of health services in the public and private arenas.

The Community Health Action Group (CHAG) considers that the following principles / directions apply:

- a) A commitment by Queensland Health, MAQ, DIMIA, General Practitioners and other health service providers to the provision of interpreters / translators for clients of non-English speaking backgrounds.
- b) As part of the government's role to provide services to Australia's multicultural population, the government should bear the cost of interpreters / translators (this currently occurs for some services but not for others and for some migrants and refugees but not for others).
- c) Health services, public and private, should routinely access TIS or other accredited interpreting services each time they see a person who is not proficient in English. Health professionals and /or other staff must be held accountable for this.
- d) Accurate information on TIS and other services must be available to all health services.
- e) Health professionals require training in cross cultural communication and in using interpreters.
- f) Accredited interpreters need to be available in relevant languages and dialects, across the State for on-site interpreting and via telephone services.
- g) Appropriate measures need to be in place to address any unprofessional conduct by an interpreter.
- h) Appropriate support and professional development opportunities need to be available for interpreters.
- i) People from non-English speaking backgrounds need to know that they have the right to have an interpreter in health settings and the steps to take to ensure that services fulfill their obligation to provide an interpreter.

It is envisaged that this discussion paper will form the basis of future initiatives to address the above concerns. Language and interpreting services are paramount for many non-English speaking background people (both migrants and refugees) throughout the settlement period and beyond. Cultural diversity within Queensland contributes positively to a multicultural society, but access issues relating to the provision of language services need to be addressed.

Members of the Community Health Action Group commend the government on the commitment made and the policies and resources developed on this issue. CHAG members call on stakeholders to work cooperatively to see that the policies are fully implemented and to address the long standing issues addressed in this Paper.

# Section 1

## Provision of interpreting and translating services in Queensland

### 1.1 Background

This Discussion Paper is an initiative of the Community Health Action Group (CHAG), the advocacy arm of the Multicultural Health Network in Queensland. CHAG members are community and bilingual workers in Queensland who advocate for increasing and improving health access and resources for people from non-English speaking backgrounds in Queensland. (See Attachment 1 for additional information about CHAG).

### 1.2 Aim and scope of this Discussion Paper

The aim of this paper is to highlight ongoing concerns expressed by clients and workers within the multicultural health sector regarding interpreting issues for people of non-English speaking backgrounds. It is widely recognised by community workers as well as some government personnel, such as Queensland Health staff, that communication difficulties and lack of provision of services in languages other than English is the major barrier for this client group when accessing and using health services.

This paper aims to be a starting point for discussions between State and Commonwealth governments, community based workers, consumers, general practitioners, and service providers. While recommendations are made to address the long-standing issues, they are not exhaustive, and CHAG envisages that further recommendations or strategies will arise out of the proposed Working Party of major stakeholders.

Systemic changes and policy reforms are necessary to ensure that equitable participation can occur for non-English speaking background people accessing government and non-government services.

This report provides an overview of the issues based on anecdotal information supported by literature review findings. The anecdotal evidence has been provided by health workers, community settlement workers, interpreters, ethnic service providers and staff within health care settings. The paper draws on a number of informal interviews and case studies provided by those who support migrants and refugees and who have seen or heard directly of the difficulties clients face when attempting to have their health needs addressed. This information was collected between 2002 and 2004. This information, while anecdotal, graphically highlights the current deficiencies and points to the way forward.

This report covers a diverse range of professional health care settings and situations in Queensland including:

- Consultations with general practitioners including assessments, diagnosis and treatment plans;
- Hospital interviews including general communication, admission procedures, signing of informed consent forms, discharge planning, outpatient clinic visits and use of medication;

- Specialist assessments made by occupational therapists, psychiatrists, speech pathologists, surgeons;
- Diagnostic procedures such as radiology and pathology;
- Aged care services;
- Community health nurses;
- Immunisation clinics;
- Private hospitals; and
- Mental health settings.



### 1.3 Interpreters and Translators – Definitions

For the purpose of this discussion paper, the following definitions and understandings will apply:

- An interpreter is a person who conveys an oral message or statement from one language into another language.
- A translator is a person who makes a written transfer of a message or statement from one language into another language.
- The Translating and Interpreting Service (TIS) is Australia's only national interpreting service and has been operating for over 20 years.
- A professional interpreter is one who has National Accredited Association Translators and Interpreters (NAATI) or equivalent accreditation.

### 1.4 Services in Queensland

The Translating and Interpreting Service (TIS), a section of the Department of Immigration and Multicultural and Indigenous Affairs (DIMIA), provides interpreting services free of charge to doctors, emergency services, certain non-government organizations and local government for communication with eligible migrants and refugees (those with permanent resident visas or Australian citizenship) (See [www.immi.gov.au/tis](http://www.immi.gov.au/tis)).

TIS also provides services on a fee for service basis. TIS has recently abolished its non commercial rates, resulting in a 100% increase in fees for organizations previously eligible for non commercial rates (or 90% increase if using the Interactive Voice Response Unit service).

Samples of rates from their Schedule of Service Charges (February 2004) include:

- \$50 Business Hours or \$102 After Hours for up to 30 minutes pre booked phone interpreting.
- \$141.05 for up to 90 minutes with an on-site interpreter.
- The minimum cost is \$21.70 for up to 15 minutes over the telephone.

According to Multicultural Affairs Queensland, Queensland requested over 15,000 interpreting jobs from TIS during 2002/2003. 38,568 people in Queensland indicated in the 2001 census that they do not speak English well or do not speak it at all. Clearly, only a minority of those people have received any interpreting assistance.

Queensland Health services use TIS and pay for this from their individual budgets. TIS price rises have an adverse effect on hospitals and other services' budgets. TIS gives priority to interpreters with accreditation from the National Accreditation Authority for Translators and Interpreters (NAATI). There are shortages of professional interpreters in some languages and in certain regions in Queensland.

The Princess Alexandra Hospital in Brisbane has their own Interpreting Services Unit, with contracted interpreters who are treated as part of the hospital team. This model has proven to be highly effective, as judged by patients of non English speaking background, staff of the hospital and interpreters in a survey (Princess Alexandra Hospital, 2004). Between July and December 2003 the Unit provided 2951 occasions of service, resulting in a massive saving of \$147,420.30 compared to the cost of TIS providing the same services (Princess Alexandra Hospital, 2004).

DIMIA has appointed TAFE Queensland's English Language and Literacy School and Hilton International College to facilitate TIS's translating services. The eligibility criteria for free translations are very restrictive.

Apart from the Interpreters Unit servicing the Princess Alexandra Hospital in Brisbane, Queensland does not have a pool of specialist health-trained interpreters, as exists in Victoria and New South Wales. However, some interpreters have studied the health setting as an elective in NAATI's professional level accreditation or as further studies / professional development.

Victoria's Department of Human Services funds the Central Health Interpreting Service (CHIS) which provides free services to approved organizations and has over 950 interpreters. These interpreters participate in training specific to their role with health services ([www.chis.org.au](http://www.chis.org.au)). Other State governments fund their own interpreting services, rather than rely totally on TIS.

Current interpreters can only have a limited role in the overall health outcomes of their Queensland clients. They are not able to assist clients in any role other than straightforward interpreting within a defined context. However, health trained interpreters interstate and overseas are able to broaden their role from interpreter to interpreter-counsellor-advocate when necessary to assist the client. In addition, they have the mandate to provide advice to health professionals on cultural or other environment factors which may progress or impinge on their health status.

One report from Canada states that “*observation of interpreters at work showed that their roles had expanded beyond language translation activities and included a wide range of advocacy and cultural brokerage functions*” (Kaufert and Koolage, 1984)

This diversity of health settings has implications on the demands of interpreters. Nasir, in the paper *The Future of the Interpreting and Translation Professions*, states: “*The demands of an interpreter are somewhat different when the client is trying to explain a source of discomfort and anxiety to a general practitioner or when the client is being assessed by an occupational therapist.*” Due to this complexity, there is a clear need for health trained interpreters and translators. This is particularly evident for refugees from newly emerging communities who lack infrastructure and resources. However, there are still other established migrant communities who continue to express concern with the Queensland health care system.

## 1.5 Interpreting and language services policies and reports

Under the Principles of the Commonwealth’s *Charter of Public Service in a Culturally Diverse Society* (endorsed by Commonwealth, State and Territory Governments in June 1998) all government services are required to be responsive to the language difficulties experienced by people from a non-English speaking background. DIMIA’s resource *The Language Services Guidelines A Toolkit for Commonwealth Agencies* (2002) highlights the importance for organizations of addressing issues associated with interpreting and translating as an integral component of the services they provide. It aims to assist agencies to put language services into practice by providing step by step advice for delivering effective language services.

Through the Charter, Queenslanders with limited proficiency in English have the right to use interpreters and translators to assist with all necessary communication transactions.

A *Memorandum of Understanding* is a document that is signed by both the Commonwealth and State governments and sets a level of service standards to be provided by TIS to Queensland Government agencies. This is not a public document.

There is also the *Queensland Government Language Services Policy* which states that “*The Queensland Government recognises that a significant number of people do not speak English at all or well enough to communicate adequately with officers of Queensland Government agencies. This policy is designed to enable clients to access services fairly and equitably and to ensure that service delivery is responsive and of high quality.*” (Multicultural Affairs Queensland, 2002)

The essence of this policy has been incorporated into the *Queensland Health Languages Services Policy Statement* (March 2000), which outlines some key strategies for Queensland Health to meet its commitments to ensure that the linguistic needs of our target group are met, including stating that **Queensland Health staff are to engage NAATI accredited interpreters where possible.**

In 2003, DIMIA reviewed its Settlement Services for Migrants and Humanitarian Entrants. The recommendations in this report have been endorsed by Cabinet and therefore are due to be implemented. Of particular relevance to this report are recommendations 52 to 55, covering the need to promote telephone interpreting, pilot a program to fund subsidies for NAATI accreditation fees

for suitable bilingual people (to address language gaps), clarify Commonwealth / State responsibilities and educate new arrivals on the role and availability of TIS.

A number of Queensland reports highlight interpreting and language provision as a major barrier for consumers in the health care setting. For example, the Report on the Ethnic Health Policy Consultation Process found that:

*“Issues raised in this context included uncertainty about whether adequate care has been provided to the client – “We leave smiling at each other, but I have no idea how effective it has been” – and frustration at the extra time and effort involved. Lack of resources, including multilingual information, a shortage of onsite interpreters, especially outside Brisbane, and the lack of health trained interpreters were additional problems.” (Queensland Health, 1996)*



## 1.6 Positive outcomes from effective use of interpreting services

Report contributors commented on times they had witnessed or heard about highly positive outcomes resulting from the appropriate use of interpreters within the health system.

“A long and complicated interview with an expectant Sudanese mother using a telephone interpreter to do a birth plan for her was well executed and all went according to plan.”  
(Coordinator of a regional multicultural agency)

The Princess Alexandra Hospital’s Interpreters Unit provides a highly commendable example of the provision of high quality interpreting services while saving the hospital hundreds of thousands of dollars (compared to TIS costs).

Contributors to this report highly commended certain sections of Queensland Health such as the Oral Health Unit, certain Health Districts and services, certain University faculties, such as Queensland University’s School of Dentistry, and numerous individuals for their commitment and progressive work relating to working cross culturally and contributing to the provision of language services to our multicultural communities.

## **Section 2: Issues within the health care setting in Queensland expressed by workers and clients.**

This report highlights a number of examples in which language and communication difficulties combined with lack of interpreters caused frustration, distress and confusion for clients. There was general concern that poor health outcomes would result due to inadequate assessments and misdiagnosis. Ineffective treatments continued as a direct result of health professionals not seeking the necessary assistance to ensure accurate communication with their client.

### **2.1 Insufficient use of interpreters by the health care profession and a general lack of awareness and inaccurate information about the Translating and Interpreting Service (TIS)**

#### *2.1.1 Linking the health system with available resources*

Much work has been done on the resources required to bring language services to the health system. DIMIA's Language Services Guidelines A Toolkit for Commonwealth Agencies provides checklists that can be adapted for use by State, non-government and private agencies. Useful information is available from Queensland Health's website (eg. Checklist for Cultural Assessment at [www.health.qld.gov.au/multicultural/checklists](http://www.health.qld.gov.au/multicultural/checklists) and guidelines for working with CALD people at [www.health.qld.gov.au/multicultural/guidelines](http://www.health.qld.gov.au/multicultural/guidelines) ), TIS (eg. Fact sheets, costs, eligibility, pointers for telephone interpreting at [www.immi.gov.au/tis](http://www.immi.gov.au/tis) ) and through MAQ's Interpreter Card and Interpreter Card Kit. Information on available cross cultural training for health staff is also on Queensland Health's website and MAQ provide cross cultural training for State agencies. Useful information is available from NAATI and on the Victorian Government's web site.

**The challenge is to ensure that all sections of the health system have access to this information and make use of it.**

#### *2.1.2 Queensland Health funded services*

Evidence from workers and clients demonstrates that there are still many Queensland Health hospital staff that do not access TIS interpreters for people with language difficulties. It appears that only some hospitals in Queensland have demonstrated an increased use of interpreters and have implemented relevant education and training for staff on TIS services, accessing interpreters etc. However these hospitals are still in the minority in Queensland, with workers citing many cases of clients not receiving professional interpreters when requested. This is particularly pronounced in regional hospitals.

Each Queensland Health funded service, including hospitals, has the autonomy and mandate to progress and implement the *Queensland Health Language Services Policy Statement*. However there is still a significant number of staff that are not aware of this policy and its provisions. Of particular concern is the absence of knowledge by staff of the legal implications that may arise if interpreters aren't offered or provided to clients.

Staff members will often use family members (including children), or support workers for interpreting, including diagnostic information and medication advice. While these interactions are commonplace, there is concern from workers about the appropriateness of these strategies.

Some communities in Brisbane, such as Horn of Africa communities, experience additional issues in hospitals. Many of their requests for interpreters are denied by hospital staff. While there may be insufficient trained interpreters available for the different dialects spoken, hospital staff often do not access existing interpreters. Bilingual workers from these communities constantly speak of health workers in the hospital system not using interpreters and the repercussions this has had for people within their community.

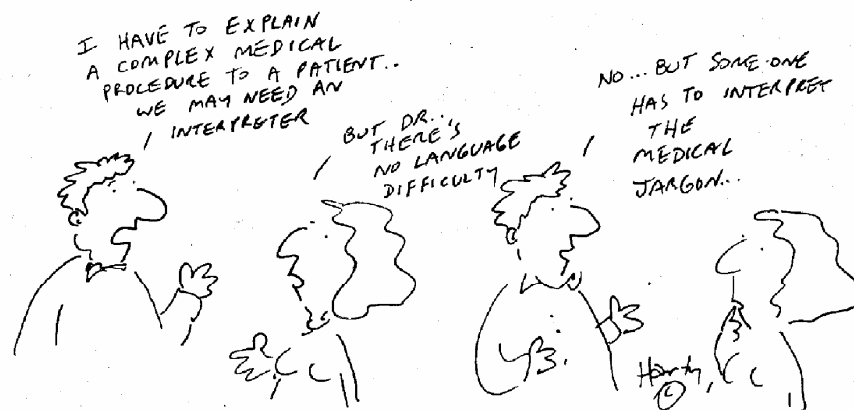
“The Somali community of women spoke of several cases of interpreters not being used when asked for. Many of the circumcised women who’ve come out with caesarian surgeries continue to be angry that they’ve had caesarians when they think this is unnecessary. Most continue to insist they don’t understand why it was performed in the first place or that there were no interpreters provided to explain “why a caesarian” was performed. The caesarians have also brought conflict in the home between parents as the husband feels they haven’t been consulted previously or counseled after surgery. Some husbands see this as a ground for divorce – aggravating tension in the home.”  
(Community worker)

“A Latin American woman presented to a large women’s hospital in Brisbane with labour pains. As this was her first pregnancy she took a support worker with her, but both women requested an interpreter on arrival. This request was refused. The client developed complications and became even more distressed but was still not offered an interpreter. She was taken into the operating theatre and was unaware that there were complications and why they were operating. The support worker was not allowed near the woman during this process but requested an interpreter again for her client. The baby was born with delayed motor development and cerebral paralysis”. (The support worker referred this case to the Health Rights Commission, but the parents withdrew the complaint due to stress from the hospital experience and not understanding the formal complaints processes)  
(Multicultural pastoral caseworker)

“A Greek male, an involuntary patient required ECT treatment as recommended by the Mental Health Tribunal. The client had six treatments, without his wishes and without having a clear understanding of the treatment. At no time during the client’s time in hospital was an interpreter engaged to explain the treatment and the reason for administering the treatment”. (Mental health community worker)

“I had my appendix removed after one night of pain, but the pain is still there after seven years. After two laparoscopies, they now discovered that I had an infection. The medical examination was not done properly, my English level was very low, no interpreter was provided so I could not explain very well the nature of my pain”. (Report on the Ethnic Health Policy Consultation Process)

Workers have also expressed concern that hospital staff rarely use telephone interpreters to inform clients of any changes or cancellations of appointments. Clients often do not understand what is being said and if no family member is available to interpret, the client will attend the original hospital appointment.



### 2.1.3 General Practitioners

The Doctors Priority Line was launched in November 2000, providing free telephone interpreting for private doctors treating patients from a non-English speaking background, particularly in rural and remote areas. However the low usage of interpreters by medical practitioners outside the metropolitan area continues to be an issue for workers. The general perception of doctors in these areas is that they have to pay for this service.

A survey of Doctors in the Mackay region revealed that only 55% of respondents were aware of the Doctors Priority Line and of those only 53% were aware that it is a fee free service. Only 8.5% had used the service (Other Settlement Needs Task Force, 2003).

While there are many general practitioners in Brisbane who are aware of and use the TIS Doctors Priority Line for clients needs, there are still a significant number of practitioners who do not access TIS. This is particularly evident with doctors at general medical centres. An overwhelming number of clients and workers mentioned that it was often the receptionist who would not access TIS, claiming they were unsure of the process to contact TIS, or they did not have the necessary telephone equipment.

Many GP's are reluctant to use interpreters. Reasons mentioned: it takes too long; booking interpreters is too complicated. Hospitals complained about lack of funding to provide interpreters. A young refugee was told by the GP, "You have enough English we don't need an interpreter here". (Brisbane Inner South Division of General Practice, The Refugee Consumer Voice, 2001)

Many workers claim that the general practitioner may not realise that the client does not understand all the information given to them:

"While the client may nod their head to the doctor, it's often a respectful gesture, but doesn't mean they understood what was said to them. The doctors are often in such a rush they don't realise that the client is still none the wiser about their health complaints." (Community worker)

Numerous examples were given of doctors not arranging an interpreter for their client, even though they had ample time to organise this. As a consequence, clients had to make another appointment or go to another medical practitioner who would arrange an interpreter. With breast and cervical cancer rates higher than the general population, it is crucial for general practitioners to be reaching people from non English speaking backgrounds.

“I took my client to a southside medical centre (Brisbane), he had recurring chest pains. No interpreter was present even though the last appointment was two weeks ago, the doctor claimed there were no interpreters available. I know this is not true – 2 weeks is plenty of time for TIS to organise” (Community support worker)

These issues are exacerbated as more medical clinics become increasingly corporately driven, privatised, and decrease their bulk-billing facilities. One worker who has been assisting migrants and refugees for many years stated “*Doctors now have to see as many clients as they can, there is only a designated time for each client, so our clients often miss out because it takes longer when using an interpreter, doctors don’t want to financially lose out*” (Community worker)

“My client got a handwritten note from her Doctor saying that there were abnormalities in her cervical screening test results and to come back in 6 months. She went overseas to die. Diagnoses like these must be given in person, with an interpreter present.” (Health information worker)

It has also been reported that some clients do not turn up to their appointments where interpreters have been arranged, causing frustration and concern for committed general practitioners and staff. Community workers and bilingual support staff have offered a number of possible reasons for this rising trend such as:

- *Many non-English speaking background clients don’t understand the health care and interpreting system in Australia – they don’t realize the process of booking interpreters etc;*
- *Information often is not explained sufficiently to clients;*
- *The onus is more on the G.P to be more specific;*
- *GP’s deal with migrants and refugees like everyone else – while this is fair, the assumption is that they understand the contents of communication like English speaking people and this is not the case;*
- *Clients are not sure why they have to go back; and*
- *Prompt timing values and appointment keeping are not practiced in all cultural groups – therefore some groups are still coming to terms with the operation of a western medical system. A courtesy reminder call could lead to a higher rate of appointment keeping.*

#### **2.1.4 Medical Specialists and Private Hospitals**

There are medical specialists such as radiologists, cardiologists, gastroenterologist, psychiatrists and personnel from private hospitals who do not access interpreters. This issue has been increasing over the past few years and is of concern to workers. Some of the reasons provided to community workers include:

- *Many specialists state they are not eligible for exemption and therefore have to pay (regardless of what workers tell them);*
- *They have never used interpreters before;*
- *Some specialists have stated that interpreters are not necessary for some procedures e.g. X-rays;*
- *They do not have the appropriate facilities i.e. 2 way phone; and*
- *The receptionist in many instances decides that an interpreter is not necessary.*

These situations are further exacerbated by:

- *The referring doctor does not have the authority to arrange or organise an interpreter for when the client goes to the specialist;*
- *Clients are often not able to convince specialists of their need for an interpreter;*
- *Where diagnostic preparatory procedure, such as fasting, is not adequately understood by clients, the tests results can either be inconclusive or incorrect. In many situations the client has gone back to the doctor again with the same pressing health complaint; and*
- *Clients will often not formally complain if an interpreter has been denied to them.*

“A client was sent to a radiology clinic by a GP for a procedure which involved a very specific pre-procedural routine of fasting and ingesting certain substances. The client does not read English and returned to the radiology clinic without having undergone the pre-procedural routine. The client came to the Community Settlement Officer (CSO) very distressed and not understanding what had happened. The radiology clinic stated that they do not arrange interpreters. The CSO called a telephone interpreter to interpret the instructions for the pre-procedural routine so that the client could prepare properly for the procedure”. (Community settlement officer – regional area)

“A CSO arranged for a client to see a specialist for consultation regarding circumcision for the client’s son. The private hospital where the visiting consultant conducts his practice stated that they were a private agency and did not arrange interpreters. The receptionist refused to book an interpreter and the client and baby had to travel 100 km to visit a specialist at another clinic where an interpreter was booked”. (Community settlement officer – regional area)

### **2.1.5 Ambulance**

A number of workers and clients raised the issue of ambulance officers – do they receive training on TIS and are they required to access interpreters when necessary?

“My client contacted the ambulance due to strong labour pains, by the time the ambulance came the baby had arrived. No interpreter was offered or arranged for the woman” Also, another client with severe stomach pains requested an interpreter to the ambulance officer and was told “*that’s the job of the hospital – not ours*”. (Community worker)

What processes or mechanisms are in place for people with language difficulty in emergency situations requiring an ambulance?

### **2.1.6 Allied Health Professionals (Pharmacists, Dentists, Optometrists, etc)**

Lack of awareness of and not accessing TIS is increasingly evident in allied health professions. There is a lack of knowledge about which allied health professions are exempt and the exemption process, including information about facilities required and TIS services such as the Doctor Priority Line.

According to TIS coverage, dentists and pharmacists are not able to apply for exemption. This raises issues such as Duty of Care. If a private dentist cannot be exempt and it is obvious the patient needs an interpreter, the dentist will need to pay. However, they often do not use an interpreter due to the cost, so where does this leave the patient (and the specialist if something goes wrong due to lack of communication)?

While the public dental system can access fee free interpreters, it appears that many staff members in some health districts do not access them willingly, especially if the client has no worker or family member to assist them with the request and follow through.

A 70 year old Latin American man had a dentist appointment at xx hospital. An interpreter was not provided, even though a request from the client had been made. The reason given to the support worker was ‘no money in the budget’. In the man’s appointment card, staff at the dental hospital had written ‘BYO interpreter’. (Multicultural counsellor)

Some other health services offer an excellent service. The University of Queensland’s School of Dentistry was commended for demonstrating a commitment to providing cross cultural experiences for students in the Community Dentistry strand.

“The South Brisbane Dental Hospital provides a fantastic service. They use telephone interpreters religiously. They asked us to train them and we provided training for their health and front counter staff”. (Team Leader, Torture and Trauma Service)

There is increasing concern by workers that optometrists’ services are not considered a ‘settlement’ issue by DIMIA and therefore interpreters are unavailable for refugees and new migrants. While interpreters are permitted for dental checks at public dental clinics and for eye checks at hospital clinics, private opticians are not eligible. Eye examinations need to be conducted by a private optician, as this is not provided in public hospitals.

“Surely it is important for new migrants, especially those on refugee visas who have been without basic health care for long periods of time to be allowed a professional interpreter to assist with their first eye exam. How can they be expected to succeed in an ESL classroom if they cannot see properly?”(Community worker)

Other workers mentioned clients experiencing difficulty in the classroom due to vision impairment, including headaches, migraines and back pain. Not surprisingly, their progress at learning a new language is severely hindered. Telephone interpreting cannot be used, as interpreters need to ‘see’ the tests and procedures to adequately explain them to the client. Clients often will bring a family member or bilingual support worker to assist, but this is usually an unsatisfactory outcome for all. Children, in particular those at school, are very vulnerable as they can experience learning difficulties and social isolation from their peers.

### ***2.1.7 Implications for safe use of medications***

Medication has been included in this paper as community based workers and family members have expressed increasing concerns that many refugee (and some migrant) clients do not have sufficient information as to the reason for medication and how to take it. Clients are constantly ‘checking’ with workers or other bilingual staff regarding dosage, application and frequency of medicine/ointment, etc. Little is known about side effects, storage of medication, the option of asking for generic brands, the importance of finishing a course of antibiotics and using repeat prescriptions.

The following examples illustrate potential harmful effects due to communication difficulties:

“Through misinterpretation of the doctor’s directions, the contraceptive pill was taken by the husband and the woman became pregnant” (Report on the Ethnic Health Policy Consultation Process, 1996:19)

“A Hmong child was used as an interpreter. The doctor said the medication was for her mother’s ear. As a result of misunderstanding, the patient crushed up the tablet and put it in her ear instead of swallowing it” (respondent; Report on the Health Policy Consultation Process)

“A non-English speaking background client wanted to know how to use a liniment. I had to show him by sign language that he was supposed to rub it in and not drink it” (Pharmacist – Health Services in a Multicultural Queensland ‘A silent crisis’ Khan, 1994).

“People coming from countries where medication is not so available and/or expensive, may share their medication with other family members who they think may have similar symptoms, but do not seek a medical opinion. This means no one in the family gets an effective dose, and someone may be mistreated for something not diagnosed. This also has the risk of children receiving adult dosages of medication.” (ex community nurse working specifically across various cultural groups).

General education on safe use of medication is vital for migrant and refugee health consumers to avoid continued ill-health due to lack of understanding and knowledge. Doctors, pharmacists and health promoters are the key to imparting the necessary information on the safe use of medications and they need to utilize interpreters and translators to do this effectively.

## 2.2 Continued usage of non-professional ‘interpreters’ (e.g. relatives / children / bilingual staff) in important health situations.



While it is considered reasonable and practical to use unaccredited bilingual workers or relatives to assist with communication in urgent situations and emergencies, it appears that staff from hospitals and medical centres continue to use non-professional ‘interpreters’ in situations or events which warrant professional interpreters.

In some cases it has been cited that minors have been used. This is particularly inappropriate and can result in adverse outcomes for the client or legal consequences for staff.

“My client told me that the nurse at the hospital said ‘you don’t need an interpreter - your son is old enough to understand what I’m saying to you.’” (Community worker)

“I have seen doctors at medical centres ask children to interpret or they ask the client to bring a friend or family member ‘next time’. (Bilingual support worker)

The continuing practice of using non-professional ‘interpreters’ (including bilingual staff) needs to be reassessed. While interpreting transactions with clients and non-professional ‘interpreters’ have been necessary and useful in many circumstances, there still remains concern that this can be and is seen as a standard practice. Some concerns include:

- *The competency of bilingual staff or relatives to impart accurate information is uncertain;*
- *Issues and concepts such as confidentiality and impartiality may not be fully understood;*
- *The relayed information may be presented to the patient in a version which is altered, exaggerated, censored, ‘played down’;*
- *The non-professional ‘interpreter’ may not have the knowledge and language of medical terminology and medical procedures;*
- *Information may be withheld from the patient/client if the ‘interpreter’ is uncomfortable or uncertain about how to relay the information; and*
- *Authority relationships in a family can be significantly challenged if children are used, and both parent and child are compromised, in particular where there is sensitive information.*

A study of health issues and problems of middle aged and older people in the Cambodian community in South-East Queensland demonstrates the high frequency of this practice:

“The majority of the participants reported that they were unable to communicate well in English and interpreters were not provided by the health agencies. In many cases, the respondents had used relatives and friends to assist in communication with health service providers. A common practice was for children (adult sons and daughters) to interpret for their parents. For instance, an elderly Cambodian woman reported “*my daughter-in-law takes me to the hospital and she helps me to communicate with the doctor*”. In many cases, family members accompany the patients to the hospital where they were often used as interpreters. It appeared that professional interpreters were not provided by health agencies when the client had difficulty in communicating”. (Cambodian Health Research Project, 1997; 24, 25)

## **2.3 Cost, access and other issues with TIS**

### ***2.3.1 TIS operational and policy issues***

The high cost of TIS services (see 1.4) affects Queensland Health and other state government services and all others not eligible for fee free services. TIS has recently abolished its non commercial rates, resulting in a 100% increase in fees for organizations previously eligible for non commercial rates (or 90% increase if using the Interactive Voice Response Unit service). In view of Queensland’s policy commitments requiring the use of such services, substantial cost savings and quality improvements stand to be gained by the establishment of a Queensland Interpreting and Translating Service.

There are a number of accessibility issues experienced on a daily level by community-based workers. They are:

- Waiting time over the telephone can be up to 20 minutes or more. While there was general agreement that TIS services had improved substantially, there were some workers who still experienced lengthy waiting periods;
- The quota number for on-site interpreters for all of Queensland is quite minimal (36), given that this is meant to be across health, schools, courts, etc;
- Community based services are unaware if the quota is full for the day for on-site interpreters and need to wait until TIS returns a faxed memorandum stating the outcome – this has many negative ramifications for clients who need to access appropriate health services, especially those requiring ongoing care e.g. Mental health, child development assessments and speech therapy;
- Some languages are not available or easily accessible through TIS – examples are Pacific Islander languages, Japanese;
- The cost of using a TIS interpreter is the same regardless of whether the person is accredited at a professional level, paraprofessional level or lesser level;
- General TIS procedures are not integrated into the health care system to ensure consistency for clients; and
- TIS policies that limit free services often impact on vulnerable families, in particular those on temporary protection visas.

### ***2.3.2 Gender and cultural considerations***

Most of the anecdotal evidence from clients and workers concerns the inappropriateness of the interpreter. Some common situations include:

#### *Gender*

This is usually where female clients are provided with a male interpreter. Often they will not disclose personal information or speak to the male interpreter due to embarrassment and shame, especially where some health issues are considered taboo. Serious problems occur where non-English speaking women in domestic violence situations are provided with a male interpreter known to the client and to the client's violent partner.

#### *Culture*

Cultural considerations are often cited, especially with death and dying procedures. There are cultural differences in perception of health and well-being, pregnancy, childbirth and communication styles. This has implications for how treatment and medication is explained to non-English speaking background clients. Of particular importance and concern is language groupings of interpreters – often people from war torn countries such as Former Yugoslavia request and require interpreters from their own cultural group. e.g. A refugee from Bosnia will usually request a Bosnian interpreter. While the language is similar to that spoken by Serbian people, a Serbian interpreter may be inappropriate and problematic for both client and interpreter.

“Another major issue is that interpreters don't even turn up. So they go to the Doctors – expecting that the interpreter will be there, no one comes and they're left with nothing. Interpreting has to be extended for our community. These people have come from war, and I think that Centrelink – well

not just Centrelink – a lot of community and government organisations are not sensitive to the fact that these people have come from war and that it’s not appropriate to provide an interpreter of another nationality” (Serbian client, Listening to Emerging Voices – Addressing Collective Needs, Multicultural Affairs Queensland, 2002;112)

## **2.4 Confusion and misunderstandings by community workers regarding coverage of TIS and the exemption process for fee free services.**

Over the last 4 years TIS closed their Brisbane office, moving operations to Sydney and have since relocated their operations to Melbourne. TIS continue to introduce new changes regarding their delivery of services, times and availability of services, new costings, regulations, changes to the quota system and so on. The communication of these changes is not disseminated efficiently or sufficiently to workers and other stakeholders at a community level. As a result, workers and other stakeholders are still unclear about coverage of services.

“As a worker with migrants and refugees I find that I’m still confused as to what TIS covers and what it doesn’t. My colleagues will say the same thing. Usually you find out as you go along with your client – which makes us look unprofessional. If we don’t have this information and we are at the grass roots level, how is the general public meant to know?” (Community worker)

A number of community workers acknowledge that TIS services are slowly becoming more efficient and that a growing number of TIS staff are helpful and responsive to their requests. It is the continual changes and lack of information that frustrates workers and clients, in particular those with sensitive health situations.

Concerns have also been expressed by some community-funded organisations that have been charged for using the fee-free interpreting service, even though they were formerly exempt from paying any fees. It appears that community funded organisations are covered for a period of 2 years from when they initially apply for exemption. They can then reapply for the next 2 years. This information has not been disseminated sufficiently to services generally, thus resulting in confusion for organisations as well as service providers within the medical arena.

## **2.5 Lack of a resource or guide which comprehensively presents all the necessary information for both workers and service providers (or which directs them to existing resources).**

A previous guide compiled by the Ethnic Health Policy Unit (1996) contained succinct and relevant information for service providers on accessing interpreters, as well as useful information for interpreter and client interactions. Brisbane City Council has produced a Translation Guide. Other information available has been referred to in section 2.1.1 of this report.

The current Queensland Health Language Services Policy includes some information (including special circumstances) but feedback indicates that this document is not read by most Queensland

Health staff. Private hospitals and specialists aren't given this document as they are not funded through Queensland Health.

Given that many private specialists do not access interpreters, it is imperative that information by TIS is produced and promoted more widely within the medical and related professions in Queensland.

## **2.6 Lack of community / consumer education on how to pursue the right to have an interpreter, when faced with a reluctant service provider.**

While new arrivals receive information about interpreters from settlement support workers, they may not know what to do in the event of a request being denied. They may not ask again should this occur to them. Since 1995, an Interpreter Card (an initiative of Multicultural Affairs Queensland) has been distributed widely to people within various ethnic communities. This card can be presented to service providers or agencies to indicate the client's request for an interpreter and for which language. An Interpreter Card Kit was also developed and distributed.

There are differing opinions as to how often it is used and how effective this card is for people with language difficulties. Some informal feedback from bilingual and community workers regarding usage within health care settings includes the following comments:

- *What card? – I have never seen them (interpreter and bilingual support worker);*
- *They weren't used much by clients – many felt too embarrassed (case worker at ethnic agency);*
- *They are excellent, we photocopy them here all the time for hospital staff to distribute (Queensland Health employee);*
- *They were better than nothing at all (client);*
- *For those people who used them and it worked well, they were comfortable with using them, but for those where interpreters were refused – they didn't use them again (community worker, settlement agency);*
- *I have found the card the most effective tool for families, especially for women who are trying to build their confidence after the initial settlement period (manager, child care program); and*
- *My issue is that there is a shortage of availability of the cards; I have been trying unsuccessfully for months to get some (manager, child care program).*

The Interpreter Card was reprinted in late 2003. Additional strategies may be needed to educate the CALD community about their right to ask for an interpreter and to educate service providers, government and private bodies on their responsibilities to meet the request. Given that many medical specialists refuse to access interpreters, clients are easily disempowered to continue their quest for an interpreter. Often it is a community or bilingual worker who assists them with advocating for their rights to one, but often the workers are refused as well.



Clarification is needed as to what pathway or mechanism exists for clients when their request for an interpreter is refused. Resource material needs to provide the following information to a service provider or government agency:

- Role and responsibility of organizing an interpreter for a client;
- Legal responsibility and consequences for service provider of not providing an interpreter;
- How to access an interpreter – telephone/on-site;
- What equipment may be needed such as conference phones;
- Exemption process and coverage by TIS; and
- Private interpreting and translation services in Queensland.

Educational activities used to be conducted by TIS and should be resumed by TIS or another agency.

## 2.7 Interpreting issues in rural and regional areas

Interpreting issues combined with health issues feature significantly in regional and rural areas of Queensland. Community workers, bilingual support workers, and family members have collated the following responses. They include:

- *Lack of qualified interpreters;*
- *Costs of training to become an interpreter e.g. travelling and accommodation costs in Brisbane;*
- *Cost of training resources;*
- *Shortage of interpreters in certain languages;*
- *Cultural problems with translating/interpreting services e.g. Bosnian, Croatian, Serbian translators;*
- *Long waiting times for TIS;*
- *Confusion by GP's and other medical specialists over who pays for interpreting services and reluctance to use them;*
- *Clients are often not aware of their right to access interpreters;*
- *TIS does not actively promote its services to key organizations and service providers such as doctors; and*
- *Hospital staff not accessing interpreters.*

According to a coordinator of a regional multicultural service, *“It is important to note that the lack of on-site interpreters compounds other service delivery regional issues in terms of lack of resources, minimal exposure to needs and resistance to an active inclusive multicultural policy in education, health and welfare. Generally, there is resistance to using telephone interpreters – cost factor, lack of experience and disregard for the impact on the client....a real casual sense that the information will be absorbed by osmosis?”*

“There is no professionally accredited pool of interpreters or translators in Mt Isa. A number of people in both the Finnish and Hungarian groups act informally as interpreters for members of their groups who have difficulty with English. The use of informal translators raises issues of confidentiality as well as medico-legal issues.

People in Mt Isa are willing to be professionally trained as official interpreters if training were made available and if arrangements can be made for those in full time employment. For example, two Finnish women who act as unofficial interpreters are employed full time and have to take time off without pay to undertake interpreting. They are most often asked for assistance for doctor’s visits” (A Double Jeopardy? NESB and Ageing Report, June 1999).

“An Iraqi couple attended a pre arranged appointment at an allied health clinic. The clinic had been previously informed by the referral agency of the need for an interpreter. On presenting, no interpreter has been arranged and the nurse continued despite being shown the interpreter card by the client. The female client has some English speaking ability and this was regarded as sufficient but the couple had no understanding of the information provided. A phone call to the Manager followed by a written expression of concern was sent...there have been no problems since” (Coordinator of a regional multicultural agency).

“A Sudanese woman attended a medical appointment (obstetrics) at a major regional hospital. At the first appointment the Doctor ignored requests by the accompanying worker to use an interpreter. The file was marked as requiring an interpreter. The Doctor and nurse used visual aids to explain why he needed to internally examine her. At the second appointment, the same worker employed the ‘broken record’ technique during the same Doctor’s explanations and made notes. Eventually the Doctor called the TIS – he had to be coaxed and directed through the process and after providing medical information to the patient, he launched into a lecture that she had been here a year and should have English by now. The patient was embarrassed and indignant afterwards and adamant that English is difficult to learn” (Coordinator of a regional multicultural agency).

In addition to the need to work towards having more people trained for on-site interpreting, videoconferencing technology could also be explored.

## **2.8 Professional standards and training for interpreters and translators**

A number of community workers and family members are concerned with the lack of professional standards exhibited by some interpreters and translators in health care settings. While interpreters and translators are professionally bound by a Code of Ethics, it appears there are some interpreters who breach this Code. Some examples include:

- Confidentiality breaches – especially in some of the smaller communities “*I was at a soccer function the other night and was told by an interpreter in our community that Mr xyz had terminal cancer*” (Client worker);
- Interpreters disclosing knowledge pertaining to sensitive issues such as domestic violence “*One interpreter went and told the woman’s husband the address of the women’s shelter – she thought the woman was lying and therefore her husband needed to know*” (Women’s refuge worker);
- Unprofessional behavior e.g. incorrect / partial information given to either client or service provider such as the doctor or specialist;
- Incidents where interpreters are known to ‘coax’ or ‘tout’ their services to clients so they can be used for future work – this is common where interpreters have no other employment. (This is different from where genuine clients or service providers request the same interpreter to assist clients in their health outcome);
- “*Issues such as subjectivity, emotive and biased personal responses to situations and tendency at times to want to ‘take over’ the interview process based on assumptions and their personal experiences of service systems*” (ACCESS – A Program of Diversity in Child Care Queensland Inc. – Issues Paper, 2000); and
- The written form of a clients prognosis and care treatment can also be translated judgmentally, especially where the translator takes the liberty to view the health issue from a moral or cultural framework e.g. Sexually transmitted diseases, alcohol or drug use related illness.

Other issues raised by some community workers and family members in reference to the professionalism of some interpreters include:

- The need for professional interpreters to have the sensitivity required for various issues e.g. torture and trauma, mental health, children’s issues, disability etc;
- The client has no prior knowledge of the accreditation standard of the interpreter/translator before the interaction occurs.

For many years there have been issues pertaining to the training and professional development of interpreters in Queensland. A recent report “*Interpreting in Queensland*” *Report from the Taskforce on Interpreting Issues convened under the Queensland Migrant Settlement Planning Committee* has collated and analysed a number of training and professional development issues, as well as proposing a number of recommendations and strategies. The Report however is not a public document and its contents therefore are unable to be used for this Discussion Paper. Suffice to say however that most of the issues mentioned below are included in the Report.

To date Queensland does not have a separate training body to provide training and professional development for interpreters and translators. The Princess Alexandra Hospital has their own Interpreting Services Unit, with contracted interpreters who participate in Queensland Health training covering topics such as the Privacy Act, Queensland Health’s Code of Conduct, infection control, signs of suicide risk, consenting for procedures, etc. While this is a highly positive initiative, these health trained interpreters are not available to other hospitals or other health services. Professional Interpreters (formerly termed NAATI Level 3) have the option of undertaking training on the health care setting as part of their accreditation. The Transcultural Mental Health Centre provides training to interpreters on ‘*Interpreting in Mental Health Settings*’ but has only been able to provide this 3 years ago and then 6 years ago before that. Southbank TAFE has provided

training in ‘Interpreting in Health Care Settings’ biannually and NAATI runs a similar workshop occasionally.

In addition, interpreting services and usage of these services falls both with State and Commonwealth governments, and there is minimal communication between the two tiers of government. Concerns have been raised by community workers, Queensland Health staff, bilingual support staff, interpreters and community members and measures are needed to increase the profile of interpreters in Queensland.

Issues raised include:

- TIS does not actively recruit interpreters. Interested people in the community are left to their own devices to gather relevant information and access appropriate training e.g. Southbank TAFE Level 2 Accreditation Course. Many are unaware of the limited pathways that exist;
- The costs involved for interpreters to receive their accreditation status is high, especially for those in regional areas;
- All on-going training and professional resources, including membership of NAATI and the Australian Institute of Interpreters and Translators (AUSIT), incurs a cost for interpreters. Practical workshops are mostly in New South Wales or Victoria. This results in a low number of Queensland interpreters available with specialized training about interpreting in a health setting;
- There is a shortage of interpreters in certain languages, especially those from new and emerging communities. Examples include Dari from Afghanistan, Kurdish (especially female interpreters), Nuer, Dinka, Nubia, Shuluk and Acholi from Sudan and Arabic speaking from some African countries such as the Horn of Africa. Most Arabic interpreters in Queensland are from countries such as Iraq or Lebanon and not from Africa. There is an Arabic dialect with various nuances which is used predominantly in Africa and not in other Arabic speaking countries. *“A South Sudanese woman who spoke broken Arabic and English language asked for an interpreter while admitted in hospital. She was given an Iraqi Arabic interpreter and didn’t understand most of the interpreting provided for her.”* (Project worker – Female Genital Mutilation project – community agency);
- There is no central co-coordinating body for interpreting services in Queensland as such. This is exacerbated for training and professional development. In contrast, Victoria established the Victorian Interpreting and Translating Service and the Central Health Interpreting Service, providing their interpreters with professional development and support. They also provide cross cultural training to health professionals. New South Wales, South Australia and the Northern Territory have also established their own language services. In Queensland, there are barely any formal or informal opportunities for interpreters to come together for training, debriefing purposes or to provide collegial support, although members of the Australian Institute of Interpreters and Translators (AUSIT) have limited opportunities for networking and professional development. ‘Burn-out’ is often mentioned for interpreters, in particular where there are sensitive situations. *“This job can be quite isolating and difficult – we are called to interpret in very sensitive situations – I have learnt my own ways to deal with this but it can be hard not having anywhere to go and professionally debrief”* (Interpreter of 5 years) The same interpreter also mentions: *“It is difficult to monitor your own performance, you are only called upon if there is a complaint or error made”*; and

- A number of bilingual support workers have experienced some difficult situations in this particular area. *“I have been with interpreters when they have been so moved by a particular situation. I’ve spent time with them to give them some support but we shouldn’t be doing this – they need professional debriefing.”* (Settlement community worker) This situation, while noble and understandable, is neither fair nor professional for the interpreter or worker. TIS, through its increasingly corporatised operations, has ensured that workers are ‘detached’ from other stakeholders and a climate of competitiveness as opposed to co-operation exists. TIS relates to its interpreters and translators as ‘contractors’ and does not take any responsibility for the professional development or support of its contractors. This contributes to the high ‘burn-out’ rate of interpreters and is in need of serious review. Interpreters need to pay for their own supervision if necessary which is costly, especially given that the demands of work can fluctuate considerably.

While the flexibility and variety appeals to most interpreters, the health care setting presents additional challenges for interpreters which need to be considered. Interpreters made the following points:

- *“Sensitive situations, such as mental health prognosis, terminal illness prognosis, domestic violence, torture accounts, are difficult when you see those people in the community; sometimes you feel that your personal safety is threatened”;*
- *“Sometimes you have to wait for nearly two hours in the waiting room, you have to find a level with the client where you can support them without being too friendly – this can be very difficult because if you don’t engage with them about other matters they see you as being quite cold and unfriendly – and then tell others in the community”;*
- *“Often hospital staff can be dismissive or unhelpful with our clients – it is a fine line as to how much I can advocate for the client, if I need to go to another appointment I will tell the Reception staff but you feel for the client because either another appointment has to be made or other people in the waiting will get cross if we go before them”;*
- *“I am not a trained counsellor, yet I get called in counselling situations where I feel inadequate and uncomfortable”;*
- *“I’m often told to wait by medical staff, sometimes I can’t wait any longer and need to go to another appointment, the client misses out”;* and
- *“Many times I do not understand medical terminology”.*

## **2.9 Impacts of the restrictive eligibility criteria for translation services**

Only permanent residents or those on provisional spouse visas whose date of arrival or grant of residency is less than 2 years are eligible for any fee free translations. They are only permitted one document from each category of identity and relationship, facilitation and education and employment.

*“My clients have less chance of finding employment because they can only have their highest qualification translated and any other descriptive material cannot be longer than 100 words. The highest qualification is not always the most useful to present for a particular job. They also have to choose between translating a car licence, or a truck licence, or a motorcycle licence – this also restricts their employment and recreational options”* (Settlement Service Coordinator)

## Section 3: The Solutions

### 3.1 The Way Forward

Clearly, professional accredited interpreters and translators are an essential component of providing an effective health service to migrants and refugees. Use of accredited interpreters can prevent adverse health outcomes due to misinformation, and thus avoid the legal repercussions to the health service that can result from not providing an interpreter. Use of untrained people, including children or other family members, is unacceptable and potentially dangerous to the patients health.

The policy framework is in place with the Queensland Government Language Services Policy (which reflects a whole of government commitment to the development of communication strategies to inform eligible clients of services and their entitlements and how they can obtain them) and the Queensland Health Language Services Policy Statement. The policy specifies that the engagement of professional interpreters paid for by the government is a key method of fulfilling that commitment. The resource material is also in place with detailed information available on Queensland Health's website.

The challenge is to achieve full implementation of the policy. With awareness, resources and a commitment to accessible, quality services, use of interpreters and translators can become a standard part of the delivery of health services in the public and private spheres.

The Community Health Action Group (CHAG) considers that the following principles / directions apply:

- a) A commitment by Queensland Health, MAQ, DIMIA, General Practitioners and other health service providers to the provision of interpreters / translators for clients of non-English speaking background.
- b) As part of the government's role to provide services to Australia's multicultural population, the government should bear the cost of interpreters / translators (this currently occurs for some services but not for others and for some migrants and refugees but not for others).
- c) Health services, public and private, should routinely access TIS or other accredited interpreting services each time they see a person who is not proficient in English. Health professionals and /or other staff must be held accountable for this.
- d) Accurate information on TIS and other services must be available to all health services.
- e) Health professionals require training in cross cultural communication and in using interpreters.
- f) Accredited interpreters need to be available in relevant languages and dialects, across the State for on-site interpreting and via telephone services.
- g) Appropriate measures need to be in place to address any unprofessional conduct by an interpreter.
- h) Appropriate support and professional development opportunities need to be available for interpreters.
- i) People from non-English speaking backgrounds need to know that they have the right to have an interpreter in health settings and the steps to take to ensure that services fulfil their obligation to provide an interpreter.

## 3.2 Conclusion

The overall aim of this Discussion Paper has been to highlight the structural, policy and resource limitations which exist with the current delivery of interpreting and translating services in Queensland's health system. It also questions where responsibility lies for tangible and constructive changes to occur to ensure access to health services for all Queenslanders irrespective of language barriers.

Interpreting and language provision issues are a major concern for many people from non-English speaking backgrounds in Queensland. This is particularly significant for the health care area where communication barriers can create additional stress and ill health as an outcome for the client. Interpreting services are the responsibility primarily of the Commonwealth government, and the state government has the mandate to ensure these services are accessed and used accordingly.

Issues mentioned throughout this paper are generally not reflected through formal complaints mechanisms such as Health Rights Commission, Complaints Officers at hospitals or industry bodies such as medical boards. Many migrants and refugees are reluctant to lodge a complaint for various reasons. However, consultations from both MAQ and Commonwealth DIMIA demonstrate that language and interpreting issues continue to impact on this target group when accessing health services.

Members of the Community Health Action Group commend the government on the commitment made and the policies and resources developed on this issue. CHAG members call on stakeholders to work cooperatively to see that the policies are fully implemented and to address the long standing issues addressed in this Paper.



# Recommendations

## *Queensland Health*

### **Recommendation 1**

That a professional on-site interpreter (or telephone interpreter if no on-site interpreter is available) be used for all health related matters for all patients not fluent in English.

### **Recommendation 2**

- a) That Queensland Health resource and monitor the *Queensland Health Language Services Policy*.
- b) That Queensland Health Corporate Office be responsible for the implementation and monitoring of progress against performance indicators, including reviewing of annual reporting on each district's implementation of the policy and usage of interpreters.
- c) That the responsible Officer/s assists those health services who have not made progress to implement the Language Services Policy.

### **Recommendation 3**

That Queensland Health funding be sufficient to enable Queensland Health hospitals and other funded services to implement the Language Services Policy, including the monitoring and reporting on all associated initiatives.

### **Recommendation 4**

That all Queensland Health staff be trained in cross cultural communication and how to access and work with interpreters.

### **Recommendation 5**

That Queensland Health provide funding to the Princess Alexandra Hospital to develop their Interpreters Unit into a resource for all of Queensland Health by developing video conferencing facilities to enable their interpreters to provide services to regional and rural hospitals and other health services.

### **Recommendation 6**

That the Princess Alexandra Hospital make their Interpreters available for on-site interpreting in other Brisbane hospitals on a cost recovery basis (generating large savings compared to continuing to use TIS).

### **Recommendation 7**

That Queensland Health district hospitals and other funded services demonstrate links with local ethnic communities and partnership projects to increase language provision services, as well as providing training for community interpreters on topics related to the health care setting, especially in rural and regional areas.

## **Recommendation 8**

- a) That each Queensland Health hospital and other funded services develop a Manual for the use of language services and disseminate it to all staff.
- b) That health and customer service staff participate in training about the provision of language services. The manual and training should include:
  - Relevant Language Policies;
  - Role and responsibility of organizing an interpreter for a client;
  - Legal responsibility and consequences for service provider of not providing an interpreter;
  - How to access an interpreter – telephone/on-site;
  - What equipment may be needed;
  - Exemption process and coverage by TIS;
  - Cultural and language considerations;
  - Working with interpreters (powerpoint presentation available on TIS web site); and
  - Private interpreting and translation services in Queensland.
- c) That the Queensland Health officer responsible for the implementation of the Language Services Policy provides a proforma for a manual and training that each service can adapt to their needs.

## **Recommendation 9**

That Queensland Health (in partnership with MAQ, DIMIA and CHAG) implement a statewide educational strategy aimed at medical practitioners, including specialists, ambulance officers and allied health professionals covering how to use language services, cross cultural communication and the medico-legal implications and potential of litigation if interpreters and translators are not used.

## **Recommendation 10**

That Queensland Health, in consultation with Multicultural Affairs Queensland, implement an education and awareness campaign for all public hospitals and other Queensland Health funded services on language and interpreting issues, including training of relevant personnel.

## **Recommendation 11**

That information and training be provided for receptionists on how to book interpreters and on cross cultural communication.

## **Recommendation 12**

That a telephone interpreter or bilingual staff member be used if there is any doubt that a person has understood that an appointment has been cancelled or postponed.

## **Recommendation 13**

That the Community Health Action Group, multicultural services and migrants and refugees be included on any working party formed for the purpose of planning an education campaign, reviewing the policy or similar brief. That regional representation be an integral part of any such working party and that adequate funding for telephone conferences be included in the budget.

## **Recommendation 14**

That Queensland Health provide training for interpreters (at no charge) on Queensland Health's Code of Ethics, the Privacy Act, informed consent, medical terminology and other topics relevant to the health care setting.

## **Recommendation 15**

That resources relating to using interpreters (intranet, training, written information, etc) developed by Queensland Health hospitals or other services (such as the Princess Alexandra Hospital and the Royal Brisbane Hospital) be made freely available to all Queensland Health and other hospitals and health services.

## ***Translating and Interpreting Services (TIS) / Department of Immigration and Multicultural and Indigenous Affairs (DIMIA)***

## **Recommendation 16**

That DIMIA reverse the decision to abolish non commercial rates for non profit organizations to prevent the loss of interpreting services that will result from a **100% increase in fees** by TIS (90% increase if the automated phone service is used).

## **Recommendation 17**

That TIS / DIMIA, in consultation with MAQ, Queensland Health, community based agencies, service providers and ethnic communities, undertake to implement a statewide education strategy on TIS services, accessibility and policies, exemption process, fees and legal ramifications information if interpreters are not accessed accordingly. That this education strategy reach Doctors and their receptionists, pharmacists, other allied health services, non government organizations, mainstream services, and other relevant organizations.

## **Recommendation 18**

That TIS produce a simple and practical Guide/Resource Kit and disseminate it widely to all relevant stakeholders. This should include the importance of using interpreters, how to access interpreters and how to work with them.

## **Recommendation 19**

That the current exemption guidelines be broadened to include optometrists, dentists and pharmacists (to be able to properly explain the use of any medications prescribed).

## **Recommendation 20**

That the criteria for a non profit organization to be granted fee free TIS services be broadened to cover all organizations providing a service to migrants and refugees.

## **Recommendation 21**

That a national/state strategy be developed and aimed at pharmacists to address concerns raised regarding appropriate communication about medication.

## **Recommendation 22**

That language services be provided to asylum seekers and refugees on Temporary Protection Visas.

## **Recommendation 23**

That TIS match the client and interpreter's gender and cultural group as far as possible.

## **Recommendation 24**

That TIS put client's interests first by sending the same interpreter for follow up visits of individual patients.

## **Recommendation 25**

That language and gender gaps amongst the pool of interpreters be identified and people with those characteristics be sought out and supported to train as interpreters. This is particularly important in regional areas. *Providing that training costs were covered, this would be achieved by implementing Rec. 53 of the Settlement Services Review: "That DIMIA pilot a program to fund subsidies for NAATI accreditation fees for appropriate bilingual people from small and emerging communities to gain NAATI recognition in languages for which interpreters are in short supply."*

## **Recommendation 26**

That where shortages exist, people from rural and regional Queensland be given scholarships to train as interpreters. That DIMIA funded services in regional areas be funded proportionately to train interpreters and bilingual facilitators.

## **Recommendation 27**

That TIS give priority to interpreters and translators who have completed specialized training (such as Interpreting in Health Care Settings, Interpreting in Mental Health). That interpreters be informed that such priority is given to create an incentive to undertake such training.

## **Recommendation 28**

That TIS further reduce waiting times for telephone interpreting and increase the quota for on-site interpreters.

## **Recommendation 29**

That DIMIA/TIS advise organizations two months prior to the expiry of their 2 year fee free period so they can reapply in time to ensure continuity of service provision.

## **Recommendation 30**

That DIMIA expand the eligibility criteria for fee free translations to further assist in the settlement of migrants and refugees.

## *Multicultural Affairs Queensland (MAQ)*

### **Recommendation 31**

That MAQ convene an ongoing Working Group with all stakeholders mentioned in this Paper, as well as community stakeholders, including those from rural and regional areas, to progress the stated issues.

### **Recommendation 32**

That the Working Group explore the feasibility of establishing an interpreting and translating service for Queensland. Such a service could include a section dedicated to the health setting or a separate service could be established specifically for interpreting within the health system, in line with practice in Victoria and New South Wales. The proposed service would include the following:

- on-site interpreting, telephone interpreting and video conferencing;
- specialist training, professional development of interpreters periodic assessment to maintain professional standards, debriefing and support for interpreters and translators;
- free services to all health services, including allied health practitioners, dentists, optometrists, pharmacists, etc;
- available to all people with a limited command of English, regardless of their visa status;
- administration of a fund to support the NAATI training of bilingual people:
  - with languages that are in short supply generally and in particular regions;
  - with health care backgrounds.

### **Recommendation 33**

That the Working Group:

- determine the steps a person can take when denied an interpreter / translator;
- determine ways to ensure all staff know their responsibilities to ensure an interpreter is organized; and
- develop methods of dealing with staff members who refuse to arrange for an interpreter.

### **Recommendation 34**

That the partnership between State and Commonwealth agencies be enhanced and increased to improve the effectiveness of the Memorandum of Understanding (relating to service standards to be provided by TIS to Queensland Government agencies). *(This is compatible with Recommendation 54 of the Settlement Services Review which refers to DIMIA and State governments clarifying responsibilities and communicating their responsibilities to service providers and service users.)*

### **Recommendation 35**

That a statewide consultative process be undertaken to explore strategies to assist non-English speaking background people on their rights to access an interpreter or translator, and process available to them if their request is refused.

### **Recommendation 36**

That a fund be established for bilingual people, especially in rural and regional areas, to access and undertake formal accreditation studies.

### **Recommendation 37**

That MAQ continue to provide Interpreter Cards for people requesting an interpreter / translator, including information on steps to take if their request is refused. That the Interpreter Card Kit (information on Interpreter Cards and booking an interpreter) continue to be provided to all health services. That health services be contacted annually to check that they have the relevant information visible to all relevant personnel.

### **Recommendation 38**

That MAQ contribute to the development of an education and awareness campaign for all health services (public and private) on language and interpreting issues (to be delivered by Queensland Health). That MAQ deliver this information to private providers, if outside the mandate of Queensland Health.

## ***Health Rights Commission (HRC)***

### **Recommendation 39**

That the HRC widely disseminate appropriate and culturally relevant information on complaints processes to ethnic communities in Queensland.

### **Recommendation 40**

That the HRC create a position of Complaints and Liaison Officer to communicate with ethnic communities and assist people from non-English speaking backgrounds through the complaints process.

### **Recommendation 41**

That the HRC complaints staff are trained in cross cultural communication and how to access and work with interpreters. This would assist staff in implementing the HRC's policy of using interpreters when needed.

### **Recommendation 42**

That complaints staff at the Health Rights Commission be representative of the wider society, especially through the employment of bilingual complaints officers.

## ***University of Queensland (Pharmacy / Medical / Dental Schools)***

### **Recommendation 43**

That all students undertake further cross cultural awareness studies which highlight issues such as cross cultural communication and the implications for medication use of language barriers.

### **Recommendation 44**

That all students from the above faculties be trained in accessing and working with interpreters.

## *National Accreditation Association for Translators and Interpreters Ltd (NAATI)*

### **Recommendation 45**

That NAATI increases communication and engages with relevant stakeholders within Queensland to promote training initiatives and consider ways of addressing issues for interpreters, translators and service providers.

### **Recommendation 46**

That NAATI explore alternative training options with interested people in rural and regional centers in Queensland and provide further training opportunities in regional areas of Queensland.

### **Recommendation 47**

That NAATI, AUSIT and other training providers offer more specialised training and advertise this to existing interpreters and translators. For example, training in interpreting in health care settings.

### **Recommendation 48**

That people fluent in English and another language who have a background in health services be recruited and assisted to train as interpreters, thus creating a pool of interpreters who can also undertake advocacy and cultural brokerage functions, as occurs successfully overseas and interstate.

## *Department of Emergency Services*

### **Recommendation 49**

That **all direct** emergency service staff and emergency **call centre** staff (i.e. fire, rescue, ambulance, counter disaster and rescue services) be trained in accessing interpreting services and in cross cultural communication.

## *General Practitioners*

### **Recommendation 50**

That all Divisions of General Practice in Queensland ensure that members are trained and proficient in accessing and working with interpreters and that all GPs know about and use the free TIS Doctors Priority Line.

### **Recommendation 51**

That Doctors who are not members of a Division of General Practice also receive the above information.

### **Recommendation 52**

That the Australian Medical Association (AMA) promote the use of interpreters in all health settings to their members in the public and private settings.

### **Recommendation 53**

That referring Doctors be able to book interpreters for their clients for their appointments with specialists. That medical specialists and their receptionists be made aware that they are eligible for fee free services if the consultation is medicare rebatable.

### **Recommendation 54**

That information and training be provided for receptionists on cross cultural communication and on how to book interpreters.

### **Recommendation 55**

That any test results that are not 'all clear' be delivered in person, using interpreting services.

## ***Health Professional Associations***

### **Recommendation 56**

That professional associations for health professionals such as psychologists, physiotherapists, pharmacists, etc. promote the use of interpreters to their members.

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## Attachment 1 - Community Health Action Group

The Multicultural Health Network was formally re-established in November 1999, after the previous Ethnic Health Workers Network disbanded in mid 1997. The new Multicultural Health Network consists of approximately 70 workers and organisations throughout the state. The Network operates under the auspice of the Multicultural Development Association through its Multicultural Advocacy project.

The primary aim of the Network is to:

- Work together for the better health of Queensland's ethnic minorities, and
- Improve access, equity and participation in Queensland's health services and programs.

Network members are keen to achieve these aims by:

- providing opportunities for partnerships and information and resource sharing,
- providing opportunities for professional development, and
- identifying and responding to issues for policy development and collective lobbying and advocacy.

Identified issues for advocacy and lobbying are passed on to the Community Health Action Group (CHAG). This network consists of community workers who are concerned with issues such as the lack of health specific interpreters, the progressing of the Multicultural Health Policy and the Language Services Policy.

### Community Health Action Group Values Statement

*To collectively advocate for improved health care resources and services for people from culturally and linguistically diverse backgrounds, incorporating social justice principles such as access, equity and participation.*

**Aim:** For CHAG members to work collaboratively in challenging current health care policies (or lack of) and practices, which are not considered culturally inclusive or appropriate.

#### **Objectives:**

- ✓ To advocate that the Queensland Multicultural Health Policy be sufficiently resourced, implemented and monitored through all Queensland Health hospitals.
- ✓ To develop and establish a sustainable partnership with Queensland Health to progress multicultural health issues.
- ✓ To share information on any data, research, trends and issues which affect people from culturally and linguistically diverse backgrounds, and to use this information to influence policy development and service delivery.
- ✓ To work towards increasing the awareness of mainstream health service providers of the needs of those groups which are seriously disadvantaged within the health care system, such as asylum seekers and temporary protection visa holders.
- ✓ To lobby for increased health care services and resources to improve the well being of people from culturally and linguistically diverse backgrounds.