



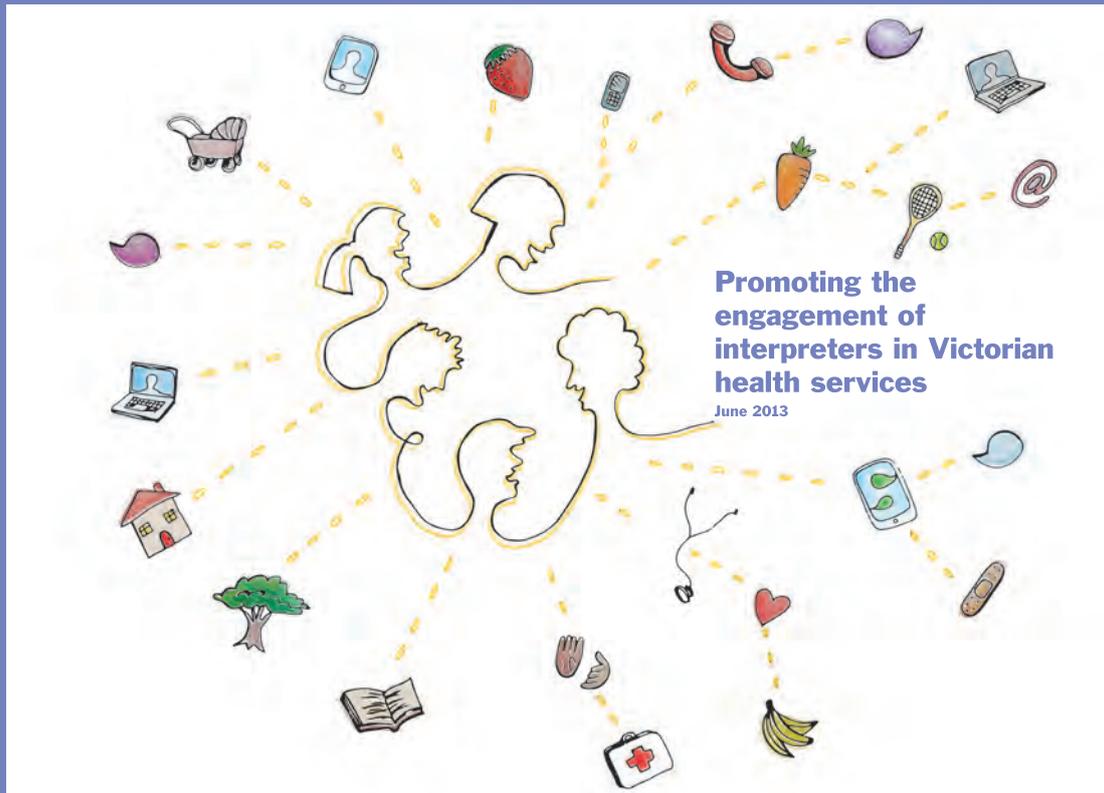
Promoting the engagement of interpreters in Victorian health services

June 2013



Foundation House

The Victorian Foundation for Survivors of Torture



Foundation House was established in 1987 to assist survivors of torture and other traumatic experiences, of refugee backgrounds, who had settled in Victoria. Our major areas of work include:

- counselling more than 3000 survivors each year;
- training service providers in the health, education and welfare sectors;
- supporting newly arrived young people to increase their education, training and employment opportunities;
- conducting research and advocacy to improve policies and services affecting the health and wellbeing of people of refugee backgrounds.

© The Victorian Foundation for Survivors of Torture (Foundation House) 2013

All rights reserved. Material in this publication may be reproduced, translated or adapted to meet local needs without prior permission, subject to acknowledgement of this publication. No commercial use or sale permitted.

Published by the Victorian Foundation for Survivors of Torture (Foundation House)

6 Gardiner St, Brunswick Victoria 3056, Australia

Email: info@foundationhouse.org.au

Web: www.foundationhouse.org.au

ISBN: 978-0-9804358-2-5 (Printed)

ISBN: 978-0-9804358-3-2 (PDF)

Cataloguing-in-Publication entry is available from the National Library of Australia: <http://catalogue.nla.gov.au>

DISCLAIMER

While best efforts have been made to ensure the accuracy of the information presented in this publication, readers are reminded that it is a guide only. It is understood that health practitioners will remain vigilant to their clinical responsibilities and exercise their professional skill and judgement at all times.

The Victorian Foundation for Survivors of Torture cannot be held responsible for error for any consequences arising from the use of information contained in this publication, or information in linked websites, and disclaim all responsibility for any loss of damage which may be suffered or caused by any person relying on the information contained herein. Please note that website primary sources may alter and it is recommended to link to the host site to search for further information.

Contents

Acknowledgements.....	iii
Abbreviations	iv
Glossary	v
Executive Summary	vi
Recommendations.....	viii
Introduction.....	1
Chapter 1: Reasons to engage credentialed interpreters	7
1.1 Quality of care	7
1.2 Client safety	8
1.3 Access to health care.....	9
1.4 Unnecessary health expenditure	9
1.5 Stress on families	11
1.6 Risk for legal implications.....	13
Chapter 2: Standards, policies and laws	16
2.1 National charters and frameworks	16
2.2 Australian Government	17
2.3 Victorian Government	18
2.4 Professional codes of conduct and assessment standards	22
2.5 Health and community services.....	23
2.6 International human rights framework	28
Chapter 3: Funding of interpreting services	29
3.1 Australian Government	29
3.2 Victorian Government	30
Chapter 4: Communication approaches between health practitioners and clients	35
4.1 Language diversity in Victoria	35
4.2 Modes of communication between health practitioners and clients.....	36
4.3 Service delivery models	40
Chapter 5: Barriers to the engagement of credentialed interpreters	44
5.1 Inadequate funding.....	44
5.2 Staff awareness and service protocols.....	58
5.3 Interpreters	69
5.4 Clients	80
5.5 Strategies to address client concerns.....	91
Chapter 6: Facilitators of the engagement of credentialed interpreters.....	93
6.1 Health practitioners and support staff.....	93
6.2 Health services.....	100

6.3	Interpreter equipment technologies	102
6.4	Service planning and data collection.....	108
6.5	Interpreter booking systems	111
6.6	Policies and procedures.....	113
6.7	Internal reviews.....	114
Appendix 1: Northern Health interpreting services.....		116
Appendix 2: NSW Health Care Interpreter Service.....		120
Appendix 3: Californian Health Care Interpreter Network		122
Appendix 4: The Victorian Health Innovation and Reform Council		124
Appendix 5: Diabetes Australia Vic – Case Study.....		125
Notes.....		127

Acknowledgements

The preparation of this report has been greatly assisted by a number of very knowledgeable people from a range of backgrounds including interpreters and health practitioners, and from sources such as community services, peak bodies, government and non-government bodies. In particular we acknowledge the lawyers of Russell Kennedy Pty Ltd, who prepared the legal information that is reproduced in Chapter 1.

Staff who contributed to the preparation of the report:

Rachel Vanstone

Josef Szwarc

Sue Casey

May Maloney

Philippa Duell-Piening

A special thank you to Willow Kellock who undertook a literature review to inform the project and to Claire Priestley for her editorial assistance.

Proof reading: Neil Conning

Cover art: Zoe McDonald

This project was financially supported by the Sidney Myer Fund and the William Buckland Foundation.

Abbreviations

ABS	Australian Bureau of Statistics
ATAPS	Access to Allied Psychological Services
CALD	Culturally and linguistically diverse
CEH	Centre for Culture, Ethnicity and Health
DEECD	Victorian Department of Education and Early Childhood Development
DH	Victorian Department of Health
DIAC	Australian Government Department of Immigration and Citizenship
DoHA	Australian Government Department of Health and Ageing
DOJ	Victorian Government Department of Justice
DPC	Victorian Government Department of Premier and Cabinet
DPL	Doctors Priority Line
FaHCSIA	Australian Government Department of Families, Housing, Community Services and Indigenous Affairs
HREOC	Australian Human Rights and Equal Opportunity Commission (now Australian Human Rights Commission)
MBS	Medical Benefits Schedule
NAATI	National Accreditation Authority for Translators and Interpreters
NESB	Non-English-speaking background
NHMRC	National Health and Medical Research Council
OMAC	Victorian Government Office for Multicultural Affairs and Citizenship
PBS	Pharmaceutical Benefits Scheme
PDRSS	Psychiatric Disability Rehabilitation and Support Services
RACGP	The Royal Australian College of General Practitioners
TCC	Targeted Community Care (Mental Health) Program
TIS National	Translating and Interpreting Service
VTPU	Victorian Transcultural Psychiatry Unit

Glossary

The following definitions have been adopted, with a number based on the advice of the National Accreditation Authority for Translators and Interpreters Ltd.¹

Term	Definition
Accreditation	The type or level of NAATI credential awarded across four levels: Paraprofessional, Professional, Advanced and Advanced (Senior) on the basis of objective assessment of an individual's translating and/or interpreting skill.
Accreditation standards	The standards against which levels of credentials to be issued are benchmarked.
Client	Person who uses the services of a health practitioner.
Credential	Evidence that the holder is competent to continue in practice at a specified level, i.e. either an accreditation or recognition.
Education	The formal process of learning, usually to acquire higher education qualifications.
Interpreting	Transfer of meaning in spoken or signed form.
Qualification	Evidence that the holder has completed successfully specialist education. In the professional context, the qualification signals the holder is prepared educationally to become a practitioner.
Recognition	The type of credential awarded on the basis of work experience, introductory training and English proficiency, but not objective assessment of skills.
Training	Vocational education either in a vocational and educational institution or other non-formal education.
Translating	Transfer of meaning in written form.

Executive Summary

Effective communication between health practitioners and their clients is fundamental to ensure the safety and quality of health care. For the thousands of Victorians with low English proficiency, effective communication in a health setting cannot be achieved without an appropriately skilled interpreter. Yet evidence shows that there are many occasions when credentialled interpreters are not engaged even though they should be, creating risks for both clients and health practitioners.

Communication in health care settings allows the health practitioner to accurately understand the client's health concerns and symptoms. It enables the client to be able to provide informed consent, understand diagnoses, receive information and understand risks associated with medication or treatment. Compliance with follow-up care also requires effective communication, as does the client's ability to advise the practitioner of any adverse effects or other concerns regarding treatment.

Around 4 per cent of Victorians speak English 'not well' or 'not at all'.² For these members of the community, effective communication in a health setting cannot be achieved without an interpreter who has the necessary range of skills to undertake the task competently and ethically.

Professional interpreting has been a key discipline in the health sector in Victoria for over 30 years. However evidence shows that the engagement of credentialled interpreters is still not commensurate with the needs of the community. The issue is of concern nationally. A recent study found that a client with low English proficiency had only a one in one hundred chance of having a professional interpreter engaged when required in a primary care setting in Australia.³

Shortfalls in the provision of interpreting services constitute a major barrier to addressing inequalities in health care.

This study examined a range of evidence about the barriers to - and facilitators of - the engagement of interpreters, as experienced by the health sector and its practitioners. Based on the evidence examined, recommendations are made in relation to:

- Strengthening legislation, organisational and professional guidelines and standards
- Closing gaps in Commonwealth funding for interpreters
- Ensuring Victorian Government funding for interpreters for state administered and funded health services is commensurate with need

- Adjusting the national funding formula for hospitals to provide weighting for the engagement of interpreters when patients have low English proficiency
- Encouraging health services and tertiary institutions to routinely provide training on working with interpreters in professional development and professional practice education
- Promoting organisational development to ensure policy and practices are in place for effective engagement of credentialled interpreters to meet a variety of demands across language groups
- Developing initiatives to ensure the supply of interpreters in new-arrival languages and the capacity of the National Accreditation Authority for Translators and Interpreters (NAATI) to test in these languages.

The evidence also indicates that there is an insufficient supply of credentialled interpreters who have skills in working in complex health environments. There is a compelling case for a broad national workforce and industry review.

Recommendations

Chapter 1: Reasons to engage credentialled interpreters

Recommendation 1.1: The Victorian Government should commission a study of the relationship between effective provision of interpreting services and hospital admission rates, emergency department presentations and length of stay.

Chapter 2: Standards, policies and laws

Recommendation 2.1: The Victorian Parliament should include provisions in the new Mental Health Act that health practitioners should engage credentialled interpreters when required; and that it is mandatory for an interpreter to be engaged for crisis situations and in relation to involuntary admissions and treatment.

Recommendation 2.2: The Royal Australian and New Zealand College of Obstetricians and Gynaecologists should strengthen its advice to members in relation to engagement of credentialled interpreters within its *Code of Ethical Practice and Guidelines for consent and the provision of information regarding proposed treatment*.

Recommendation 2.3: The Quality Improvement Council should incorporate reference to the engagement of credentialled interpreters in the accreditation standards for health and community services.

Recommendation 2.4: The evaluation of the National Safety and Quality of Health Service Standards for public hospitals should specifically examine whether the standards and guidance are adequate to ensure that hospital and day procedure services provide credentialled interpreters as a matter of course when required.

Recommendation 2.5: The Victorian Health Minister should propose to Commonwealth, state and territory health ministers that detailed advice about good practice in the engagement of interpreters be provided in the implementation guidelines for the National Standards for Mental Health Services.

Recommendation 2.6: The Royal Australian College of General Practice should include specific guidance about the engagement of credentialled interpreters in the accreditation standards for general practices.

Chapter 5: Barriers to the engagement of credentialled interpreters

Recommendation 5.1: The Australian Government should fund access to fee-free interpreting services for all allied health practitioners providing Medicare-funded services.

Recommendation 5.2: In the next edition of the Operational Guidelines for Access to Allied Psychological Services (ATAPS) program, the Department of Health and Ageing should strengthen the advice provided to Medicare Locals to promote engagement of credentialled interpreters when required.

Recommendation 5.3: The Australian Government should fund additional access to fee-free interpreting services for pharmacists working in private practice for non-PBS prescription medications and non-prescription medicines.

Recommendation 5.4: In order to allow for adequate consultation time for specialist physicians when a client requires interpreting services, the Australian Government should permit physicians to charge for four item 133s under the Medical Benefits Schedule over the calendar year.

Recommendation 5.5: The Australian Government should review costs associated with engagement of interpreting services by general and specialist medical practices and, based on that review, consider any appropriate Medical Benefits Schedule changes.

Recommendation 5.6: The Australian Government should include access to fee-free interpreting services for oral health services funded under the Dental Health Reform package announced in 2012.

Recommendation 5.7: The Independent Hospital Pricing Authority should include price loadings for the provision of interpreting services as a component of the national pricing for public hospital services.

Recommendation 5.8: The Victorian Government should review the funding model for Maternal and Child Health Services to take account of costs associated with using interpreting services, including administration and clinical time.

Recommendation 5.9: The Victorian Government should reinstate funding for interpreting services for public oral health services.

Recommendation 5.10: The Victorian Government should ensure that funding for interpreting services for community health services and the Australian College of Optometry is commensurate with demand, including direct allocations and credit line access.

Recommendation 5.11: The Victorian Government should provide a budget allocation for interpreting services associated with all new funding for health services, similar to the model used for the Refugee Health Nurse program.

Recommendation 5.12: The Victorian Government should within relevant language services policy and practice guidelines include:

- directions on determining clients' need for interpreting services
- a decision tree on whether to use on-site, telephone or videoconferencing for any particular consultation
- a self-assessment checklist for organisations to use when reviewing their language services provision
- advice about the most appropriate approach to discussing with the client their need for an interpreter.

Recommendation 5.13: The Royal Australian College of General Practice should provide advice to the Medical Software Industry Association that client management systems include interpreter required, language spoken and country of birth.

Recommendation 5.14: The Commonwealth, states and territories should fund the National Accreditation Authority for Translators and Interpreters Inc to ensure timely testing of new-arrival languages for smaller language groups at professional and paraprofessional levels.

Recommendation 5.15: The Commonwealth, states and territories should consider investment in additional educational opportunities for new-arrival communities to ensure an adequate supply of interpreters with the introduction of improved NAATI accreditation systems.

Recommendation 5.16: The Commonwealth Government should lead a broad review to ensure that Australia has an interpreting and translating workforce and industry to sustainably meet current and projected requirements for language services in key areas of government responsibilities.

Recommendation 5.17: The Victorian Government should propose to Commonwealth, state and territory governments that a study be undertaken to identify the most effective approaches to a national interpreter card or similar mechanism.

Chapter 6: Facilitators of the engagement of credentialled interpreters

Recommendation 6.1: Victorian tertiary providers should ensure education on working with interpreters is a component of practice-ready health practitioner courses.

Recommendation 6.2: Health services should ensure that induction of all staff includes skills development related to policy and procedures for engaging and working with interpreters.

Recommendation 6.3: The Victorian Office for Multicultural Affairs and Citizenship should consider including language services resources on its website, including organisational guides and professional development resources.

Recommendation 6.4: The Commonwealth Department of Health and Ageing and the Victorian Government should explore the potential for Telehealth and similar videoconferencing services to deliver cost-effective interpreting services.

Recommendation 6.5: The Australian Government should ensure that the needs assessment reports prepared by Medicare Locals include data about English proficiency and languages other than English of the populations in their areas, in order to indicate possible demand for interpreters.

Recommendation 6.6: All health services should have policies and procedures in place for the engagement of and working with credentialled interpreters.

Recommendation 6.7: The Victorian Government should support health services to review interpreting services, and to trial innovations and other quality improvements in interpreting services delivery.

Introduction

A number of Commonwealth and Victorian laws, policies and guidelines explicitly or implicitly provide that health practitioners should engage credentialled interpreters when their clients' English proficiency is low and the clients are not able to communicate effectively with their health practitioner in another language.

However, clients of the Victorian Foundation for Survivors of Torture (Foundation House) with low English proficiency regularly report not being provided with a credentialled interpreter when accessing health care. Reports from other sources indicate that the issue is widespread and longstanding in Victoria and nationally. The failure to engage credentialled interpreters creates a significant risk of flawed communications between health practitioners and their clients, which may have a number of undesirable consequences, including ineffective, time consuming or dangerous interventions.

The purpose of this report is to describe the evidence that credentialled interpreters are commonly not engaged in various health settings, and the main barriers and facilitators to health practitioners and services engaging credentialled interpreters.

The primary focus of this study is the provision of interpreting services in healthcare settings in Victoria. However, a number of the issues raised are of national significance and require a national response.

The first four chapters of this report provide the following information:

- *Reasons to engage credentialled interpreters* (Chapter 1) provides a summary of reasons for engaging a credentialled interpreter from client, practitioner and organisational perspectives.
- *Standards, policies and laws* (Chapter 2) provides an overview of standards, policies and laws requiring the use of interpreters and referencing international human rights frameworks.
- *Funding of interpreting services* (Chapter 3) provides an overview of Commonwealth and Victorian funding and other mechanisms for provision of credentialled interpreting services in healthcare settings.
- *Communication approaches between health practitioners and clients* (Chapter 4) includes basic demographic information and an overview of approaches to provision of interpreting services using various modes.

Chapters 5 and 6 explore barriers and facilitators to the engagement of credentialled interpreters as follows:

- *Barriers to the engagement of credentialled interpreters* (Chapter 5) identifies barriers associated with insufficient funding across

Commonwealth and state funded services; awareness and skills of health practitioners in engaging and working with interpreting services; and issues associated with availability of credentialled interpreters and lack of awareness by clients of the availability of interpreting services.

- *Facilitators of the engagement of credentialled interpreters* (Chapter 6) explores a number of factors, including education and training for health practitioners, both practice education and professional development; the responsibilities and approaches by health services to ensure effective interpreting services are provided; and the importance of service planning and data collection in informing effective interpreting services delivery.

The primary focus of Chapters 1 to 4 is to provide context for the discussion in Chapters 5 and 6 that lead to the bulk of this report's recommendations in relation to improving interpreting services delivery in healthcare settings.

There are also recommendations made in Chapters 1 and 2 in relation to the need for further study of the relationship between interpreting services and efficient health services delivery (Chapter 1) and the need to strengthen a number of professional standards, policies and laws (Chapter 2).

The focus of this report is on spoken English interpreting. However, some recommendations will also be relevant for sign language interpreting services.

Language

This report uses the terms 'low English proficiency', 'limited English language' and similar combinations to describe a person's ability to communicate in English, where the person would not be able to communicate to a level required to understand the content of a medical consultation. Other terms referenced in this report are 'non-English-speaking background' (NESB), 'culturally and linguistically diverse' (CALD), 'non-English-speaking', 'English not first language', 'primary language not English', and 'English is not the client's preferred language'. These terms, strictly speaking, do not always mean that someone has low English proficiency. However, they may have at times been used interchangeably as primary references cited have used these terms.

The report refers to engaging an interpreter to assist with communication between a health service provider and client as 'working with an interpreter'. 'Interpreter mediated health consultations' is another term sometimes used in literature.

The report uses the term 'patient' and 'client' interchangeably to describe a person receiving a service from a health professional. Interpreting services also view health professionals as clients. When this is discussed in the report it is explicitly stated that the health professional is the client.

Methodology

This report draws on the following sources of information: published documents; a survey of Victorian tertiary institutions that provide education to health practitioners; analysis of data regarding the Translating and Interpreting Service (TIS) National; legal information; consultations with individuals from health services and practitioners, government and non-government bodies; two roundtable discussions with key stakeholders; and submissions received as a part of a formal consultation process.

Published material

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

Academic databases used covered Australian healthcare publications, including the *Medical Journal of Australia*; the *Australian Journal of Primary Health*; *Australian Family Physician*; the *Australian Health Review*; the *Australian and New Zealand Journal of Public Health*; and the *Australian Journal of Rural Health*.

International studies were also drawn upon for evidence about reasons to engage credentialled interpreters and to identify facilitators to encourage working with credentialled interpreters.

Survey of tertiary institutions

A survey was sent to nine Victorian tertiary institutions that provide education to health practitioners. The survey sought information about education available in practice-ready courses for health practitioners on working with interpreters, cultural competency, and the impact of refugee trauma and torture. Six universities responded regarding 33 practice-ready courses covering all health disciplines.

TIS National data

Data provided by the Department of Immigration and Citizenship regarding the use of the TIS National fee-free interpreting service for general practitioners, specialists and pharmacists for the period 2005–06 to 2010–11 was analysed.

Legal information

Lawyers from Russell Kennedy Pty Ltd provided a legal review, which is included in this report.

Consultations

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

- Australian Government: Department of Immigration and Citizenship; Department of Families, Housing, Community Services and Indigenous Affairs
- Victorian Government: Department of Health; Department of Education and Early Childhood Development; Department of Premier and Cabinet; Department of Justice
- Victorian Public Hospitals: Northern Health; Royal Women's Hospital; Western Health; the Royal Children's Hospital; Southern Health
- Community Health Centres: Western Region Health Centre; ISIS Primary Care; Primary Care Connect Community Health Services
- Centre for Culture, Ethnicity and Health.

Roundtable discussions

Two roundtable discussions were convened in March and August 2012, firstly to explore preliminary findings and then to canvass draft recommendations. Organisations represented at these were:

Australian Catholic University
Australian Health Practitioner Regulation Agency
Bendigo Health
Centre for Culture, Ethnicity and Health
Commonwealth Department of Health and Ageing
Doutta Galla Community Health Centre
Ethnic Communities Council of Victoria
ISIS Primary Care
National Accreditation Authority for Translators and Interpreters
Northern Health
Pharmacy Guild of Australia
Royal Australian and New Zealand College of Psychiatrists
Royal Australasian College of Physicians
Royal Australian College of General Practitioners

Royal Children's Hospital
South Eastern Melbourne Medicare Local
Southern Health
St Vincent's Melbourne
Statewide Refugee Health Nurse Facilitator
The Royal Women's Hospital
TIS National, Department of Immigration and Citizenship
Victorian Government Department of Education and Early Childhood
Development
Victorian Government Department of Health
Victorian Government Office of Multicultural Affairs and Citizenship,
Department of Premier and Cabinet
Victorian Office of the Health Services Commissioner
Western Region Health Centre.

Submissions and comments

In May 2012, a discussion paper was widely circulated inviting interested parties to make a submission. Submissions and comments were received from:

AMES Settlement
Australian College of Rural and Remote Medicine
Australian Institute of Interpreters and Translators
Australian Psychological Society*
Australian Red Cross
Avant*
Ballarat Community Health Centre
Bendigo Health*
Department of Immigration and Citizenship (Commonwealth)
Dr Andrew Lovett, Regional Victorian paediatrician*
Dr Christine Boyce, Tasmanian general practitioner
Dr Christine Phillips, ACT general practitioner and senior researcher at the
Australian National University*
Dr I-Hao Cheng, South East Melbourne Medicare Local, Monash
University, general practitioner
Dr Georgia Paxton, Royal Children's Hospital
Dr John Scopel, Melbourne general practitioner*
Dr Thomas Schulz, Royal Melbourne Hospital, ID physician
Eastern Health*
Ethnic Communities Council of Victoria
G21 – Geelong Region Alliance
Health West Partnership*
Inner South Community Health Service
Manningham Community Health Services
Mercy Health*
Municipal Association of Victoria
New South Wales Health Care Interpreter Service
Peter MacCallum Cancer Centre*
Pharmacy Guild of Australia*
Refugee Council of Australia*

Royal Australian and New Zealand College of Obstetricians and
Gynaecologists*
Royal Australian and New Zealand College of Psychiatrists*
South Eastern Melbourne Medicare Local*
St Vincent's Hospital*
Sunraysia Community Health Services
Swan Hill District Health
Victorian Government Department of Health (Vic)
Western Health
Western Region Health Centre

* Denotes submissions

Chapter 1: Reasons to engage credentialed interpreters

Good communication between a health practitioner and a client during a clinical consultation is essential to ensure the safety, quality and effectiveness of care.^{4, 5, 6, 7, 8, 9, 10}

When interpretation is required, credentialed interpreters should be engaged as they are less likely to make errors and any errors made are less likely to be of clinical consequence.^{11, 12, 13} Credentialed interpreters operate under a code of professional ethics to ensure their services are impartial and confidential,¹⁴ and their level of skill is of a sufficient standard.¹⁵

As described in this chapter, working with credentialed interpreters in health consultations improves quality of care, improves client safety, promotes access to health care, reduces unnecessary health expenditure, reduces stress on families and minimises risk of legal complications.

1.1 Quality of care

‘When I did my glucose test I had no interpreter booked for that appointment. After consuming the fluid my condition was very bad I was fainting but I was not able to let the staff know about my condition. I had to wait till I was better. If I had interpreter I could have let them know about my condition.’

Participant in Foundation House supported research project, 2013.

When communication barriers exist, the quality of care for clients diminishes.^{16, 17} Some consequences are: poor understanding of discharge diagnosis, poor understanding of treatment plans, late presentation of symptoms, and reduced likelihood of participating in medical decision making.^{18, 19, 20} Victorian community services workers have reported that they ‘are aware of multiple incidences where miscommunication within consultation rooms and hospital settings have had negative impacts on clients health outcomes’.²¹

The Australian Psychological Society noted in its submission to this study the way in which quality of care diminishes in the therapeutic context when communication barriers exist.

It is impossible to provide a high quality psychological service without effective communication between the psychologist and the client. Inadequate communication with clients who have low English proficiency limits their ability to access services and also has a profound impact on the quality of treatment received when they do access services.

In psychological settings communicative demands are complex. Clients are required to communicate difficult experiences and to discuss interpersonal relationships. In the case of refugees, extremely sensitive issues of torture and trauma are also likely to be raised in a psychological context. In the presence of a thought disorder, delirium, dementia, anxiety or depression, the capacity to communicate in a second language is further impaired.

Inadequate communication will limit the capacity of the psychologist to:

- develop a therapeutic relationship
- understand the point of view of the client
- understand the cultural context of the client
- conduct an assessment
- formulate a diagnosis
- reach agreement on an appropriate treatment plan, and
- monitor and evaluate the effectiveness and any adverse effects of treatment.²²

Conversely, working with credentialled interpreters has demonstrated more effective clinical treatment, greater client satisfaction with treatment, and increased likelihood of desired health outcomes.^{23, 24}

A WA government review recommended the utilisation of interpreter services after finding that ‘Client care was compromised by communication difficulties between clinicians and clients whose primary language was not English.’

Government of Western Australia, (2008), From death we learn, p 6.

1.2 Client safety

A number of preventable adverse events have occurred in Australia where qualified interpreters were not engaged, including a 35-year-old Afghan refugee who died and two clients who had procedures undertaken on incorrect body parts.

Bird, S., (2010), Failure to use an interpreter, Australian Family Physician, Vol. 39 (4), p 241;
Department of Human Services, (2004), Sentinel event program: annual report 2003–04, p 24.

Communication barriers increase the risk of medication errors^{25, 26} and adverse health outcomes.^{27, 28, 29}

An Australian study found that some informants reported ‘adverse events such as missing dialysis appointments, taking medications inappropriately, and non-compliance with renal diet and fluid restrictions’ associated with language barriers among dialysis patients.³⁰ A study at a Queensland hospital found that that use of interpreting services was associated with a reduced likelihood of an adverse pregnancy outcome.³¹ Failure to recognise this relationship ‘stands as a resident pathogen within the health care system’.³² Good communication facilitated by a credentialled interpreter is therefore considered essential to client safety.^{33, 34}

1.3 Access to health care

Research demonstrates that communication barriers reduce access to health care,^{35, 36, 37, 38, 39, 40, 41} including:

- fewer hours of home and community care⁴²
- fewer visits to health practitioners^{43, 44}
- lower attendance at antenatal classes^{45, 46}
- lower likelihood of being referred for a follow-up appointment following an emergency department visit⁴⁷
- less participation in preventive screening^{48, 49}
- less utilisation of telephone support/advice lines.⁵⁰

Credentialed interpreters have been found to improve access, with increases in clinical visits, follow-up visits, number of prescriptions written and filled, preventive screening services, and the likelihood of referral for mental health care for asylum seekers.^{51, 52, 53, 54, 55, 56, 57} Parents have reported that availability of interpreters would make it easier to access health care for their children.⁵⁸

Concern has been expressed that many elderly clients from a non-English-speaking background are isolated in their homes and are not accessing services due to both language and service delivery barriers.

HREOC, (2005), Not for service: experiences of injustice and despair in mental health care in Australia, p 762.

1.4 Unnecessary health expenditure

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

- higher non-attendance rates at clinics⁵⁹
- increased diagnostic investigations⁶⁰
- higher hospital admission rates^{61, 62, 63}
- increased length of stay in hospital and emergency departments^{64, 65, 66, 67}
- decreased likelihood that clients will seek early treatment at the onset of cardiovascular disease⁶⁸
- more frequent intravenous hydration.⁶⁹

Conversely, providing credentialed interpreter services has been linked with reduced rates of people returning to emergency departments⁷⁰ and failing to attend appointments.⁷¹

Further, working with credentialled interpreters has been found to increase the use of preventive or early detection services, which reduces the costs associated with late-stage disease treatment or emergency visits.^{72, 73}

Recent US research suggests that working with credentialled interpreters can also significantly reduce the likelihood of patients being readmitted to hospital.⁷⁴ This research examined the cases of 3,060 low-English-proficiency patient admissions for readmission and found that the rates of readmission were significantly higher for patients who did not have an interpreter at admission or discharge.

24.3% (103/423) patient admissions who did not have an interpreter present at admission and discharge were readmitted within 30 days, compared to 16.9% (163/963) of patients with an interpreter at admission only, 17.6% (85/482) of those with an interpreter at discharge only, and 14.9% (178/1192) with an interpreter at both admission and discharge day (Chi-square = 19.5, df = 3, P < 0.001).

In Victoria, Northern Health has demonstrated a link between the engagement of credentialled interpreters and the length of stay in hospital. Specifically, Northern Health has found that since the Transcultural and Language Services Department was created in 2007, there has been a reduction in the average length of stay for low-English-proficiency clients from 9.14 days in 2007 to 5.9 days in 2012, which has resulted in significant cost-efficiencies for the hospital (see Appendix 1 for further details).

There have been similar findings overseas, with one study reporting a reduction of three days length of stay in hospital (over a four-year period with interpreter interventions).⁷⁵ There is a need for further formal research in this area, particularly in the Australian context.^{76, 77}

An associated question is the costs associated with failure to use interpreters in emergency departments. A study regarding access to specialist services identified 'unknown or unspecified causes of morbidity' as the most common diagnosis for those from refugee source countries presenting to emergency departments in Victoria in the period 2003–2008. In comparison, for the broader Victorian population 'unknown and unspecified causes of morbidity' was the 16th most common reason for presentations to emergency departments.⁷⁸ There may be a number of causes for this, including clinical presentations that were unable to be classified. However, it certainly indicates the need for further investigation regarding the care provided to patients with low English proficiency in emergency departments, and clinical outcomes.

The Victorian Cultural Responsiveness Framework (see Chapter 2) encourages health services to undertake research into the outcomes of CALD patient care needs, Standard 3 includes, 'Accredited interpreters are provided to patients who require on.' An example provided is 'comparative studies between English-speaking and non-English-speaking patients regarding length of stay, emergency

presentations, diagnostic tests, failure to attend appointments, evaluation of post consultation outcomes'.⁷⁹ Research into the length of stay is a useful measure, with the potential to track the cost to the hospital of interpreting services and the cost-efficiencies derived by any reductions in length of stay due to credentialed interpreters being engaged when required.

Recommendation 1.1: The Victorian Government should commission a study of the relationship between effective provision of interpreting services and hospital admission rates, emergency department presentations and length of stay.

A body that has an interest in these issues is the Victorian Health Innovation and Reform Council, which has two initial priority terms of reference: reviewing hospital readmission rates and associated practice to provide advice on clinical, quality and operational improvements; and considering and advising on innovative models of care that can be provided through Telehealth services, particularly in rural and regional areas (Appendix 4). The Australian Government also has a strong interest in exploring the potential benefits of Telehealth, and the subject is therefore one that would be well served by collaborative action, as is proposed in Chapter 6.

1.5 Stress on families

'I was very embarrassed to be talking about my pregnancy with my son and I could see that he was not very happy or comfortable himself.'

Australian Human Rights Commission, (2010), In our own words, African Australians: A review of human rights and social inclusion issues, p 18.

When family members are used as interpreters, they are emotionally involved and may become privy to sensitive, confidential and potentially distressing information, for example, about the diagnosis of a terminal illness.^{80, 81, 82} Further, there have been situations where having a relative present (who may be a perpetrator) as an interpreter can act as a deterrent where women may want to disclose an experience of sexual abuse and/or domestic and family violence.⁸³

While not well documented in the literature, there is potential for harm to family members acting as interpreters, as the content of the interpreted consultation may be emotionally burdensome and the family member has not been trained to deal with it.^{84, 85} It has been reported that informal interpreters in a Californian hospital were unprepared for interpreting in emotionally loaded encounters and felt traumatised by interpreted consultations where bad news had been imparted.⁸⁶ One family member reported that 'As the examination progressed and the severity of my father's condition became apparent, I became increasingly uncomfortable with my role ... But for my part I had come to fear the role of

medical interpreter.’⁸⁷ A senior project officer at the Health Issues Centre has similarly reported that the role creates significant anxiety.⁸⁸

Requiring a child to take on such a potentially stressful role raises significant ethical concerns.⁸⁹ In one documented case, a child of 10 years, suffered a severe post-traumatic stress reaction that saw her hospitalised for eight months; one of the triggers was being used as an interpreter between her family and medical staff for her younger sibling, who died of renal failure at the age of 13 months.⁹⁰

If family members are called on to accompany relatives in order to provide this sort of informal interpreting, this may also adversely impact on their other commitments, such as attending school.^{91, 92, 93}

One consultation participant related the story of a nine-year-old who translated for female relatives regarding cancer and hysterectomy. It is doubtful that a child would be able to satisfactorily explain the subtleties of this complex diagnosis, and furthermore, relating such information might cause children to become traumatised.

Federation of Ethnic Communities’ Council of Australia, (2012), Opening the door to access and equity: FECCA Access and Equity Report 2011–2012, Submission Paper, p 46.

‘If I wanted to go to the doctor, my daughter has to cancel her day from school and then take me.’

Henderson, S., & Kendall, E., (2011), Culturally and linguistically diverse peoples’ knowledge of accessibility and utilisation of health services: exploring the need for improvement in health service delivery, Australian Journal of Primary Health, Vol. 17, p 197.

A woman arrived in Australia to join her husband; within weeks she was taken to a GP where her husband and mother-in-law acted as interpreters. She later presented to the Immigrant Women’s Support Service because of domestic violence and in the assessment she showed the worker what happened at the GP: she had been implanted with a contraceptive device – IMPLANON – without her knowledge or consent.

Allimant, A., & Ostapiej-Piatkowski, B., (2011)., Supporting women from CALD backgrounds who are victims/survivors of sexual violence: challenges and opportunities for practitioners, Australian Centre for the Study of Sexual Assault, p 10.

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

Consultation with a Victorian Refugee Health Nurse.

1.6 Risk for legal implications

This section was prepared by the legal firm Russell Kennedy Pty Ltd in 2012. It is intended for general information only and should not be regarded as legal advice. If you have any concerns regarding the use of interpreters you should seek independent legal advice.

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

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

Legal implications may include:

(a) Health practitioner disciplinary proceedings

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

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

(b) Civil claim for trespass

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

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

† National Law and the Health Services (Conciliation and review) Act 1987.

(c) Civil claim for negligence

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

Vicarious liability

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

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

Qualified interpreters

Qualified and accredited interpreters should be used.

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

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

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

Refusing to treat a client

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

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

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

End of advice from Russell Kennedy Pty Ltd

In the case of *Medical Board of Australia v. Venkataraman*, a cosmetic surgery client signed consent forms which were translated to the client by the doctor's receptionist. The client's understanding of English was limited and the receptionist was not an accredited or qualified interpreter. Dr Venkataraman admitted that she failed to adequately inform the client of the risks associated with the procedure and thereby failed to obtain informed consent; constituting unprofessional conduct.

Medical Board of Australia v. Venkataraman (Occupational and Business Regulation) [2011] VCAT 751 (12 May 2011).

In Victoria the failure to obtain informed consent led to a client being dialysed against his wishes resulting in him becoming aggressive towards staff (the situation was later resolved with the assistance of a qualified interpreter).

Zimbudzi, E., Thompson, S., Terrill, B., (2010), How accessible are interpreter services to dialysis clients of non-English speaking Background?, Australasian Medical Journal, 1, 3, p 208.

Australia's largest medical defence organisation 'Avant' states "As medical practitioners we have a duty of care to ensure that our patients understand the information provided to them. This can be easily managed by making interpreter services available for patients not confident in speaking or understanding English."

<http://www.avant.org.au/WorkArea/DownloadAsset.aspx?id=2220> accessed on 16/4/2012.

Kate Rapsey, the Claims and Operations Manager of Australian-owned medical indemnity underwriting agency 'Invivo' recommends the recording of the interpreter's identification number to manage risk in case of a future dispute.

http://www.invivo.com.au/newsletter1707_2.html accessed on 16/4/2012.

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

Chapter 2: Standards, policies and laws

This chapter provides an overview of the national standards, Commonwealth and Victorian Government policies and laws, and professional codes of conduct related to the engagement of credentialled interpreters by health practitioners and health service providers.

The purpose of this chapter is to provide context for the discussions in Chapters 5 and 6 relating to barriers and facilitators to engagement of credentialled interpreters. However, where shortfalls have been identified in standards, policies and laws, recommendation is made in this chapter for amelioration.

The chapter also describes the international human rights framework on the right to health and credentialled interpreters.

2.1 National charters and frameworks

2.1.1 Australian Charter of Healthcare Rights

The Australian Charter of Healthcare Rights was adopted by Commonwealth and state and territory health ministers in July 2008.⁹⁴ Communication is one of the seven charter rights and working with credentialled interpreters is a strategy identified in the guidance material to support both users and providers of health services to achieve this right. More specifically, the advice to clients is, 'You can use interpreters if English is not your first language.'⁹⁵ The advice to health practitioners is, 'Wherever practical, health care providers should make sure arrangements are made to meet patient or consumer language needs.'⁹⁶ Further, health service organisations are advised that their role is to 'make all reasonable efforts to afford access to services such as interpreters and patient support groups to assist with clear communication'.⁹⁷

2.1.2 Australian Safety and Quality Framework for Health Care

The Australian Safety and Quality (ASQ) Framework for Health Care was endorsed by Australian health ministers in November 2010. The framework specifies three core principles for safe and high-quality care: consumer centred; driven by information; and organised for safety.⁹⁸ An area for action by people in the health system is that they 'provide care that respects and is sensitive to different cultures' (1.4).⁹⁹

To embed the ASQ Framework in the Australian healthcare system a series of guides were developed to advise various types of personnel.¹⁰⁰ They include advice relating to the use of interpreters as follows.

- Healthcare teams: 'Clinicians should use translated information about routine clinical and administrative matters as well as using interpreters for more specific discussions'.¹⁰¹ Further, members of healthcare teams should 'be aware of how to organise an interpreter in your service and be able to find alternatives if an interpreter is not available'.¹⁰²
- Managers: should 'support your workforce in their use of interpreters with patients and families. This includes making sure that the process for requesting, booking and using an interpreter is well organised, simple to use and that assistance is available where problems arise. In some cases, healthcare workers may also need assistance in determining whether a patient requires an interpreter and this is another area where support could also be provided'.¹⁰³
- Senior executives and board members: should 'ensure that interpreting services are available based on demand and in line with best practice. Protocols and policies need to be developed to support routine use of these services.'¹⁰⁴
- Policy makers: should 'provide a policy framework for health services to help them improve the way they work with patients and consumers from different cultures. This framework could include competency requirements for healthcare workers and interpreters and identify policies and protocols that should be in place within health services.'¹⁰⁵

2.2 Australian Government

2.2.1 Policy

In 2009, the Commonwealth Ombudsman published a report on the use of interpreters by the following government services: the Australian Federal Police, the Department of Education Employment and Workplace Relations, Centrelink and the Department of Immigration and Citizenship (DIAC).¹⁰⁶ The report sets out eight best practice principles for Commonwealth agencies when using interpreters, which cover:

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

The Commonwealth Government Access and Equity Framework for government services lists ‘communication’ as one of its four guiding principles. An identified strategy for communication is ‘recruiting and training staff who have appropriate linguistic and cultural skills or using interpreting services to ensure effective communication with clients as necessary’.¹⁰⁷ The framework applies to all government-funded services, whether they are delivered by government agencies, community organisations or commercial enterprises.¹⁰⁸

The Access and Equity Framework was recently reviewed.¹⁰⁹ The report of the inquiry noted, among other things, that ‘There needs to be a greater level of Australian government agency responsiveness to the particular circumstances of some migrants – for example, migrants with low levels of English proficiency.’¹¹⁰ It made 20 recommendations to strengthen action to enhance the responsiveness of Australian Government services to Australia’s culturally and linguistically diverse population. They include a recommendation that the government ‘develop a whole-of-government policy on communication by its agencies in languages other than English, including use of interpreters and translators’. (Recommendation 9).

The government announced in March 2013 that it supported all the recommendations. With respect to the recommendation for a whole-of-government policy on communication, the government stated that it intended to meet this in two ways:

- All agencies are required to have a language and communication plan for CALD communities.
- DIAC is updating the Commonwealth Language Services Guidelines, which will be included in a toolkit of resources and practice guidelines to assist agencies to develop ‘multicultural plans’, including the language and communication plans.

2.3 Victorian Government

2.3.1 Policy

Victoria has adopted the Australian Charter of Healthcare Rights for patients as follows:

You have a right to an accredited interpreter for communication needs with your publicly-funded healthcare service. Interpreters should be provided at important points during your care, such as when discussing medical history, treatments, test results, diagnoses, during admission and assessment and when you are required to give informed consent.¹¹¹

An abbreviated version of this statement appears in the brochure *Summary of the Australian Charter of Healthcare Rights in Victoria*, which is available in 25 community languages.¹¹²

The *Victorian Health Priorities Framework 2012–22* identifies ‘improving every Victorian’s health status and health experience’ as a health service priority for the next decade. An implementation action for this priority in metropolitan Victoria is ensuring interpreters are available where needed. The framework also includes a commitment to develop a plan to improve refugee health and wellbeing under the strategic priority to develop a system that is more responsive to people’s needs.¹¹³ The initiatives outlined below also support the priorities outlined in the framework.

Victorian health services are required to develop and implement the *Cultural responsiveness framework: guidelines for Victorian health services*, which have six standards across four domains and improvement measures and sub-measures for culturally responsive practice. Many of these relate to the provision of language services. For example, Standard 3 is ‘Accredited interpreters are provided to patients who require one’ and this is measured by reporting on the number of clients requiring interpreting services and the occasions of interpreting services provided. Reporting on the achievements of the ‘cultural responsiveness plan’ takes place annually through each health service’s quality of care report. All public health services, including registered community health services are required to produce a quality-of-care report.¹¹⁴

The document *Using interpreting services: Victorian Government policies and procedures* states that clients who have low English proficiency should ‘... have access to professional interpreting and translating services when required to make significant decisions concerning their lives; or when being informed of their rights; or where essential information needs to be communicated to inform decision making, including making informed consent’. Further the document states: ‘It is Victorian Government policy that interpreters be accredited at the Professional level where possible’.¹¹⁵

The Victorian Department of Human Services (DHS) departmental Language Services Policy, which covers both DHS and Department of Health services, specifies that to comply with Victorian Government policy ‘All departmental programs and funded agencies must have policies and procedures in place to meet three minimum language service requirements.’¹¹⁶ These are as follows.

- Clients who are not able to communicate through written or spoken English must have access to information in their preferred language at critical points, e.g. to give informed consent.
- Language services are provided by appropriately qualified professionals.
- People – including family members – aged under 18 should not be used as interpreters.

Implementation of the DHS departmental language services policy is one of the assessment measures of the *Cultural responsiveness framework: guidelines for Victorian health services* discussed earlier.¹¹⁷

Diversity planning and practice is a strategic population planning initiative that supports and encourages Home and Community Care (HACC) program service delivery that is responsive to and respectful of the specific characteristics of the person seeking services.¹¹⁸ To support the implementation of the strategic initiative a diversity planning and practice guide has been developed for HACC-funded agencies. The guide encourages agencies to develop an organisational language services policy and procedures for using interpreting services based on the Victorian Government language services policy.¹¹⁹

2.3.2 Law

A number of Victorian laws provide responsibilities and rights relating to interpreters.

The *Health Services Act 1988* specifies as an objective to ensure that ‘users of health services are provided with sufficient information in appropriate forms and languages to make informed decisions about health care’ [section 9(e)].

The *Multicultural Victoria Act 2011* requires all Victorian Government departments to report annually on the use of interpreting services and communications in languages other than English [section 26].

The *Victorian Charter of Human Rights and Responsibilities Act 2006* includes rights that may be relevant when considering access to interpreters in the delivery of healthcare services. In particular, it provides that a person must not be subjected to medical treatment without his or her full, free and informed consent [section 10]. Under the Act, it is unlawful for public authorities (which includes state government established health service providers) to act in a way that is incompatible with a human right or, in making a decision, to fail to give proper consideration to a relevant human right [section 38].

The *Mental Health Act 1986* prescribes that the language needs of a person with a mental illness should be taken into consideration as a principle of treatment and care [section 6A(g)]. However, it does not explicitly state that a credentialed interpreter should be engaged when required to make significant decisions, when being informed of their rights, or when providing informed consent, as is Victorian Government policy.¹²⁰

The Act mandates the provision of a statement of rights to clients upon becoming a patient [section 18 (1)]. This statement may be printed in different languages so that a patient may be given the statement in their own language [section

18 (2)]. The patient must be given an oral explanation of the statement and if the patient appears not have understood, arrangements must be made to convey the information to the patient in the language he or she is most likely to understand [section 18 (3)]. However, it does not explicitly state that a credentialed interpreter should be engaged when required.

The *Mental Health Act 1986* is currently under review and it is anticipated that a Bill will be introduced in parliament in 2013.¹²¹

The *Mental Health Bill Exposure Draft 2010*¹²² is similar to the Act, in so far as it does not explicitly state a credentialed interpreter should be engaged if required as a principle of responsiveness to specific needs and rights [section 8 (1)] or principles relating to information [section 9 (1)].

In a submission following the release of the *Mental Health Bill Exposure Draft 2010*, the Victorian Transcultural Psychiatry Unit (VTPU) noted that CALD clients are over-represented in relation to involuntary admissions and that this may be due in part to the fact 'that clinicians may fail to engage interpreters to ensure accurate communication, and may lack cultural competence and confidence in cross-cultural assessments'.¹²³ VTPU also noted that the explicit requirement for engaging a credentialed interpreter in satisfying language needs is:

... particularly important for coercive procedures such as compulsory admission, treatment without consent, restrictive interventions and regulated psychiatric treatments. For CALD migrants and refugees who may have experienced oppressive regimes and possibly torture in their country of origin, failure to understand such proceeding has the potential to re-traumatise individuals.¹²⁴

The Health Consumers Council Western Australia¹²⁵ and the Transcultural Mental Health Centre¹²⁶ have in the past made representations regarding the importance of standards for engaging credentialed interpreters in crisis situations. There are certain situations where health practitioners should be required to engage a credentialed interpreter when required. Neither the Act nor the Exposure draft provide that it is mandatory for clinicians to engage credentialed interpreters when required for crisis situations and involuntary admissions and care such as involuntary patients at admission (assessment orders), involuntary patients after examination (treatment orders), other treatments without consent, restrictive interventions and regulated psychiatric treatments.

Recommendation 2.1 : The Victorian Parliament should include provisions in the new Mental Health Act that health practitioners should engage credentialed interpreters when required; and that it is mandatory for an interpreter to be engaged for crisis situations and in relation to involuntary admissions and treatment.

2.4 Professional codes of conduct and assessment standards

2.4.1 Professional codes of conduct

The Medical Board of Australia's Code of Conduct for Doctors in Australia states that doctors should ensure 'arrangements are made to meet patients' specific language, cultural and communication needs' and familiarise themselves with, and use whenever necessary, credentialed language interpreters.¹²⁷ The code was developed by the Australian Medical Council and adopted under the National Registration and Accreditation Scheme.¹²⁸

The National Health and Medical Research Council's (NHMRC) advice for medical practitioners on communicating with patients is that 'when and wherever possible use should be made of qualified interpreters'.¹²⁹ It advises against the use of family members or friends but indicates that doctors should be 'sensitive' to the patients' preferences without specifying what that might entail.

For privacy reasons it is inappropriate to use family members or friends to interpret at medical consultations. However, not all cultural groups welcome the use of non-family members in such circumstances, and doctors need to be aware of, and sensitive to, such a possibility.

As detailed in Chapter 1, there are strong reasons in addition to privacy for doctors to seek the engagement of credentialed interpreters as the preferred option.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) *Guidelines for consent and the provision of information regarding proposed treatment* contains the following.

When the patient's first language is not English, the medical practitioner must assess whether the patient has a sufficient understanding of the information provided to consent to the treatment (taking into consideration the complexity of the issues and the patient's proficiency in English). If an interpreter is required, it is highly desirable that an independent, professionally qualified health interpreter assist either in person or by telephone. If a professionally qualified interpreter is not available (or is not acceptable to the patient), assistance may be sought from family members or bilingual staff.¹³⁰

Similarly, the RANZCOG Code of Ethical Practice states:

Doctors should provide information in a form and manner that is relevant to the patient's circumstances, personality, expectations, fears, beliefs, values and cultural background. It is desirable that a professional interpreter is involved in care when translation is necessary.¹³¹

These codes and guidelines are relatively weak, given the significant risks and sensitivities associated with obstetric and gynaecological care. At a minimum the Guidelines and Code of Ethical Practice should ensure that a credentialed

interpreter is engaged when required for diagnosis, treatment and informed consent.

Recommendation 2.2: The Royal Australian and New Zealand College of Obstetricians and Gynaecologists should strengthen its advice to members in relation to engagement of credentialled interpreters within its *Code of Ethical Practice and Guidelines for consent and the provision of information regarding proposed treatment*.

The Australian Psychological Society *Code of Ethics* states that psychologists who engage interpreters should:

- (a) take reasonable steps to ensure that the interpreters are competent to work as interpreters in the relevant context;
- (b) take reasonable steps to ensure that the interpreter is not in a multiple relationship with the client that may impair the interpreter's judgement;
- (c) take reasonable steps to ensure that the interpreter will keep confidential the existence and content of the psychological service;
- (d) take reasonable steps to ensure that the interpreter is aware of any other relevant provisions of this Code; and
- (e) obtain informed consent from the client to use the selected interpreter.¹³²

Information for other health practitioners can be found under the codes of conduct for their respective national board.¹³³

2.4.2 Standards for health services

Standards have been developed for general health and community services, public hospitals, mental health services and general practice. The following sections suggest areas where guidance to ensure credentialled interpreters are engaged when necessary could be strengthened.

2.5 Health and community services

2.5.1 Quality Improvement Council

The Quality Improvement Council is 'an Australasian standards development and accreditation body serving the health and community services sectors'.¹³⁴ The council is responsible for the development of accreditation standards for health and community services and organisations, including those described as adult

health services, mental health services and community health services.¹³⁵ The standards are designed to be applicable to ‘organisations based in the public, commercial or community sectors’. (page 6).

The standards do not explicitly refer to the engagement of credentialled interpreters. Standard 2.3 specifies that ‘services and programs are provided in a culturally safe and appropriate manner’. The definition of ‘cultural safety’ is that services are provided ‘in a way that recognises and is compatible with the client’s cultural values, beliefs and needs’. A number of examples are given (e.g. gender, culture, age and race) but English language proficiency is not included as a pertinent indicator of need.

Identifying the provision of credentialled interpreters as necessary to ensure *consumer safety* rather than ‘cultural safety’ would be more appropriate and accurate.

While it is appreciated that the guidance provided by the standards is of a general rather than detailed character, there is scope for the inclusion of a clear statement to draw the attention of services to the importance of ensuring there is effective communication with clients whose English proficiency is limited.

Standard 2.2 specifies that ‘Services and programs are provided in an effective, safe and responsive way to ensure positive outcomes for consumers and communities.’ An ‘evidence question’ relating to effective communication with clients with communication needs should be included to assess whether services meet this standard.

<p>Recommendation 2.3: The Quality Improvement Council should incorporate reference to the engagement of credentialled interpreters in the accreditation standards for health and community services.</p>
--

2.5.2 National Safety and Quality of Health Service Standards for public hospitals

The new accreditation scheme for health service organisations commenced in January 2013. Under the scheme, all hospitals, day procedure services, day surgeries and day hospitals are assessed against the National Safety and Quality of Health Service (NSQHS) Standards that were endorsed by the Commonwealth, state and territory health ministers in September 2011.¹³⁶ The standards were developed by the Australian Commission on Safety and Quality in Health Care and the Commission has also prepared an ‘Accreditation Workbook to assist hospitals to determine if they meet the requirements’ of the standards.¹³⁷ The standards will be evaluated and updated by 2017.

The NSQHS Standards are designed to address areas in which there are:

- a large number of patients involved
- known gaps between the current situation and best practice outcomes
- existing improvement strategies that are evidence-based and achievable.¹³⁸

The evidence presented throughout this report indicates that these criteria apply to the area of routine engagement of credentialled interpreters for people whose English proficiency is inadequate for effective communication with healthcare professionals.

While NSQHS Standards do not explicitly refer to the use of credentialled interpreters, the requirement to do so appropriately is clearly implied. For example, a criterion of Standard 1, 'Governance for Safety and Quality in Health Service Organisations' is that 'patient rights are respected' and the actions required to achieve this include that an 'organisation has a charter of patient rights that is consistent with the current national charter of healthcare rights' (1.17.1). As described in Chapter 2, one of the rights the Australian Charter of Healthcare Rights specifies is 'communication', and working with credentialled interpreters is a strategy to support the achievement of this right that is outlined in the guidance material for users and providers of health services.

A further pertinent action specified in the standards is that 'Systems are in place to support patients who are at risk of not understanding their healthcare rights.' (1.17.3) The *Accreditation Workbook* indicates as examples of evidence for achieving this that a 'register of interpreters ... [is] ... available to the workforce, patients and carers,' and 'patient clinical records reflect assessment of need and support provided.'¹³⁹

It will be important for the evaluation in 2017 to establish whether the standards and guidance are adequate to ensure that hospital and day procedure services provide credentialled interpreters as a matter of course when required or have to be strengthened by the inclusion of more explicit and detailed advice about specific measures that should be considered, such as:

- displaying the national interpreter symbol in their reception area where it can be readily seen by clients
- indicating in referral letters whether a credentialled interpreter is required and the preferred language spoken by the client
- providing training on engaging credentialled interpreters for medical practitioners and clinical and administrative staff
- having suitable equipment available in necessary locations for telephone interpreting
- having policies on communicating with people with low English proficiency.

Recommendation 2.4: The evaluation of the National Safety and Quality of Health Service Standards for public hospitals should specifically examine whether the standards and guidance are adequate to ensure that hospital and day procedure services provide credentialled interpreters as a matter of course when required.

2.5.3 Mental health services

The National Standards for Mental Health Services were endorsed by the Australian Health Ministers Conference in September 2010.¹⁴⁰ Standard 4 relates to ‘diversity responsiveness’ and requires services to ‘take into account the cultural and social diversity of [their] consumers and meets their needs and those of their carers and community throughout all phases of care’. The standard has a general criterion that the staff of services ‘are trained to access information and resources to provide services that are appropriate to the diverse needs of its consumers’. (4.5)

The national standards are accompanied by implementation guidelines for public mental health services and private hospitals, non-government community services, and private-office-based mental health practices.¹⁴¹ The guidelines relating to Standard 4 refer to the use of interpreters but do not provide detailed advice about what good practice might entail. The guidelines would be enhanced with more specific advice, for example that:

- services engage a credentialled interpreter when required by any of the parties to communicate effectively or adequately, emphasising the critical importance for crisis situations and in relation to involuntary admissions and treatment
- services display the national interpreter symbol in their reception area where it can be readily seen by clients
- staff include in their referral letters and relevant pro formas whether a credentialled interpreter is required and the preferred language spoken by the client and any other requirements such as gender and ethnicity
- services have access to working telephone equipment suitable for telephone interpreting and appropriate to the environment, e.g. three-way phones or speaker phones
- services record country of birth, interpreter required and preferred language in health records
- services adopt a policy about how they communicate with patients, including patients with low English proficiency
- professional and administrative staff are trained to engage credentialled interpreters.

Recommendation 2.5: The Victorian Health Minister should propose to Commonwealth, state and territory health ministers that detailed advice about good practice in the engagement of interpreters be provided in the implementation guidelines for the National Standards for Mental Health Services.

2.5.4 General practice

The Royal Australian College of General Practice standards for the accreditation of general practices require practices to demonstrate they provide for the ‘communication needs of patients who are not proficient in the primary language of our clinical team and/or who have a communication impairment’.¹⁴² (Standard 1.2, Criterion 1.2.3)

The guidelines specify two indicators of compliance:

- The ‘clinical team can describe how they communicate with patients who do not speak the primary language of our staff or who have a communication impairment’.
- The ‘practice has a list of contact details for interpreter and other communication services including the Translating and Interpreter Service’.

Based on the findings of this study, it would be helpful for the standards to provide additional specific guidance to address impediments to the engagement of credentialled interpreters and to promote adoption of measures that facilitate such engagement (see Chapters 5 and 6). Additional guidance that could be included in the RACGP Standards is as follows.

- Practices have policies about how they communicate with patients with low English proficiency.
- Practices have equipment suitable for telephone interpreting and appropriate to the environment, e.g. three-way phones or speakerphones.
- Practices display the national interpreter symbol in their reception area where it can be readily seen by clients.
- Health records and referral letters should indicate whether an interpreter is required, the preferred language spoken by the client and any other requirements such as gender and cultural sensitivities
- Training on engaging credentialled interpreters for medical practitioners, clinical staff and administrative staff.

Recommendation 2.6: The Royal Australian College of General Practice should include specific guidance about the engagement of credentialled interpreters in the accreditation standards for general practices.

2.6 International human rights framework

Australia is party to a number of international human rights treaties, i.e. it has committed to complying with the obligations they impose and to promoting the achievement of the objectives they contain.

Of particular relevance to this report is the International Covenant on Economic, Social and Cultural Rights. Under this treaty, States Parties 'recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' [Article 12]. One of the measures specified for the full realisation of this right is 'the creation of conditions which would assure to all medical service and medical attention in the event of sickness' [Article 21(2) (d)]. The right to health and all other rights enshrined in the covenant are subject to a guarantee by States Parties that they will be exercised without discrimination of any kind, including language [Article 2(2)].

The Committee on Economic, Social and Cultural Rights, the body responsible for monitoring implementation of the covenant, has issued guidance to States Parties on the interpretation of the right to health.¹⁴³ This states that essential elements of the right to health include 'accessibility', which incorporates:

- 'non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact ...'¹⁴⁴
- 'information accessibility: includes the right to seek, receive and impart information and ideas concerning health issues.'¹⁴⁵

Further guidance on the right to health has been provided in a document prepared by the Office of the United Nations High Commissioner for Human Rights and the World Health Organisation.¹⁴⁶

This states:

- 'Accessibility also implies the right to seek, receive and impart health related information in an accessible format ...'¹⁴⁷
- Migrants' 'enjoyment of the right to health is often limited merely because they are migrants, as well as owing to other factors such as discrimination, language and cultural barriers ...'¹⁴⁸

Chapter 3: Funding of interpreting services

The funding and provision of interpreting services in Australia can appear confusing, due to the complex funding arrangements for health services provision across Commonwealth, state and territory governments. In essence, the funding responsibility for interpreting services is consistent with the funding stream for the specific health service being provided. For example, where funding for optometrist is through Commonwealth funding, so interpreting services should be funded by the Australian Government (e.g. MBS); the Victorian Government funds the provision of generalist counselling services in community health services and accordingly, the interpreting services of those agencies is funded by the Victorian Department of Health.

As detailed in this chapter, both the Commonwealth and Victorian governments provide substantial funding for interpreting services, but it is not commensurate with demand: there are significant shortfalls, and in some instances simply no provision made for interpreting services in major funding programs.

3.1 Australian Government

All Commonwealth agencies are responsible for designing, delivering, monitoring and evaluating their services so that they are accessible and responsive to cultural and linguistic diversity. This includes being responsive to the needs of clients who have limited English language skills through the provision of translated information or interpreting services where appropriate.

The Australian Government's Translating and Interpreting Service (TIS) National is administered by the Department of Immigration and Citizenship. TIS National provides telephone interpreting nationally and is available 24 hours a day, seven days a week. Since 2000, TIS National has had priority processing for medical practitioners – the Doctors Priority Line (DPL).¹⁴⁹

Free access to TIS National is provided to medical practitioners (general practitioners and specialists) for items claimable under Medicare and pharmacists prescribing PBS medications (as well as their reception staff) working in private practice.¹⁵⁰ Access is unlimited for telephone interpreters, but quotas exist for the provision of on-site interpreters.¹⁵¹ The 2013–14 forward estimates for DIAC free Translating and Interpreting Service (TIS National) delivery was \$14,716,000¹⁵². This includes the cost for the free service delivery of TIS National not only to medical practitioners and pharmacies, but also to:

non-profit, non-government, community-based organisations providing settlement services and case work; members of parliament for constituency services; local government authorities; trade unions; and Emergency Management Australia.¹⁵³ A breakdown of expenditure in health was not provided.

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

... nurses, radiographers, medical technicians, psychologists, chiropractors, optometrists and dieticians ... There is some flexibility for nurses, radiographers and other medical technicians, when assisting a doctor to deliver eligible services working directly under private [medical practitioners], to access fee-free interpreting services, under the doctor's TIS National client code (with that doctor's approval).¹⁵⁴

The exclusion of these services is discussed in Chapter 5.

The Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) funds access to language services for specific services funded to provide the Targeted Community Care (Mental Health) program (TCC) service streams: personal helpers and mentors; mental health respite; and/or mental health community-based services.¹⁵⁵ FaHCSIA was unable to provide advice regarding funding for language service access but advised there is no limit on the level of language services TCC program service providers can access for their clients.¹⁵⁶

The Access to Allied Psychological Services (ATAPS) program is intended to provide 'access to effective, low cost treatment for people with a mental illness who may not otherwise be able to access services'.¹⁵⁷ The Department of Health and Ageing (DoHA) has issued operational guidelines for ATAPs that identify certain 'priority population groups' for ATAPS services, defined as 'groups which have particular difficulty in access mental treatment in the primary care sector'.¹⁵⁸ Culturally and linguistically diverse communities are specified as one of these. However, use of interpreters by these services is not consistent. (See Chapter 5).

3.2 Victorian Government

The Victorian Government provides funding for interpreting services in the health sector mainly through direct agency funding and credit lines. Smaller funding streams exist for program and project funding.

3.2.1 Direct agency funding

Direct agency funding is provided for organisations with a significant volume of interpreter usage, e.g. large community health services. This direct funding enables services to independently establish formal contracts with an interpreting and translating service suited to their needs, and to employ in-house interpreters.¹⁵⁹

A number of programs also have specific interpreter funding. These include:

- Refugee Health Nurse program
- Nurse-on-Call¹⁶⁰
- Maternal and Child Health Line¹⁶¹
- Parent Line¹⁶²
- Gambler's Help¹⁶³
- Victims' Assistance and Counselling program helpline.¹⁶⁴

The approach used for the Refugee Health Nurse program, where a funding allocation for interpreting services is provided for all new positions (\$25,000), should be considered for all new Department of Health funding.

Case mix funding is an activity-based funding tool that has been in place for many years in Victoria to determine public hospital funding. Case mix funding is based on a client episode (separation) that is cost weighted according to its treatment classification (Diagnosis Related Group) and length of hospital stay. A cost-weighted separation is called a Weighted Inlier Equivalent Separation (WIES) and is calculated using different cost weights for different types of stay within each Diagnosis Related Group.^{165, 166}

In some instances, patients have higher costs, but these higher costs are not found for all patients within the Diagnosis Related Group. In those situations, a number of loadings exist (WIES co-payments) to help hospitals offset these costs, e.g. mechanical ventilation in the intensive care unit, patients with the inherited blood disorder 'thalassaemia', Aboriginal and Torres Strait Islander patients, and patients requiring stent prostheses.^{167, 168}

Health services receive an annual budget consisting of WIES funding for a target level of activity, plus a range of specified grants. The majority of current funding for interpreting services in hospitals is based on WIES-related income. There has also been a specified grant named the training and development grant. As a part of the complexity stream of this grant (five streams in total) the department provided top-up funding for interpreting services because it considers that patients requiring interpreters are usually more complex medically than other patients in their Diagnosis Related Group.^{169, 170}

In August 2011, the Victorian Government signed a new National Health Reform Agreement (NRHA).¹⁷¹ An objective of the NRHA is to 'improve public hospital

efficiency through the use of activity based funding based on a national efficient price' [clause 3(a)].¹⁷² The Independent Hospital Pricing Authority (IHPA) will set the national efficient price, which is the new national pricing for public hospital services. Activity in public hospitals will be described using the National Weighted Activity Unit (NWAU), which will replace the WIES in Victoria. Price loadings in addition to the NWAU have been approved for location (e.g. rural) and Indigenous status. Price loadings for the new activity-based funding can only be approved by the IHPA if there is evidence to support them.¹⁷³

The complexity stream of the training and development grant recognised the cost of interpreting services. However, in 2012–13 a number of previous specified grants, including complexity grants, were rolled into the WIES price as a part of the transition to the NWAU. Hospitals which previously received the complexity grant will effectively receive the same funding. However, it will not be tagged for this purpose. Through statements of priorities, the Department of Health (DH) will require health services to maintain programs and services previously funded by such grants.¹⁷⁴

DH reported hospital expenditure and direct funding to community health services for language services for 2008–2012 is provided in Table 1. This may be included in global budget case mix funding (as is the case for hospitals) or be specific funding for language services (as is the case for community health).

Table 1: Department of Health expenditure for language services 2008–2012 – direct to agency

	2008–09 (as part of DHS)*	2009–10†	2010–11‡	2010-11F
Hospital expenditure on language services	\$10,946,000	\$9,362,218	\$11,964,644	\$13,427,357
Direct funding to community health services	\$1,349,000	\$1,678,007	\$1,946,000	\$1,793,022
TOTAL	\$12,295,000	\$11,040,225	\$13,910,644	\$15,220,379

Sources:

* Department of Premier and Cabinet Office of Multicultural Affairs and Citizenship, *Victorian Government Achievements in Multicultural Affairs 2008–09*, p 29.

† Department of Premier and Cabinet Office of Multicultural Affairs and Citizenship, *Victorian Government Reporting on Multicultural Affairs 2009–2010*, p 35.

‡ Department of Premier and Cabinet Office of Multicultural Affairs and Citizenship, *Victorian Government initiatives and reporting in multicultural affairs 2010–11*, pp. 31, 32.

F Correspondence from the Department of Health received 13 June, 2013.

3.2.2 Credit line funding

The credit line system is a contract for language services between the relevant department and the interpreting and translating service provider. Each credit line has an annual budget broken down into monthly limits by program areas. Once the available funds for the month have been used for a particular credit line, no more bookings can be made against that credit line.¹⁷⁵

DH-funded credit lines are available to services or agencies that: deliver DH-funded services, do not receive direct funding for language services, and use the language services for eligible programs, e.g. alcohol and other drugs; Psychiatric Disability Rehabilitation and Support Services; community health; aged care; Victorian College of Optometry Services; all rural acute services; Royal District Nursing Service; palliative care, children, youth and families (now DHS); and disability services (now DHS). Each rural region has access to a credit line and can access the services on the same basis as the metropolitan services.¹⁷⁶

In 2007, the newly established Department for Education and Early Childhood Development (DEECD) integrated a number of functions from the Office for Children.¹⁷⁷ As such the Office for Children language services credit line moved to DEECD and is internally regarded as the ‘early childhood credit line’.¹⁷⁸ The early childhood credit line enables agencies that deliver services funded by DEECD and who do not receive direct funding for language services to have access to an interpreting service. Eligible health practitioners include maternal and child health services, Early Childhood Intervention Services and primary and secondary school nurses.¹⁷⁹

The total expenditure for the credit lines for the Victorian health sector for 2009–12 is provided in Table 2.

Table 2: Credit line expenditure for the Victorian health sector 2009–2012

	2009–10**	2010–11***	2011-12****
DH credit line	\$925,725 ⁿ	\$944,060	\$1,009,595
Early Childhood credit line	\$1,100,000	\$1,100,000	*****
TOTAL	\$2,025,725	\$2,044,060	

Sources:

**Department of Premier and Cabinet Office of Multicultural Affairs and Citizenship, *Victorian Government reporting on multicultural affairs 2009–2010*, p 35.

***Department of Premier and Cabinet Office of Multicultural Affairs and Citizenship, *Victorian Government initiatives and reporting in multicultural affairs 2010–11*, pp. 31, 32.

****Correspondence from the Department of Health received 13 June, 2013.

ⁿEstimated by adding an additional 25% (25% of \$740,580 is \$185,145) to the reported figure for the nine month period. Source: Department of Premier and Cabinet Office of Multicultural Affairs and Citizenship, *Victorian Government Reporting on Multicultural Affairs 2009–2010*, p .35.

*****Not available at the time of writing.

3.2.3 Maintenance funding

In the 2012–13 Victorian Budget, an additional \$4 million over four years was allocated to maintain language services.¹⁸⁰ The additional funding was allocated to address expected price increases for language services to health services, community health services and the credit line¹⁸¹ as a result of the decision of the Federal Court of Australia in *On Call Interpreters and Translators Agency Pty Ltd v. Commissioner of Taxation*. The court determined that the credentialed interpreters used by the language services company On Call were employees within the meaning of the *Superannuation Guarantee (Administration) Act 1992 (Cth)* instead of what On Call regarded as self-employed independent contractors. On Call was therefore deemed to be liable for the superannuation guarantee charges for these interpreters.¹⁸² The ruling will impact other organisations as the Australian Taxation Office has said it will continue to apply the superannuation guarantee ruling, by ‘distinction or organisation test’, that contractors are common law employees if they are operating in the business of the payer rather than operating on their own account.^{183, 184}

3.2.4 Direct project funding

Funding has been made available to improve access to interpreting services. The sum of \$400,000 a year ongoing was allocated for marketing strategies and grants as a part of the 2011–12 Victorian budget.¹⁸⁵ It included a program to improve access to health services for seniors in rural and regional Victoria. The Victorian Government also invested over \$2 million in projects as a means to address translating and interpreting industry issues.

Chapter 4: Communication approaches between health practitioners and clients

This chapter describes the communication means used by health practitioners with clients who are not proficient in English. This includes situations in which:

- the health practitioner shares a language other than English in which the client is proficient
- an untrained interpreter such as the client's family, a friend or a bilingual staff member is used
- the consultation proceeds in English without assistance
- a credentialled interpreter is engaged.

Sometimes the method of communication is the preference of both parties; sometimes it is the preference of one or the other or simply the only method possible in the circumstances.

4.1 Language diversity in Victoria

According to the 2011 Australian census, 212,634 (3.97%) of Victorian residents spoke English either 'not well' or 'not at all'.¹⁸⁶ This was nearly 26,000 more than the number recorded at the 2006 census when 186,759 Victorian residents were reported to speak English either 'not well' or 'not at all'.¹⁸⁷

The 10 most common languages or language groups spoken by Victorian residents who speak English either 'not well' or 'not at all' in 2011 were:¹⁸⁸

- Chinese languages (including Cantonese and Mandarin) – 45,377
- Vietnamese – 28,293
- Greek – 21,211
- Italian – 19,466
- Arabic – 11,019
- Indo-Aryan languages (including Punjabi, Sinhalese and Hindi) – 8,632
- Turkish – 6,803
- Iranic languages (including Dari and Persian) – 5,640
- Macedonian – 5,344
- Khmer – 4,077.

Speakers of these languages comprised 73% of the low-English-proficiency population.

The Australian Bureau of Statistics reported that, apart from English and Indigenous languages, more than 160 languages are spoken in the home in Australia.¹⁸⁹

4.2 Modes of communication between health practitioners and clients

4.2.1 Health Practitioner shares language other than English

People who are not proficient in English often seek a general practitioner (GP) who is 'language-concordant', i.e. speaks the same language.

In an analysis of Bettering the Evaluation of Care and Health (BEACH) data, it was found that for 2006–07, 24% of GPs consulted in a language other than English and 2.9% of GPs consulted in a language other than English for more than half their consultations.¹⁹⁰ In two general practice studies, it was found that the most common communication strategy for people with low English proficiency was the use of a language-concordant GP or nurse.^{191, 192}

In two consumer-focused studies, it was found 60–90% of clients chose to consult a language-concordant GP.^{193, 194} A rural NSW study found language-concordant GPs provided health care for people of refugee backgrounds. However, the referring party was sometimes confused about the languages the client spoke. For example, one practice manager referred Dari-speaking refugees to a GP who spoke English and Arabic.¹⁹⁵

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

For example, the Victorian Transcultural Psychiatry Unit (VTPU),¹⁹⁶ the North West Melbourne Division of General Practice,¹⁹⁷ the Victorian branch of the Australian Medical Association¹⁹⁸ and the Pharmacy Guild of Australia¹⁹⁹ have produced directories of health practitioners who provide consultations in languages other than English. The Centre for Ethnicity and Health (CEH) has produced guidelines for recruiting, employing and working with bilingual staff in organisations.²⁰⁰

While language concordance between health practitioners and clients is an ideal communication approach, there is an insufficient number of multilingual health practitioners to meet language demands. For example, Australia supplements its GP workforce with international medical graduates but they originate primarily

from India and neighbouring countries and there are relatively few from the other main language groups present in Australia.²⁰¹

Melbourne physician Dr Thomas Schulz noted in his submission to this study that cost-efficiencies are apparent where GPs consult in languages other than English.

GPs who consult in a language other than English lead to a huge cost saving to the system. This is largely overseas trained GPs who are providing consultations in other languages and in many cases are the care providers for refugees and immigrants.²⁰²

There has also been activity in Victoria in relation to utilising the language skills of staff for non-clinical communication that does not require the use of a credentialed interpreter. For example, the 2010 Royal Women's Hospital Language Aide Pilot Project²⁰³ provided training and allowances to a small number of bilingual staff to enable them to provide non-clinical interpretation for clients; the project has not been formally evaluated.²⁰⁴ Furthermore, a course in language assistance has recently been accredited under the Victorian Registration and Qualifications Authority, which enables the development of the additional skills and knowledge needed to use existing language proficiency in English and a language other than English for oral language assistance in the workplace. The requirements for people who wished to participate in the course was that they possess spoken English and second language proficiency to a level that enables low-risk information to be conveyed, for example:

- giving directions
- making or changing appointment times
- selecting food menu options
- identifying forms.²⁰⁵

4.2.2 Informal interpreters

Health practitioners commonly use informal interpreters such as family members, friends and bilingual staff for health consultations. This may be due to their ready availability and the barriers associated with engaging credentialed interpreters discussed in Chapter 5, including a lack of understanding of potential risks associated with such an approach by practitioners (see Chapter 2), while the term 'untrained interpreter' is often used in the literature. This practice is more accurately described as 'informal' as there is no formal contractual arrangement between the health practitioner and the person who informally takes on this role.

Using informal interpreters is one of the most common strategies used by GPs.^{206, 207} Surveys have found that informal interpreters were used: by 80% of

practices weekly or more often; by 35% of practices daily; by 35% of GPs 'at every opportunity'; by 11% of GPs 'rarely'; and the most common reason given for not engaging credentialled interpreters (37%) was that family members were used.²⁰⁸

Using informal interpreters is also reportedly a common strategy used in maternity services and maternal and child health services (MCH).^{209, 210, 211} The Municipal Association of Victoria commented that this may be the case for several reasons:

When a parent presents to the MCH service and has a family member present the option of 'family member as interpreter' may be adopted and may be perceived as acceptable by family and nurse because the consultation can proceed immediately. Preference for using another family member may sometimes be due to the cultural or individual compliance with the male opinion being paramount. Or the man not wanting a male interpreter involved in a health consultation with his wife.²¹²

In Australian hospitals, it has been found family or friends are used anywhere from 20–61.5% of the time.^{213, 214, 215, 216} Clients also report the common practice of using untrained interpreters.^{217, 218, 219}

In a Melbourne hospital with high usage of credentialled interpreters, it was found that in situations where a credentialled interpreter was not available 71% of health practitioners reported they would use a client's family and friends and 52% would use bilingual staff.²²⁰

However, using informal interpreters is often not merely a fall-back position when a credentialled interpreter cannot be engaged; many health practitioners prefer to use family to interpret.^{221, 222, 223, 224} Clients similarly report that health services actively encourage them to use family members.²²⁵

4.2.3 Consultation in English without assistance

Many consultations between health practitioners and clients with low English proficiency proceed with no assistance.

A study of the experience of dialysis patients at Southern Health found that staff used no one for interpreting in 40% of the encounters.²²⁶ In a NSW hospital, it was found that in 7% of consultations where interpreter assistance was required no one was used to interpret.²²⁷

A 2012 Melbourne pilot study on perinatal depression in refugee communities found that most of their 15 participants 'recounted narratives of birthing experiences in Australian hospitals, either straightforward or difficult, without interpreters'.²²⁸

A recent study exploring the pregnancy and birth experiences of women of refugee backgrounds living in SE Melbourne reported:

a number of occasions an interpreter was not present at the home visits by domiciliary nurses or maternal child health nurses, despite the needs of the mother ... The KPMG evaluation of the Victorian maternal and child health services in 2006 found that the program was less accessible for women from CALD backgrounds due to language and cultural barriers.²²⁹

This is further supported by recent Melbourne-based research on parents from refugee backgrounds accessing maternal and health services where it was reported that interpreters were not always engaged service providers.

Participants reported that interpreters were not always used at appointments and that they often relied on using body language and facial expressions to communicate. Some participants reported that they replied 'yes' to the health professional even if they did not fully understand what was being asked.²³⁰

'Attempting to manage without help' was found in one Melbourne hospital to be a fall-back communication strategy for many health practitioners (46%) when a credentialed interpreter is not available.²³¹

A client-focused study regarding language services in health settings found: 'newly arrived participants had little or no English-speaking networks or no family networks at all. This meant that when language services weren't provided to these participants, these participants often utilised health services without being able to communicate at all.'²³²

'When I had a caesarean I did not have an interpreter. I was by myself in the room with the doctor and nurses. I would have liked someone there, especially to explain all the anaesthetic things and what was going to happen, actually for many things ...'

Nicolaou, M., (2011), The pregnancy and birth experience of women from refugee backgrounds living in the Outer East of Melbourne, EACH Social and Community Health, p 12.

4.2.4 Credentialed interpreters

The National Accreditation Authority for Translators and Interpreters (NAATI) is the national standards and accreditation body for translators and interpreters in Australia. It is the only agency that issues credentials for practitioners who wish to work in these roles in Australia.²³³ NAATI is owned jointly by the Commonwealth, state and territory governments.²³⁴

Credentialed interpreters may be accredited at four levels: Paraprofessional Interpreter, Interpreter, Conference Interpreter and Advanced Interpreter (Senior). There are various university level and TAFE courses that lead to qualifications from advanced diplomas through to postgraduate qualifications.

There is also ‘recognition’ for those languages where there is no testing available, where a person who is working as an interpreter in a community language can apply for ‘recognition’. However, there are generally no financial or other career incentives for higher qualifications or accreditation.

The University of New South Wales released a report commissioned by NAATI that recommends mandating training for all interpreters, including specialisation in health and other settings. It also recommends minimum educational standards qualifications or equivalent as the basis for ‘recognition’ for those seeking to become interpreters in languages where there is no testing available.²³⁵

The total revenue for NAATI for 2011-12 financial year was \$5,653,982, of which \$1,951,830 (34.5%) came from government sources.²³⁶ The Australian Government has provided base funding for NAATI of just over \$0.6 million annually.²³⁷ The Australian Government provided an additional \$0.6 million in 2011-12 to ensure NAATI could continue to deliver on its objectives, while a review of its future governance and funding arrangements was undertaken.²³⁸

4.3 Service delivery models

4.3.1 On-site interpreters

Health practitioners generally prefer on-site interpreting over telephone interpreting.^{239, 240, 241} The recent study of maternal and child health services in Melbourne reported that both the nurses and service users of a refugee background preferred on-site interpreters.²⁴²

A preference for on-site interpreters is typically based on an assessment of the clinical situation. For example, Victorian Foundation for Survivors of Torture staff engage on-site interpreters to establish rapport in the counselling setting and staff seek to engage the same interpreter for multiple appointments to promote continuity of care. The Australian Psychological Society strongly supports engaging on-site interpreters for psychological services.

Using face-to-face interpreters for psychological services is beneficial as sessions are likely to be lengthy and may involve multiple consultations. Onsite interpreting provides a more personal approach, particularly relevant for more complex and detailed issues which are likely to be discussed in a counselling context. There is increased opportunity for human interaction and visual clues to be accessed in the session.²⁴³

Health West Partnership noted further situations where clinician preference for on-site interpreters is based on clinical need.

Clinicians report an aversion to using a telephone interpreting services due to the difficulty in conducting consults in this way. In particular, mental health assessments, discussion of terminal diagnosis and patients with complex co-morbidities are extremely difficult to undertake using a telephone interpreter.²⁴⁴

However, if health practitioners choose to engage on-site interpreters as a matter of course, rather than in situations when the telephone modality would be unsatisfactory, this may lead to unnecessary deferral of treatment with risks to the health of clients and may be more costly.

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

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

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

4.3.2 Telephone interpreting

'[A] perspective from a small community, where face to face interpreters are often poorly accepted by refugee clients, for reasons pertaining to confidentiality. In this setting, I have found that there is often a large benefit attached to phone interpreters, and this is much appreciated by the clients.'

Correspondence with a GP based in Tasmania.

Telephone and on-site interpreters are subject to the same criteria to be credentialled.

Telephone interpreting provides the easiest access to credentialled interpreters. For example, in February 2012 TIS National connected to an interpreter in a major community language within 3 minutes on 99% of occasions.²⁴⁵

The telephone modality also provides the greater level of flexibility in relation to access, particularly for rural and regional health services. It also provides access to services for very small language groups where there may be only a limited number of interpreters available nationally. In some circumstances, engaging an interpreter by telephone (and from another location) can address issues of privacy where particularly sensitive issues are being discussed. Specifically,

'... patient confidence in the confidentiality of the consultation may be higher when the interpreter is not present, especially if physically present interpreters would otherwise be recruited from the patient's local community'.²⁴⁶ In one rural study, a number of participants in focus group discussions stated that they preferred the anonymity of the telephone service.²⁴⁷ Further, at Companion House, a service for survivors of torture and trauma, it has been found that:

... on ten occasions during the last five years, patients have declined to have the interpreter after these preparatory narrative discussions, citing concerns about confidentiality or lack of trust of the interpreter because of his or her background. These instances of rejecting a remote interpreter are very small compared with the number who have requested one in preference to an onsite interpreter for the same reasons.²⁴⁸

This is an important factor, given many clients will decline an offer of interpreter assistance if they have concerns regarding confidentiality as discussed in Chapter 5.

The engagement of telephone interpreters is generally less expensive than engaging an on-site interpreter,²⁴⁹ unless the telephone consultation exceeds 50 minutes.

St Vincent's Hospital noted the versatility of the telephone modality, with some exceptions.

Telephone interpreting has many advantages ... confidentiality, wider availability and cost effectiveness for consultations up to 15–30 minutes. It is not a suitable mode for patients who have hearing or cognitive impairment, are in a noisy environment (this may exclude emergency use sometimes) or where the consultation takes place over a large area (speakerphone limitations). Ultimately, in the absence of an onsite interpreter most information except for bad news (which should be imparted face-to-face) can be discussed with a telephone interpreter, unless the patient requires an Auslan interpreter for the Deaf.²⁵⁰

4.3.3 Choosing mode of service

Presently there is limited information on factors to consider when deciding which mode of service is the most appropriate for health consultations in the Victorian Government policies and procedures, and similar guidelines.²⁵¹ Health practitioners may benefit from advice about considerations they might have regard to when arranging interpreting services, for example:^{252, 253, 254, 255}

- initial visits
- consultation length
- the nature or complexity of the consultation, e.g. mental health, oral health, a difficult decision need to be made, when delivering bad

news, or sensitive issues such as sexual and reproductive health will be discussed

- when demonstrating the use of an appliance or requiring visual support for the consultation, e.g. a model, diagrams
- emergency or unplanned presentations
- the client's location, e.g. rural
- the client's language, e.g. a new-arrival language
- the client's gender
- the client is a child
- health issues of public health concern
- the client has a cognitive, psychiatric, or hearing impairment
- when in a noisy environment
- when clients are afraid or distraught
- when there are several people, e.g. family consultation.

Increased use of telephone interpreting in appropriate circumstances may yield various benefits, particularly:

- reducing the unnecessary deferral of treatment and the associated risks to client health
- addressing clients' confidentiality and sensitivity needs
- reducing interpreter travel time allowing the current workforce to produce more interpreted hours
- providing cost-efficiencies to organisations.

The potential for greater use of hands free telephones and videoconferencing, including Telehealth to facilitate in the delivery of effective interpreting services is explored in Chapter 6. This may have particular applicability as an alternative to face to face interpreting services in a variety of clinical settings.

Chapter 5: Barriers to the engagement of credentialed interpreters

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

This chapter describes a range of constraints affecting health practitioners and health services that are identified in the literature and in communications and submissions received for this study. It also looks at issues affecting the availability of interpreters that may frustrate the efforts of health practitioners who do attempt to engage credentialed interpreters.

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

... interpreting in health care is a complex communicative interaction between provider, interpreter and patients; parties which have unequal power relations and each of which has their own socially and institutionally mediated values, demands, beliefs, expectations and goals.²⁵⁶

If health practitioners do not provide interpreters as a matter of course, then it is left to clients to request a credentialed interpreter, and it is pertinent to indicate how their capacity to do so may be enhanced.

5.1 Inadequate funding

5.1.1 Commonwealth funding for credentialed interpreters for allied health practitioners in private practice

Medical practitioners and pharmacists receive fee-free access to interpreting services (Chapter 3). Practice nurses, radiographers and other medical technicians may also access fee-free interpreting using the TIS Doctors Priority Line under the direction of an eligible medical practitioner.²⁵⁷

However, allied health practitioners working in private practice providing Medicare-funded²⁵⁸ services do not have funded access to interpreting services.^{259, 260} This exclusion applies to psychologists, social workers, audiologists, dieticians, occupational therapists, optometrists, physiotherapists, radiographers, speech therapists, chiropractors, diabetes educators, exercise physiologists, osteopaths, podiatrists and Aboriginal health workers.^{261, 262} The availability of funded interpreting services under the Commonwealth Access to Allied Psychological Services (ATAPS) program is discussed below.

The cost of engaging unfunded credentialled interpreting services must be met by either the allied health practitioner or the client. In practice, this means that unless the client can afford to pay for an interpreter the practitioner is likely to decline the referral, or the client will attend and try to manage on their own, or with the assistance of a friend or family member.^{263, 264, 265}

The Australian Psychological Society (APS) has reported this to be the experience of their members.²⁶⁶ Further, in its submission to this study, the APS noted that the absence of Commonwealth funding was the single biggest access issue for clients accessing psychological services and outlined case examples illustrating the consequences, as follows:

Overwhelmingly the biggest issue facing clients of psychological services (and therefore psychologists) is the lack of access to Commonwealth funding for qualified interpreters. Psychologists, as well as other allied health practitioners, working in private practice, and including those providing Medicare funded services, do not currently have funded access to interpreting services.

The APS and its members have consistently raised this as an issue of access and equity for clients using psychological services. Some more recent case examples illustrate the consequences of this lack of access (and benefits in having used interpreters).

- There have been times when a child in the family has been used to interpret and this made the child anxious as the material discussed was frightening to them.
- A psychologist who was completely unaware of the specific cultural ritual (and had not used an interpreter) and had therefore inappropriately assigned a psychotic diagnosis to a client from a CALD background.
- The psychologist who did not use an interpreter, but had made a diagnosis of psychosis for a refugee client; however, when the refugee was referred to another psychologist who used an interpreter no psychotic behaviour diagnosed.
- The psychologist who intended to see asylum seekers in her practice for no charge but was not able to do so due to not having access to funded interpreters.
- The case of a client who was misdiagnosed with schizophrenia (as a health professional did not use an interpreter) but this was later (correctly) diagnosed as complex PTSD [post-traumatic stress disorder] as she had seen her whole family killed before her. The

client then had to retell her story and this was, not surprisingly, re-traumatising for her.²⁶⁷

The Refugee Council of Australia (RCOA) also noted the need for fee-free interpreting service for mental health services.

RCOA strongly supports a recommendation that access to fee-free TIS be expanded to allied health professionals. This has been called for across the country. A particularly strong theme from last year's consultations is the need for greater accessibility and use of interpreters in the mainstream mental health sector.²⁶⁸

The South Eastern Melbourne Medicare Local reported that the gap in funding has implications for GPs referring clients to allied health professionals, where time is spent locating a culturally competent practitioner who speaks a particular language before referral.

There needs to be discussions around the time spent on finding allied health professionals who are culturally competent and can speak a particular language before referral. This time spent would be reduced if we knew interpreting services were accessible by non-medical practitioners. This would increase choice for clients, reduce waiting time and improve timely access.²⁶⁹

The Commonwealth Access to Allied Psychological Services (ATAPS) program does include the cost of use of interpreting services in its funding to Medicare Locals, as is explicitly stated in the program's operational guidelines.²⁷⁰ However, there are concerns that GPs who refer patients and health professionals to whom referrals are made may not be aware of this, and that interpreters are not engaged by many ATAPS-funded services, despite culturally and linguistically diverse communities being identified as a priority population group in the ATAPS guidelines.

The operational guidelines prescribe 'minimum requirements for a referral to an allied health professional to deliver ATAPS services', such as 'personal details', whether the patient lives alone, and any medication prescribed for the person.²⁷¹ The specified requirements do not include providing information including 'interpreter required' and 'language spoken'.

Medicare Locals take different approaches to determining whether or not patients who are referred require interpreters. This study examined referral forms of three Medicare Locals. Two asked the general practitioner (GP) to indicate whether the patient required an interpreter and if so what language. The third asked how well the patient speaks English but not whether an interpreter is required.

While the operational guidelines 'encourage ... Medicare Locals to consider model suitable for [priority groups]' they do not provide advice about the types of models or where Medicare Locals can seek such advice. It would be helpful

constructive for the Department of Health and Ageing to provide more detailed advice in the guidelines and in particular that Medicare Locals should as a matter of course require GPs to indicate whether referred patients require an interpreter and if so the relevant language.

Recommendation 5.1: The Australian Government should fund access to fee-free interpreting services for all allied health practitioners providing Medicare-funded services.

Recommendation 5.2: In the next edition of the Operational Guidelines for Access to Allied Psychological Services (ATAPS) program, the Department of Health and Ageing should strengthen the advice provided to Medicare Locals to promote engagement of credentialed interpreters when required.

5.1.2 Access to fee-free interpreting for non-PBS pharmaceutical services

Pharmacists prescribing PBS medications have access to fee-free interpreting. (Chapter 3) However, pharmacists cannot use the fee-free interpreting services for non-PBS prescription medications and non-prescription medicines. This may be a significant issue of concern when pharmacists are dealing with clients with particular health conditions or clients using medicines that may interfere with prescription medication. As advised by the Pharmacy Guild of Australia:

... there are a number of prescription medicines which are not covered by the PBS and supplied as private prescriptions. In 2009, private prescriptions represented 7.2% of community prescriptions. In addition to this, there are many non-prescription and complementary medicines available through pharmacies and other retail outlets. While regarded as lower risk, these medicines can interact with prescription medicines and may also be contra-indicated in people with certain health conditions, such as diabetes, asthma, heart disease or blood-pressure. Many of these medicines should not be used in pregnant or lactating women.²⁷²

The Pharmacy Guild concludes that 'It is important that pharmacists have access to fee-free interpreting services for all medicines and professional pharmacy services.'²⁷³ There is merit in this view.

Recommendation 5.3: The Australian Government should fund additional access to fee-free interpreting services for pharmacists working in private practice for non-PBS prescription medications and non-prescription medicines.

5.1.3 Medical practitioners

While medical practitioners have access to fee-free interpreting via TIS, the low take-up rate has been attributed by many to insufficient financial remuneration for practice costs and additional consultation time required.

Length of consultation

Many health practitioners believe working with a credentialled interpreter during a consultation takes extra time,^{274, 275, 276, 277, 278, 279} anywhere up to twice as long.^{280, 281} In one study, 54% of GPs believed the extra time needed to use phone interpreters was too long to be practical in general practice.²⁸² This is exacerbated if the interpreter is running late, as appointments will either need to be rescheduled or will run over time leading to delays for other appointments.²⁸³

Studies of the length of time of consultations using interpreters have been identified in the international literature, but not Australia. These findings cannot be directly applied to Australian healthcare settings because the studies do not relate to services provided only by credentialled interpreters.^{284, 285, 286}

Submissions received from stakeholders noted the additional consultation length when working with credentialled interpreters for medical practitioners and concerns were expressed regarding levels of financial remuneration through the Medical Benefits Schedule (MBS).

The RACGP Standards for general practices, which form part of general practice accreditation, require that practice systems include consultations of appropriate length for clients with complex needs, whereby 'longer consultations may be required if the patient has complex medical needs, complex communication needs, impaired cognition, or if the patient's carer or translator is present'. Further, 'Although it is difficult to predict how much time will be needed for a particular consultation, this criterion requires that practices have systems that predict and endeavour to meet this need.'²⁸⁷

There is no specific statement in the MBS regarding the time taken to organise the services of an interpreter or the time taken for an interpreted consultation.

However, the introduction of timed assessment and general consultation items allows GPs to charge for a longer consultation even if there is only one health concern being investigated, which allows the additional time taken when working with an interpreter to be recognised (for example, Level C MBS item number 36).²⁸⁸

A number of submissions suggested that the current MBS system provides inadequate incentives for doctors to offer longer consultations. The Refugee Council of Australia captured this in their response as follows.

GPs are reluctant to engage interpreters because refugees requesting interpreters are often bulk billing patients and GPs do not consider additional payment under Medicare sufficient for longer appointments when an interpreter is engaged. RCOA have heard reports that some GPs are not providing services to refugee clients for this reason or because they do not believe there is any additional payment for seeing a patient with an interpreter.²⁸⁹

These concerns were reiterated by the Australian Institute of Interpreters and Translators.

GPs, particularly those working for big multi-practitioner health centres, are tightly managing their time and even if they are aware of the TIS Doctors Priority Line, they may be using it as a last resort for economic reasons.²⁹⁰

For private practices running a private billing system, as opposed to a bulk billing system, clients with low English proficiency may incur a greater out-of-pocket expense for a long consultation than for a standard consultation.²⁹¹

The remuneration of longer consultations in which interpreters are engaged appears particularly problematic with respect to specialist physicians. This was noted in the submission of Dr Thomas Schulz:

Although GPs can use long consult item numbers when using interpreters, this is not clearly the case with specialists. A patient with a complex number of medical problems can be billed for a longer consultation. It is not clearly stated that the use of an interpreter allows for the billing of a complex consultation, although use of an interpreter clearly adds both time and complexity.²⁹²

The current provisions for specialist consults allow for two item 133s (19 minutes or more) in a 12-month period following the use of item 132 (45 minutes or more). In follow-up consultations using an interpreter, this only represents 10 minutes of conversation, which in many circumstances is insufficient when a client has complex health concerns and/or limited health literacy.

Recommendation 5.4: In order to allow for adequate consultation time for specialist physicians when a client requires interpreting services, the Australian Government should permit physicians to charge for four item 133s under the Medical Benefits Schedule over the calendar year.

Administration time spent engaging interpreters

The NHMRC advises that guidelines for reception staff who make appointments should include enquiring whether the patient requires access to a credentialed interpreter.²⁹³

The time taken to book credentialed interpreters represents an expense to practices in clinician and/or front-of-house staff time liaising with multiple interpreting services in order to schedule appointment times that align with the respective schedules and availability of interpreters in the preferred language of patient.^{294, 295, 296, 297, 298, 299} Anecdotally this is particularly the case for new-arrival languages where fewer credentialed interpreters are available.

Further, practices may incur other expenses related to the engagement of credentialed interpreters, including reconciling accounts, the purchase of equipment for telephone interpreting and other set up or associated costs and the training of clinical and front-of-house staff.

Australian researchers have recommended the introduction of an MBS item number or a practice incentive payment to address the costs associated with working with a credentialed interpreter.^{300, 301, 302} The Health West Partnership recommended in its submission an MBS item number for interpreter use.³⁰³

Melbourne GP Dr Joanne Gardiner has suggested an MBS item number in addition to the 'bulk billing for children and pensioners [item number 10990]'. Currently this has a scheduled fee of \$6.90,³⁰⁴ which GPs are able to charge in addition to other consultation items whenever they bulk bill a child or pensioner. Dr Gardiner believes a small fixed amount between \$6–10 in addition to the bulk billing scheduled fee would promote bulk billing, the engagement of a credentialed interpreter and a reduced likelihood of costs being passed on to clients with low English proficiency. This standard item number could be applied to all consultations, irrespective of the length or complexity involved.³⁰⁵

In Norway, GPs and specialists in private practice can claim a financial rebate for engaging credentialed interpreters. Under Norwegian law, a person with low Norwegian or English (English is a common language spoken in Norway) proficiency has a right to a credentialed interpreter for health consultations. There is a specific item number attached to working with an interpreter, which provides a rebate of 230 kroner (equivalent to \$A38) for each standard consultation. Claiming this rebate precludes GPs and specialists from also claiming the long consultation item number for working with an interpreter during a health consultation. However, the incentive payment for using an interpreter in combination with the claim for a standard consultation item number is greater than the extra payment for claiming a long consultation item number. GPs and

specialists may, however, choose to claim the long consultation item number when a credentialed interpreter is engaged.³⁰⁶

The failure for general practitioners (GP) and others to engage interpreters when required may represent a cost shift to other services. Victorian Refugee Health Nurses report spending a lot of time advocating for their clients to ensure that other health practitioners use interpreting services during consultations with their clients.* Foundation House staff report similar levels of advocacy.

Recommendation 5.5: The Australian Government should review costs associated with engagement of interpreting services by general and specialist medical practices and based on that review consider any appropriate Medical Benefits Schedule changes.

5.1.4 Oral health services

There are shortfalls in Commonwealth funding to health services for interpreting services, generally in public healthcare settings. Of particular concern is the recently announced oral health package.

Australian research into access to dental care for people of refugee backgrounds provided by public dental services has found that access to interpreting services is limited and a contributing factor for those of a refugee background not using dental services.³⁰⁷

A collaborative project carried out by the Council of Social Service of NSW (NCOSS) that surveyed 212 NSW human service non-government agencies in late 2008 found that access to interpreting services was a factor affecting client access to dental services.³⁰⁸

Clearly engagement of credentialed interpreters is crucial to the provision of adequate oral health care.

Reduced access to services based on lack of availability of interpreters is concerning. Refugees have high reliance on bilingual health professionals and interpreters for communication. If dental health for refugees is to be meaningfully tackled, interpreter services need to be made available to all dental health providers caring for refugees.³⁰⁹

In the 2012–13 federal budget, \$515.3 million was allocated to oral health over four years. \$345.9 million of this allocation will be directed towards treating patients on waiting lists over the next three years. The remaining \$169.4 million will be directed to increasing the capacity of the dental workforce, improving regional dental infrastructure, coordinating the provision of pro bono dental health services to low-income Australians, and promoting oral health.³¹⁰

In addition to the \$515 million funding injection, a further \$4 billion was announced as a part of a six-year Dental Health Reform package, replacing the Medicare Teen Dental Plan and the Chronic Disease Dental Scheme. The package includes:

- \$2.7 billion for subsidised dental care for around 3.4 million children
- \$1.3 billion for better access to public dental care for adults on low incomes under a national partnership agreement for around 1.4 million additional service
- \$225 million targeted to improving dental infrastructure and increasing the capacity of the dental workforce outside metropolitan areas.³¹¹

Information regarding the provision of funding under this program for interpreting services was not available.

Recommendation 5.6: The Australian Government should include access to fee-free interpreting services for oral health services funded under the Dental Health Reform package announced in 2012.

5.1.5 State funding for credentialled interpreters for organisations

The two main mechanisms used by the Victorian Departments of Health, Human Services, and Education and Early Childhood Development for the provision of language services are access to a credit line or direct funding (Chapter 3). As indicated below, the amount of funding in each is less than required to meet the level of need for interpreting services.^{312, 313, 314, 315, 316}

The requirement for interpreting services in Victoria will increase with the growth in the number of people of non-English-speaking background who are ageing and require additional health services,³¹⁷ and significant increases in migration, including skilled stream and humanitarian entrants. In the skilled stream, family members may have poor English proficiency even if the primary applicant is proficient in English. In 2012–13, the humanitarian program increased from 13,750 places to 20,000 nationally, plus 4,000 dedicated family migration places for sponsors who are humanitarian visa holders.

Organisations report that they deal with the shortfall in funding by topping up the budget for interpreting services from other sources,^{318, 319} and rationing existing resources³²⁰ by, for example, using quotas or waiting lists.^{321, 322}

5.1.6 Public hospitals

A Lebanese Muslim woman, was brought into casualty confused and severely ill with acute renal failure. She had both end-stage renal failure and a psychiatric illness. She was admitted to a general medical ward. It was four days before an interpreter was called to come to the ward. Once during an agitated period, a male Arabic-speaking taxi driver who happened to be on the ward was used to interpret.

Blackmore, D., (1998), Cross Cultural Issues in Health, Australasian Psychiatry, Vol. 6 (6), p 294.

Most public hospitals employ in-house interpreters and supplement their services with commercial interpreter providers. Evidence suggests there are many occasions when emergency departments do not access the service at all. Studies of emergency departments in NSW and Queensland hospitals indicates credentialled interpreters were engaged 6–33.3% of the time.^{323, 324, 325, 326}

G21 Geelong Region Alliance noted in its submission to this study that health practitioners tend not to use interpreters for unplanned presentations, especially for accident, emergency and pharmacy.³²⁷

In a Victorian study of client experiences across health settings, only one in 86 participants with limited English proficiency had been offered and engaged a credentialled interpreter in an emergency department.³²⁸ The Refugee Council of Australia has reported on the need for emergency departments to engage credentialled interpreters.³²⁹

Studies indicate considerable variations between public hospitals in the frequency of engagement of credentialled interpreters by the inpatient services.³³⁰ Furthermore, credentialled interpreters are significantly more likely to be used when patients have a high or moderate clinical complexity.

A study of the use of professional interpreters by dialysis patients of Non-English Speaking Background (NESB) at a major teaching hospital in Melbourne found that

- Professional interpreters were used in only 25% of observed interactions between staff and dialysis patients of NESB
- There was no evidence of interpreter use in 32% of the medical records of dialysis patients of NESB who were admitted 24 months prior to the study.³³¹

A 2011 study of the Prince of Wales Hospital (NSW) found that ward pharmacists ‘rarely used interpreters’, but that nurses engaged credentialled interpreters routinely for consent issues and to identify at-risk clients. However, ‘Interpreters were not used when patients were interviewed about their medication histories or to explain how they should take their medicines while in hospital.’³³²

In 2002, staff at Northern Health were found to have engaged credentialled interpreters 90% of the time with individual clients, but much less frequently with groups (27%) and when speaking with people by telephone (31%).³³³ The Royal Women's Hospital reported for the financial year 2010–11 that on 91% of occasions clients who presented at the hospital and were identified as requiring interpreting services were provided with a credentialled interpreter.³³⁴

VTPU reported a 'lack of interpreting during admission to inpatient facilities up to the point of the mental health review; and lack of engagement of interpreters at critical points in the pathway through care'.³³⁵

It has been found that credentialled interpreters are significantly more likely to be engaged when the client presents with high or moderate clinical complexity, for example invasive surgery, explanation of major health events, and when serious illnesses are diagnosed and treated.³³⁶ However, this study also found that on a number of occasions even clients with moderate to high clinical complexity were not provided with credentialled interpreting services.³³⁷

A Victorian consumer study found many participants had rarely received interpreting services when consulting with a specialist in an outpatient setting. A small number of clients said when they had regularly seen the same specialist as an outpatient they had mostly been provided with an interpreter.³³⁸ Similar findings have been reported in other states.³³⁹

A number of hospitals have reported not being able to employ the required number of in-house interpreters due to budgetary constraints or exceeding allocated budgets for interpreting services. This may be in part a reflection of the budget priorities within the hospital, within a context of overall budget considerations. However, it is also in part a reflection of inadequate funding for interpreting services in public hospitals.

Peter MacCallum Cancer Centre relies solely on commercial interpreting services and has found that, with increasing demand for services, spending on language services exceeds their allocated budget. 'We have seen an approximately 30% increase in interpreter occasions of service over the last five years and our spending on language services exceeds our allocated budget figure every year.'³⁴⁰

Some hospitals have expressed concern that current case mix funding is not based on actual need or level of service provided.

For example, Mercy Health noted a need for a loading, i.e. WIES co-payment for interpreting services as a component of pricing for public hospital services.

Systematic change that would see funding based on real needs, i.e. having a specific WIES [Weighted Inlier Equivalent Separation] code for interpreters that

would bring additional resources to hospitals, may be an added incentive that would encourage better use of interpreters. Currently a similar funding arrangement is in place for public health services provided to Aboriginal and Torres Strait Islander people.³⁴¹

This sentiment was reiterated by Eastern Health.

The current funding levels are not based on individual client presentations with respect to identified health service language need. The funding is also based on acute hospital presentations and does not include the needs of sub-acute and community based clients.³⁴²

Victorian hospitals will move from case mix funding to activity-based funding under the new National Health Reform Agreement (NHRA) (Chapter 3). There are currently no price loadings for interpreter use under the NHRA. There is substantial evidence throughout this report that warrants the investigation of price loadings for the necessary engagement of credentialed interpreters under the NHRA.

Failure to engage a credentialed interpreter was considered by HREOC to be a contributing factor to the involuntary commitment of a Bosnian refugee with an intellectual disability who was misdiagnosed as having PTSD.

HREOC, (2005), Not for service: experiences of injustice and despair in mental health care in Australia, p 262.

Recommendation 5.7: The Independent Hospital Pricing Authority should include price loadings for the provision of interpreting services as a component of the national pricing for public hospital services.

5.1.7 Mental health services

One former immigration detainee had been involuntarily admitted to a local mental health service due to suicidal ideation. He was placed in a high-dependency unit (secure facility) due to risk of self-harm. When our worker arrived, he had been there for over an hour without the service using an interpreter to explain why he was being detained. He was extremely distressed and did not understand why he was being locked up. When queried, the service stated an interpreter was booked for when the psychiatrist was available later that afternoon and they would explain then. There appeared very little regard or understanding for his basic need to be informed and the impact of being detained on his mental state. As a result of continued bad experiences, the client refuses all contact with any health services due to serious and well-founded mistrust in our system.

A Victorian Service Provider Participant in the Refugee Council of Australia Annual Intake Submission Community Consultations 2011.

The Refugee Council of Australia conducts annual consultations about refugee and humanitarian matters and noted ‘a particularly strong theme from last year’s

consultations is the need for greater accessibility and use of interpreters in the mainstream mental health sector'.³⁴³

The Victorian Transcultural Psychiatry Unit has reported staff from Crisis Assessment and Treatment Teams 'acknowledged that they should book interpreters more frequently with [clients] who were sometimes admitted involuntarily when staff were uncertain of the client's mental state'.³⁴⁴

A study of admissions during 1996 to an acute unit of aged psychiatric services for north-west Melbourne found that interpreters were used in 62.3% of those clients for whom English was not their preferred language; involuntary admissions were significantly higher for clients from a non-English-speaking background (NESB) who required an interpreter, than for those NESB clients who did not require an interpreter.³⁴⁵

5.1.8 Community health centres and Australian College of Optometry

Evidence obtained for this study suggests that the funding for interpreting services to community health centres is inadequate. Table 3 describes the information received:

Table 3: Community health language services funding shortfalls

Financial year	Organisation	Expenditure	Funding	Shortfall
2011-12	Merri Community Health Services Ltd	\$133,204	\$85,990	\$47,314
2010-11	ISIS Primary Care	\$600,000	\$120,000	\$480,000
	Western Region Health Centre	\$344,000	\$94,000	\$250,000
	Doutta Galla Community Health Service	\$249,000	\$109,000	\$140,000
	Plenty Valley Community Health	\$131,000	\$52,000	\$79,000
	Merri Community Health Services Ltd	\$111,000	\$82,000	\$29,000

Source: Information provided by listed Community Health Centres

Community Health also received funding from the Victorian Dental Health Program allocated to centres for language services in relation to oral health services based on reported usage data during the transition period to a new funding model in 2011-12. Initial agency allocations were based on actual 2010-11 reported usage of the language services item and were to be for the transition period of two years. According to the Department of Health Guidelines, these allocations were to have been reviewed and adjusted using interpreter data when 'need an interpreter' is indicated during the transition period.³⁴⁶

However, advice received from oral health agencies is that this funding ceased in 2012–13.

The Australian College of Optometry (ACO) places Victorians who require an interpreter on a specific waiting list and notes that low-English-proficiency clients will wait longer to receive services.³⁴⁷ The ACO receives \$24,000 for interpreting from Department of Health and allocates \$12,000 from other sources, which is significantly less than the estimate of \$50,000 annually that would be required to respond to existing demand.³⁴⁸

The funding model for the Refugee Health Nurse program (see Chapter 2), provides a useful model for making funding allocations for other service types into the future, i.e. all new service funding has an allocation for interpreting services that is provided to services through direct funding or credit line relative to increase targets.

5.1.9 Credit line funding

A number of services reliant on monthly credit line funding for interpreting reported that the credit lines are commonly exhausted prior to the end of the month, so that they are unable to provide access for this period (see Chapter 3 for explanation of credit line).

Sunraysia Community Health Services in Mildura has reported that ‘Our credit line regularly runs out prior to the end of the month; sometimes it runs out in the first week.’³⁴⁹

Further, Bendigo Health has reported, ‘Limitations to language services credit line funds can be shown by the fact that the provider often advises that this funding has already been exhausted for the month on the first or second day of that month’.³⁵⁰

Similarly, Gateway Community Health noted that the Hume Rural Region credit line is regularly exhausted prior to the end of the month. For the first half of 2012 the agency had to allocate \$8,047 from other sources to maintain access to interpreting services.

The Municipal Association of Victoria has reported similar funding shortfalls with the DEECD credit line.

Although the DEECD has a credit line funding for interpreters for early years services this funding is spread across all EY [early years] services – MCH [Maternal and Child Health], kindergartens. The monthly allocation is regularly exhausted well before the end of the month, particularly in municipalities like Dandenong, Brimbank and others with a high CALD population and new arrivals.³⁵¹

AMES has noted that the limited time allocated for maternal and child health consultations does not encourage MCH nurses to work with interpreters.³⁵² The Municipal Association of Victoria has recommended that 'MCH service funding (be adjusted) to allow additional time per standard consultation when an interpreter is involved, e.g. double time'.³⁵³

This issue is longstanding, as Allen Consulting in 2002 found credit line funding 'may be exhausted prior to a booked appointment taking place'.³⁵⁴

Recommendation 5.8: The Victorian Government should review the funding model for Maternal and Child Health Services to take account of costs associated with using interpreting services, including administration and clinical time.

Recommendation 5.9: The Victorian Government should reinstate funding for interpreting services for public oral health services.

Recommendation 5.10: The Victorian Government should ensure that funding for interpreting services for community health services and the Australian College of Optometry is commensurate with demand, including direct allocations and credit line access.

Recommendation 5.11: The Victorian Government should provide a budget allocation for interpreting services associated with all new funding for health services, similar to the model used for the Refugee Health Nurse program.

5.2 Staff awareness and service protocols

5.2.1 Lack of awareness of interpreting services by health practitioners and front-of-house staff

Evidence reviewed for this study suggests that many health practitioners and other staff working in various health settings may not know about the availability of interpreting services at all, or be unfamiliar with important aspects of how the services operate.

Studies of Australian doctors and other personnel in general practices in 2008 and 2009 found that 36–39% of those surveyed were unaware of the TIS National Doctors Priority Line.^{355, 356}

If agencies employ casual staff or have a mobile workforce, staff may not be aware that the organisation at which they are working offers interpreting

services. For example, AMES noted the impact staff mobility has on the awareness of interpreting services by staff.

Changing staff/staff mobility is an issue for service providers so that the person with the knowledge and information about how to contact and work with an interpreter may not always be on the spot, information and knowledge needs to be deeply embedded at service provider level. Information and procedures for getting an interpreter need to be on hand as part of practice procedures including how they will fund the use of an interpreter. For large organisations this information needs to be in standard operating procedures or similar. All staff need induction on the process of getting an interpreter and how to work with one.³⁵⁷

Health practitioners and front-of-house staff who are aware may have misconceptions about the types of services provided. A number of studies have reported that practitioners were confused about aspects of TIS National services such as their entitlement to free access,^{358, 359, 360} and that telephone interpreters can be utilised³⁶¹ and accessed on demand^{362, 363} and after hours.³⁶⁴ One rural study found even practices geared towards refugee health misunderstood the TIS National service, asking clients to arrange their own interpreters, which meant that clients were required to pay for a service that is free for the doctor to access.³⁶⁵

One Melbourne study conducted across three health service campuses found hospital ward pharmacists and community nurses were unaware of telephone interpreting services.³⁶⁶ A study of a Melbourne hospital found that 17% of health practitioners from a variety of disciplines were unfamiliar with the available interpreting services. As a consequence, these practitioners were less likely to engage credentialled interpreters and were more likely to use family or friends as interpreters. The study also reported a lack of protocols and guidelines for interpreter use negatively affected their engagement of credentialled interpreters.³⁶⁷ It has also been reported that mental health practitioners are often unaware of the processes in which to use interpreting services when they are available.³⁶⁸ Knowledge gaps have also been reported in Victorian community health and Queensland.^{369, 370}

It follows that increasing health practitioners' awareness of interpreting services and how to access them makes it more likely they will use the services.³⁷¹

Since late 2007, TIS National has promoted the Doctors Priority Line with activities including service information packs for practices, online registration and other promotional activity.³⁷²

RACGP accreditation standards and TIS National promotional activities may be contributing factors to an increase in GP registrations for TIS National and smaller though still marked increases in total demand for TIS National services (see Table 4). However, there is evidence of significant underutilisation of

interpreting services by medical practitioners. An Australian study reports that one in 35 Australians had low English proficiency in 2006–07; in this period this population visited a doctor more than 3 million times; and only 0.97% of these Medicare-funded consultations included interpreting services.³⁷³

There has been a significant increase in the number of requests for interpreting services by GPs between 2006–07 and 2010–11.

Demand for TIS National fee-free interpreting services for medical practitioners (specialists and GPs) and pharmacists in private practice almost doubled in the period between 2005–06 (39,905) and 2010–11 (75,730). The proportion of total demand in 2010–11 was: 70% GPs (53,389); 29% specialists (21,928); and 1% pharmacists (413). In that year, specialists used on-site interpreters three times more often than telephone interpreters. In contrast, GPs used telephone interpreters twice as often as on-site interpreters.³⁷⁴

This study located only one major quantitative study that sought to assess whether and to what extent interpreters are not engaged when their employment seems indicated. This analysed census, Medicare and TIS National datasets and found that After adjusting for language concordant consultations, this study estimated that in 2006–07 an interpreter employed by TIS National was used in less than one in 100 consultations where the patient had limited proficiency in English.³⁷⁵

However, a review of more up-to-date data indicates that the rate of use is still unacceptable. In 2010–11, ABS data reports that there were 654,964 Australians with limited English proficiency,³⁷⁶ and that on average Australians visited a GP five times in that year.*³⁷⁷ This would suggest that people with low English proficiency visited a general practitioner on 3,274,820 occasions and that on 53,389 visits an interpreting service was provided by TIS, i.e. on 1.6% of visits.

Underutilisation of credentialled interpreters by specialist medical practitioners has also been reported.^{378, 379, 380}

Only 1,200 of the more than 5,100 community pharmacies have registered to use the TIS National service since becoming eligible in 2007.³⁸¹

* This is calculated based on a total ABS reported Australian population of 21,504,688, and 107,629,331 GP services provided out of hospital and charged to Medicare. Indicating an average of five visits per year for the Australian population. This figure has not been adjusted for age or other factors that may impact on service access, so should be considered indicative.

Table 4: TIS National GP registrations and GP service requests, 2005–06 to 2010–11

Year	GP registrations	Increase in GP registrations	Total GP requests for TIS service	Increase in GP requests for TIS service
2005–06	300		25,684	
2006–07	438	46%	30,612	19%
2007–08	608	39%	33,317	9%
2008–09	1,275	109%	36,356	9%
2009–10	2,229	75%	43,975	21%
2010–11	2,399	8%	53,389	21%

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

5.2.2 Inaccurate assessment of English language proficiency

'The receptionist advised that despite the clients expressed need for an interpreter, the psychiatrist had cancelled the interpreter, believing that the client's English was good enough ...'

Queensland Accessing Interpreters Working Party, (2008), A Matter for interpretation: the case for access to high quality accredited interpreting and translating services and cultural competence in Queensland services working with culturally and linguistically diverse people, p 9.

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

A New Zealand study of interpreter use by health practitioners found one of the reasons health practitioners reported not using interpreters was a misjudgement of their clients' language ability.³⁸² In rural NSW, it was found health practitioners who used no interpreter assessed the clients as 'spoke English' without first checking their comprehension level or asking them if they wanted an interpreter.³⁸³

In a Victorian study, 37% of GPs reported they did not engage a credentialled interpreter because there was no need, but the accuracy of their assessment is questionable as 9% of the population in the catchment area where the GPs worked had poor proficiency in English.³⁸⁴ Clients have reported doctors have told them they do not need an interpreter.³⁸⁵

Clients may also be prone to mistakenly believe their proficiency in English is adequate for certain situations and therefore decline interpreter assistance (see 5.4.3). In its submission, St Vincent's Hospital noted the subjectivity of assessing English language proficiency.

Language proficiency is subjective and not recorded on the patient registration dataset which is absolute (either Yes/No). This means there is often no record of which patients who generally need an interpreter for medical consultations consider themselves to be proficient enough in English not to use an interpreter at times, since this depends on their perception of the nature of the appointment.³⁸⁶

Eastern Health noted in its submission the challenges staff face determining whether clients require an interpreter and their preference. Eastern Health therefore encourages clients to indicate their need for interpreting services.

Healthcare staff are not linguists with the training or skills to determine proficiency with the English language in the health context. While there have been checklists devised to assist staff over the years, at Eastern Health, we have focused on encouraging patients and their families to identify their 'preferred language', based on self-identified language that the person feels most comfortable communicating in on a daily basis. This approach prevents the reliance on staff judgement, which could be influenced by many factors.³⁸⁷

Victorian Government policy recommends that health practitioners initiate a short informal interview asking for basic details regarding the client's reason for attending and information about his/her background and English language proficiency.³⁸⁸

As noted by Eastern Health, a number of English proficiency assessment tools and guidance materials have been developed by various organisations nationally, suggesting various ways of assessing English language proficiency. Examples include the following.

- An emergency department assessment tool has been developed as a quality assurance measure and is used in Western Sydney to assess the need for an interpreter.³⁸⁹
- The Goulburn Valley Primary Care Partnership has developed an English language proficiency test for healthcare organisations.³⁹⁰
- The Victorian Transcultural Psychiatry Unit has developed an English proficiency scale to determine which clients should have an interpreter engaged.³⁹¹
- The Queensland Government has developed a tip sheet for health staff that includes cues that indicate a client's level of English language proficiency.³⁹²

A study of an English proficiency assessment tool developed in the US found that it accurately identified clients most likely to benefit and screened out those who are unlikely to benefit from interpreting services. The tool uses a US census

English proficiency question: ‘How well do you speak English? (very well, well, not well and not at all)’, followed by ‘In general in what language do you prefer to receive your medical care.’ Clients answering ‘Not at all’ or ‘Not well’ to the question and those answering ‘Well’ but indicating a language preference other than English were assessed as most like to benefit from interpreting services.³⁹³

The review of the assessment tool found it to be ‘a practical, accurate method for screening patients for their need for linguistic access services that will make it easier for health care organisations to collect the data they need to adequately plan for and provide linguistic access services to the LEP [low English proficiency] populations’.³⁹⁴

In terms of offering interpreter assistance, the Victorian Centre for Culture, Ethnicity and Health recommends that health practitioners ask clients directly whether they require or want an interpreter.³⁹⁵ The Californian Academy of Family Physicians recommends an indirect approach: ‘In what language do you (or the person for whom you are making an appointment) prefer to receive your health care?’³⁹⁶ While this seems simple, it has been raised that health practitioners can feel uncomfortable directly asking whether a client may like the assistance of an interpreter. For example Eastern Health noted, ‘There appears to be a reluctance to ask the question for fear of embarrassing the patient and/or their family.’ It may also be the case that some clients may take offence to a direct offer of assistance if they consider that the health practitioner is misjudging their English proficiency.

In light of these factors, guidance on the most appropriate approach to discussing with the client their need for an interpreter is indicated.

‘The first time I was asked if I wanted an interpreter but thought because I have a little English I should say no. I did not realise that a lot of information I did not understand and then I felt embarrassed and did not ask for one after that, but it would have been good.’

Nicolaou, M., (2011), The pregnancy and birth experience of women from refugee backgrounds living in the Outer East of Melbourne, EACH Social and Community Health, p 12.

Recommendation 5.12: The Victorian Government should within relevant language services policy and practice guidelines include:

- directions on determining clients’ need for interpreting services
- a decision tree on whether to use on-site, telephone or videoconferencing for any particular consultation
- a self-assessment checklist for organisations to use when reviewing their language services provision
- advice about the most appropriate approach to discussing with the client their need for an interpreter.

5.2.3 Professional deferral to presumed client preference

Health practitioners often believe clients prefer having family or friends interpreting in health consultations.^{397, 398} The Australian Institute of Interpreters and Translators advised that: 'We have anecdotal evidence of some GPs holding the view that patients are more comfortable communicating through a family member or bilingual friend than a stranger.'³⁹⁹ GPs have also expressed concern that engaging a credentialed interpreter may undermine the clients' family support.^{400, 401}

However, research suggests the majority of clients prefer credentialed interpreters be engaged as they 'ensure both basic and thorough understanding; ensure essential information was not missed; reduce anxiety; enable privacy and full understanding and to reduce embarrassment around private or serious health issues'.^{402, 403}

Some food for thought: 'A patient arrives with a suspected broken bone and requires an X-ray. The radiographer on duty is busy and the patient is required to wait for one hour before they can be X-rayed. The patient's spouse (or for example, another member of staff not employed as a radiographer) offers to help and says "Take me to your X-ray machine, I'm a qualified radiographer and I'll take the X-ray." How would you feel about this? Would you let them do this? Of course not. So why allow a spouse, friend or any bilingual staff member to interpret?'

NSW Health Care Interpreter Service, (2006), SWAHS Health Care Interpreter Service Users Guide, p 15.

5.2.4 Lack of understanding of the importance of interpreting services

A number of Australian studies indicate that many health practitioners consider interpreting needs can be met adequately and appropriately by family members and untrained bilingual staff.^{404, 405, 406} In one study, it was found that 20% of GPs did not believe working with a credentialed interpreter was needed to gain informed consent.⁴⁰⁷ In another study, it was found 46% of doctors did not require interpreters to have qualifications, only 23% required NAATI professional accreditation, and only 30% believed interpreters should be university trained.⁴⁰⁸

The Australian Psychological Society submission to this study noted the importance of interpreting services delivered by a credentialed interpreter.

The APS acknowledges that interpreting is a highly specialised skill involving precise, effective and timely translation of information from one language to another.⁴⁰⁹

In consultations for the present study, a number of parties remarked that there was inadequate appreciation in health services of the role and importance of

credentialed interpreters. Participants believed that credentialed interpreters were commonly viewed as providing an add-on or ancillary service rather than being regarded as integral members of the team delivering health care to clients of low English proficiency.

Many interpreters reported that they do not feel their work is valued by those who employ them, as was documented in a recent survey.

One of the most fundamental findings of the survey was that Translating and Interpreting professionals want their contribution acknowledged and appropriately recognised. While 66 per cent thought their services were valued either highly or very highly by those individuals to whom they provided services, there was a significant level of concern about the value attached to Translating and Interpreting work by Government departments, labour hire and booking agencies and the general community with 51, 61 and 60 per cent of respondents respectively saying that their work was valued only moderately, somewhat, little or not at all. The lack of recognition for the value of the work of Translators and Interpreters has a direct impact on the viability of the industry and profession.⁴¹⁰

The NSW Health Care Interpreter Service noted the workforce implications in its submission to this study.

The low status of interpreters in the healthcare system (perceived and real) contributing to the increasing difficulties in attracting the well-educated and qualified interpreters. Health Care Interpreter Service (HCIS) as well as the non-government interpreter agencies have access to the same pool of qualified interpreters; however, many prefer to specialise in legal interpreting because of the higher financial benefits as well as professional/social standing.⁴¹¹

Lack of awareness by front-of-house staff of the necessity to engage credentialed interpreters for clients with low English proficiency is also a significant barrier to access. This is suggested by a study of general practices, which found 30% of front-of-house staff would not contact an interpreter if asked by a client because they considered the decision to access interpreting services to be the responsibility of the GP. The staff gave a number of reasons for this: the process of engaging a credentialed interpreter is a medical decision; and accessing an interpreter was felt to be so cumbersome that they would not initiate contacting an interpreter without express direction of the GP. It was noted that this may reflect respect for professional hierarchies.⁴¹²

However, delegating responsibility for engaging interpreters to front-of-house staff may not be practical in settings where health practitioners need to book interpreters in order to manage their own diaries, or for engaging telephone interpreters on-demand.

5.2.5 Need for interpreter not identified

Initial contact

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

Correspondence with a Regional Victorian Paediatrician

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

An Australian study of 131 clients attending a hospital emergency department who required an interpreter found that reception staff had recorded this need in only 54 cases.⁴¹³ Poor identification of need for an interpreter on patient records was also noted at three other Australian hospitals.^{414, 415, 416} Southern Health recently set up a working group to survey the patient information management system registration screen and audited medical records for compliance with interpreter requests. The working group recommended front-of-house staff training to respond to issues it identified.⁴¹⁷ Poor documentation can cause interpreter client language mismatch^{418, 419} and can have 'implications on the provision of adequate services such as calculating reliable estimates of interpreter need and utilisation'.⁴²⁰

In some cases, the failure to record the need for an interpreter may be the result of not being able to record the language as it has been reported that some patient management systems do not specify new and emerging languages. G21 Geelong Region Alliance has reported difficulties entering the correct dialect into drop-down menus of patient management systems.

Some dialects are being identified wrongly. Geelong has had a few issues with services asking for the wrong dialect or there is no opportunity to pick a particular dialect on a drop-down box. The company may also not have any interpreters of a certain dialect. In particular, the people who speak Karen, Karenni and other hill tribe dialects. Most mistakes happen when people book either Karen or Burmese for a Karenni person and they are unable to converse at all.⁴²¹

Eastern Health has found that failure to identify the need for interpreter at the point of initial contact may reflect a variety of factors, including 'individual prejudices'.

Preliminary investigations at Eastern Health into the poor documentation of the need for an interpreter has identified anecdotally that there are a number of factors that may contribute to this ... there appears to be a reluctance to ask the question for fear of embarrassing the patient and/or their family, concerns about the cost to individual cost centres should an individual require an interpreter, but also in some instances, individual prejudices are brought into the workplace. A belief that 'people should be able to speak English if they live here' can be reflected in the reluctance or failure to arrange for interpreter services. Appropriate responses to cultural diversity is an ongoing challenge but sometimes that needs to be addressed.⁴²²

It follows that health service providers with good systems for recording the needs of clients who are not proficient in English at initial presentation are well placed to ensure interpreting is available during the consultation; as frequently as required for inpatients; and for subsequent appointments.^{423, 424, 425}

In Victoria, services use various approaches to record interpreting needs at point of initial contact. Primary Care Connect Community Health Services in Shepparton uses a central intake system to enable an initial needs assessment that flags when an interpreter is required and the appropriate language.⁴²⁶ The Goulburn Valley Primary Care Partnership has developed an initial contact procedure checklist that may assist organisations to identify the need for an interpreter at initial contact.⁴²⁷

For general practice accreditation, the RACGP includes an indicator that 'Practices can demonstrate that we are working toward recording the other cultural backgrounds of our patients in our active patient health records.'⁴²⁸ It would be of benefit if this indicator also included reference to whether an interpreter is required and the preferred language for patients with low English proficiency. It is recommended the standards incorporate this proposal (Chapter 2). At the Peter MacCallum Cancer Centre initial registration interviews identify the need for an interpreter. This can include contacting the referring agency.

At an initial registration interview a patient will be asked questions about country of origin, language preference and interpreter requirements. Where possible language needs information is obtained prior to the initial needs consultation by contacting the referring health facility.⁴²⁹

Eastern Health uses an interpreter alert sticker on the records of those patients who require interpreter assistance.⁴³⁰

In NSW, the Health Care Interpreter Service noted that hospitals have action checklists attached to patients' files to remind health practitioners of the need to provide an interpreter. Further, requirement for interpreting is identified at a few points:

- At the point of registering for admission.

- The information is then reinforced and/or re-introduced at pre-admission/pre-anaesthetic clinic, e.g. the interpreter box is ticked in the patient contact details form.
- In addition, a bright yellow 'interpreter needed' sticker is placed on the cover of the patient's file; a yellow 'interpreter' sticker is affixed and signed by the interpreter inside patient notes at the end of the consultation.⁴³¹

Health West Partnership recommended in its submission to this study that the 'identification of the need for an interpreter to be included as a part of the compulsory minimum data sets for services'.⁴³²

Referral documentation

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

Consultation with a Victorian mental health professional.

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

Where referrals do include information regarding the need for an interpreter, they often do not indicate the specific language required. Each in their evaluation of the Refugee Health Nurse program found that referral documentation often did not include information regarding the dialect required.

One such example involved the process of sending birth notices from the maternity unit to the maternal and child health service. On many occasions, maternal and child health (MCH) nurses received the notice identifying that an accredited interpreter was required. However, there was no further information regarding the dialect spoken. This created difficulty in booking an accredited interpreter to be present during the first home visits. Many MCH nurses then needed to find other means to aid communication, which often meant asking if a partner, family or friend would be present at the time of the visits.⁴³³

The Municipal Association of Victoria has noted similar omissions in referral documentation to maternal and child health services.

At times, the MCH service may not have adequate information about the need for an interpreter or a particular dialect required. The official birth notification sent to councils by maternity services has a space for this information but this may be omitted.⁴³⁴

AMES also noted the omission of language spoken, or the correct language more broadly in referrals.⁴³⁵

Following a review in 2007 by the Victorian Auditor-General, in relation to access to specialist outpatient care, Bendigo Health amended its referral form so that the person completing it is required to indicate whether a client needs an interpreter.^{436, 437}

Health West Partnership recommended in its submission that 'GP client management systems (e.g. Medical Director) could include compulsory prompts for booking an interpreter when the patient record is accessed. This would also transfer onto referral forms regarding the need for an interpreter.'⁴³⁸ These data items are included in the Victorian Department of Health Minimum Data Sets and the Service Coordination Tool Templates.

Recommendation 5.13: The Royal Australian College of General Practice should provide advice to the Medical Software Industry Association that client management systems include interpreter required, language spoken and country of birth.

5.3 Interpreters

5.3.1 Unavailability of interpreters

Health practitioners and clients alike regularly report having difficulties in accessing interpreters in a timely manner.^{439, 440, 441, 442, 443, 444, 445, 446, 447}

In the literature, certain circumstances have been identified as challenging in terms of engaging credentialled interpreters in a timely manner. These are:

- credentialled interpreter not pre-booked – including unplanned and emergency presentations^{448, 449, 450, 451, 452}
- after hours – including weekends and public holidays^{453, 454}
- rural or regional location^{455, 456, 457, 458, 459}
- new-arrival language required^{460, 461, 462, 463, 464, 465, 466}
- high-demand languages such as Italian and Greek
- health or mental health experience required⁴⁶⁷
- gender requirements
- hospital clinics running late resulting in the booking time elapsing for the credentialled interpreter⁴⁶⁸
- interpreters not being able to wait for long hours for triage in public hospital emergency departments, which may lead to a poor first impression leading to interpreters not coming back the next time they are booked⁴⁶⁹

- lack of coordination between health and interpreting services.⁴⁷⁰

Submissions to this study reiterated these findings.

The Australian College of Rural and Remote Medicine noted the challenges of engaging credentialled interpreters in rural and remote areas.

The lack of availability of qualified interpreters for health consultations in rural and remote areas is obviously a major barrier to provision of safe health care in many settings.⁴⁷¹

Melbourne physician Dr Thomas Schulz noted the challenges of engaging an interpreter in a new-arrival language and the difficulties of engaging accredited interpreters for these language groups.

Languages in refugee groups are often hard to access and often represent new languages with limited interpreters of lower skill level. My experience has been that it often takes a lot longer to find an interpreter than the 3 minutes quoted when needing an interpreter for these 'refugee languages'.⁴⁷²

Bendigo Health reported the same issues.⁴⁷³

Melbourne General Practitioner Dr John Scopel noted the shortage of credentialled interpreters in new-arrival languages as well as established languages.⁴⁷⁴ Eastern Health raised the same issues.

It relates to the apparent general shortage of qualified professional interpreters (previously accredited as Level 3) for use in health services with newly arrived refugee groups and for older more established groups. In the case of the latter, the older, experienced interpreters are retiring and not being replaced and no language scholarships are being offered for these groups, although there is still strong demand for Italian, Greek, Macedonian, Turkish, Hungarian and Polish interpreters.⁴⁷⁵

The Health West Partnership noted similar experiences in engaging the services of an interpreter for new-arrival language groups, but also raised the difficulties in engaging an interpreter of a desired gender.

There is very limited availability of interpreters in emerging languages and/or if the gender of the interpreter is specified. This problem is exacerbated by varying dialects, e.g. Arabic as opposed to Sudanese Arabic, or Karen as opposed to Burmese.⁴⁷⁶

Mercy Health also noted the challenges associated with meeting requests for gender specific interpreters. '... women's health services face particular challenges in dealing with requests for female only interpreters, which significantly reduces the pool of available qualified interpreters.'⁴⁷⁷

The Peter MacCallum Cancer Centre relies solely on interpreters from external sources and has difficulty in engaging their services for last-minute bookings. The centre's submission also raised the difficulty of engaging interpreters for new-arrival language groups.

In our experience, agencies are able to meet booking requests 95% of the time. However, last minute bookings, in particular for inpatient wards, are a daily occurrence given the nature of our work and we find that we often struggle to find available onsite interpreters at short notice.⁴⁷⁸

The Pharmacy Guild of Australia also noted challenges when engaging credentialed interpreters for pharmacy services outside of standard business hours.

Community pharmacies often have extended opening hours, operating in the evenings and on the weekends. Accessing interpreting services can be problematic if patients present at unsociable hours.⁴⁷⁹

TIS National provided this study with data relating to its capacity to meet demand. When a health practitioner requests an on-site interpreter, TIS National will confirm the job within three days of the request in 85% of the cases.⁴⁸⁰ For the 2010–11 financial year, unmet demand for TIS National fee-free interpreting services by medical practitioners (general practitioners and specialists) and pharmacists was 6% for telephone interpreting and 27% for on-site interpreting. The average levels of unmet demand over the last six years (2005–06 to 2010–11) for medical practitioners and pharmacists have been 7% for telephone and 29% for on-site interpreting.⁴⁸¹ The level of unmet demand recorded by TIS may be significantly less than the extent of need. TIS data documents the number of requests received but services do not make requests if they are aware when the quota of on-site interpreters has been reached in a particular month or if a TIS does not have certain language groups available.

The primary reason for unmet demand for telephone interpreters for medical practitioners over the past six years has been that no interpreters were available at the time of job because TIS National was not able to source an interpreter in the requested language.⁴⁸²

For on-site interpreters the main reason for unmet demand was that no interpreters were available at the time of the job. The fee-free quota being exceeded was also a significant reason for 2005–06 to 2008–09. However, it has not been included as a reason for unmet demand since 2008–09.⁴⁸³

This study did not locate recent data about unmet demand for interpreting services in Victoria, The only available source was compiled in 2002, where unmet demand was estimated to be 3% of bookings; it is not stated how the estimate was calculated.⁴⁸⁴ New reporting requirements for quality of care reports^{485, 486} will assist in determining the number of instances when an

interpreter was required but not provided. However, this data will not capture the reasons why an interpreter was not provided.

A client of a refugee background presented as an emergency at a dental clinic with severe pain and bleeding gums. After a couple of hours, the client was seen and then told that because an interpreter was not booked (and a telephone interpreter was unavailable) she would have to come back when the clinic could book an interpreter. The relative with her was not permitted to interpret, as the clinic had recently been advised that only a dentist and a professional interpreter could interpret, provide treatment advice and follow up options. The clinic sent the patient home. It was not until a worker from VFST followed up the issue that the patient understood there had been a problem regarding interpreter access and that she needed to return later to the clinic.

Davidson, N., Skull, S., Calache, H., Chesters, D., Chalmers, J. (2007), Equitable access to dental care for an at risk group: a review of services for Australian refugees, Australian and New Zealand Journal of Public Health, Vol. 31(1), p 73.

5.3.2 Translating and interpreting workforce shortages

A recurring theme in submissions and other evidence examined in the course of preparing this report is that a key reason that interpreters cannot be accessed in a timely manner is that there are insufficient interpreters available in the workforce; the size of the credentialled interpreter workforce is less than the requirement for services. There are particular shortages of female interpreters and of interpreters in both new-arrival and emerging languages and a number of established community languages such as Greek, Italian, Vietnamese, Macedonian, Turkish, Hungarian, Polish and Cantonese. The arrival of migrants and humanitarian entrants from new language groups is a further challenge in meeting service requirements.^{487, 488, 489}

The Joint Standing Committee on Migration conducted an inquiry into multiculturalism in Australia and tabled its report, *Inquiry into Migration and Multiculturalism in Australia*, in March 2013.⁴⁹⁰ The Committee noted concerns relating to the availability of appropriately skilled interpreters and cited a submission from the Royal Women's Hospital in Melbourne that communication difficulties 'could lead to untreated illnesses, medication errors and a lack of knowledge regarding overall health and wellbeing'.⁴⁹¹ The Committee recommended that the Australian Government 'evaluate the adequacy of interpreting services available to the CALD community' (Recommendation 23).

A number of factors have been identified as affecting the supply of credentialled interpreters, including issues associated with retention, recruitment, deprofessionalisation, performance and accreditation. While a comprehensive analysis of the concerns and proposed remedies is beyond the scope of the

present study, it is considered worthwhile to provide the following overview to inform stakeholders and provide the foundation for the review that is recommended.

5.3.3 Retention

‘Full time positions are very rare ... hence it’s hard to get a mortgage or financially support children at school.’

APESMA, (2012), Lost in translation: Barriers to building a sustainable Australian translating and interpreting industry, p 14.

Interpreters are reportedly leaving the profession at higher rates than those entering the profession. A recent survey of interpreters and translators conducted by the Association of Professional Engineers, Scientists and Managers, Australia (APESMA) found that there are significant retention issues that may impact on the long-term viability of the workforce.⁴⁹²

Almost a third of respondents said they were intending to leave the profession in the next five years. Only 25 per cent said they were positive about the roles and opportunities available in the translating and interpreting industry in the upcoming 12 months while 30 per cent reported that they were not positive and expected more of the same.⁴⁹³

The suggested reasons why interpreters are leaving the profession and not sufficiently being replaced by new interpreters include:^{494, 495}

- an ageing workforce⁴⁹⁶
- a highly casualised working environment⁴⁹⁷
- poor remuneration⁴⁹⁸
- lack of career pathway
- limited professional development, supervision and debriefing.

People working in the interpreter industry often experience fluctuating work and no certainty of income or job security. St Vincent’s Hospital noted in its submission to this study the impact of these issues on the provision of language services. ‘Intractable workforce issues related to a largely casualised workforce have had a significant impact on the ability of language services to provide professional interpreters consistently for each patient.’⁴⁹⁹

The APESMA survey found that income insecurity and incomes not keeping pace with inflation were issues of significant concern for translating and interpreting professionals. Interpreters may also be unable to recoup costs for items such as communication tools, travel time, time for briefing prior to engagement, interpreter training and professional development courses and fees for NAATI

accreditation tests.⁵⁰⁰ The Western Australian Government conducted a review of language services that found that 'Interpreter pay rates are considered low and many interpreters can earn a higher income working in business and industry.'⁵⁰¹

Hospital in-house interpreters typically earn more than agency interpreters as they receive employee entitlements, e.g. annual leave, sick leave, public holidays. However, hospital in-house interpreters in Victoria with a degree in languages and NAATI accreditation earn considerably less than their allied health colleagues working in public hospitals. The Transcultural and Language Services Coordinator at Northern Health noted: 'I have interpreters with degrees in languages + NAATI accreditation in interpreting + NAATI accreditation in translation + Masters degrees, and they still get paid less than allied health professionals who have less years of tertiary education.'⁵⁰²

St Vincent's Hospital also noted that award wages were too low:

Agency pay is low, yet is a more lucrative and flexible alternative to a permanent position while award wages for hospital interpreters are unrealistically low for the level of expertise which they are required to have. This discourages new applicants to vacancies despite evidence that clinicians are more likely to use an interpreter if there is an in-house staff team.⁵⁰³

Poor working conditions, including excessive travel, which incurs out-of-pocket expenses, represents a loss of income earning potential. 70.1 per cent of respondents to the APESMA survey indicated that covering expenses was a moderate or significant concern.⁵⁰⁴ APESMA noted that out-of-pocket travel expenses are significant, including: petrol, parking fees (up to \$12 for a 90-minute hospital booking), road tolls, parking fines when consultation is longer than expected, travel time, traffic navigator and car maintenance.⁵⁰⁵

Limitations in career paths and professional development opportunities were also identified in the APESMA survey. Lack of specialised training in medical and mental health terminology have also been identified as an issue of concern for interpreters and this has quality implications.

A recent study of Kurdish refugee interpreters working in UK mental health services found debriefing to be an important strategy to manage stress. The results showed that interpreters often felt overwhelmed by the emotional impact of interpreting in mental health services, particularly at the beginning of their careers. Interpreting for refugees with shared histories was particularly challenging, and participants used different strategies to cope with the work. However, there was a sense of needing to have a space to both offload their experiences and to make sense of their emotional responses to the work. Professional input would be one important way to achieve this; for instance through regular debriefing and supervision with clinicians.⁵⁰⁶

At an agency level, counsellors working at Foundation House debrief accredited interpreters regularly and especially where they have noticed distress during a session. While debriefing at an agency level is important, it will not be sufficient for cumulative exposure to the strong emotional impact of mental health consultations over time for accredited interpreters working at multiple agencies. The responsibility for debriefing is often unclear for interpreters who are working on a contract basis.

5.3.4 Recruitment

'The [problem] ... with our industry is... the use of non-accredited individuals. As a professional I feel like I've wasted two years studying to get the accreditation...when I see any non-accredited relative, friend or an employee doing my job for the same money or less or even free.'

APESMA, (2012), Lost in translation: Barriers to building a sustainable Australian translating and interpreting industry, p 21.

Fifty-seven per cent of respondents to the APESMA survey said that the industry was becoming less attractive to new people and 78% were not aware of mentoring and peer support for those entering the profession.⁵⁰⁷

Recruitment is difficult for new immigrant groups. They may not be aware of employment opportunities, and interpreter courses do not cater for languages such as Karen and Swahili spoken by more recently arrived and smaller populations. AMES noted that 'Minority groups will always be disadvantaged in that there will not be interpreters available for them due to small numbers of speakers of the minority languages as well as good English.'⁵⁰⁸

5.3.5 Deprofessionalisation

According to APESMA, 'Deprofessionalisation is a process which occurs in a workplace or industry when non-qualified or less qualified individuals are used to perform work which is more properly performed by appropriately qualified/accredited individuals.'⁵⁰⁹

The APESMA survey found that 86.4 per cent of interpreters and translators were concerned or very concerned about deprofessionalisation of the industry.⁵¹⁰ While the survey did not provide a comprehensive analysis of the issue of deprofessionalisation, APESMA did comment on what may be contributing factors.

These factors include the use or oversupply of non-accredited Translators and Interpreters, little differentiation between rates paid to accredited and non-

accredited practitioners, perceptions of declining demand/work opportunities, the fact that those purchasing Translating and Interpreting services are often not informed about trade-offs in quality, turnaround and price, offshoring and rates of pay in competition creating a 'race to the bottom' ... The consequences of deprofessionalisation are generally a lack of public trust in the profession.⁵¹¹

5.3.6 Accreditation

A number of issues regarding the accreditation process have been identified, including declining levels of accreditation due to limited incentives to upgrade, the high cost of accreditation and high failure rates for accreditation testing.

Mr Sundaar Nadesan, Vice Chair of the Australian Institute of Interpreters and Translators (AUSIT) in Victoria, noted that there was no incentive for interpreters to upgrade their qualifications as they all get paid the same rate.⁵¹² St Vincent's Hospital also noted the absence of a pay differential.

Currently there is also very little pay differential between NAATI L2 (paraprofessional) and NAATI L3 (professional) reducing the incentive to upgrade an accreditation, particularly if a language is in high demand, and a shortage of interpreters in that language leads them to being booked regardless of accreditation level.⁵¹³

According to a Monash University report, *Pathways to Interpreting and Translating*, there are issues associated with prospective interpreters in emerging languages being able to meet entry requirements for interpreting courses and a lack of pathways once they have been recognised by NAATI, to obtain a higher level of accreditation.⁵¹⁴ This means private interpreting services are 'often obliged to send out non-accredited interpreters or paraprofessional interpreters' (in place of professional interpreters).⁵¹⁵

AMES commented that prospective interpreters in new-arrival languages are unable to meet entry requirements for interpreting courses because they typically have low levels of English language proficiency.⁵¹⁶

Mercy Health noted the constraints in terms of ensuring that interpreters are accredited rather than recognised by NAATI for emerging languages. '... there are situations where practically this is impossible to achieve. Demographic profile of our service users is constantly changing and services are currently provided to various communities, e.g. Karen where qualified interpreters are not available.'⁵¹⁷

There is no testing available for a number of relatively new-arrival languages (Chin, Karen) and only paraprofessional available in others for populations that have been in Australia now for at least a decade (for example, Assyrian, Dinka, Hazaragi, Tigrinya, Oromo and Nuer).⁵¹⁸ Health West Partnership commented on

the shortage of professional interpreters for new-arrival languages, acknowledging the reality that there is no testing for a large number of these language groups.⁵¹⁹

In relation to the accreditation framework, the Monash University report found that the pathway to accreditation is slow and the exam has a high failure rate. This was considered to have a negative impact upon interpreter recruitment.

The current accreditation framework in Australia is not reflective of workplace practice. There is a high failure rate of candidates sitting the accreditation exam and delays in movement from recruitment/training to successful accreditation. A testing system that accredits so few practitioners creates disillusionment and dissatisfaction among candidates, stops 'new blood' from entering the profession and encourages translators and interpreters to work without accreditation. It is counterproductive to both the individual and the industry to focus solely on creating ways to attract potential practitioners from new and emerging languages (at the recruitment stage) without addressing some of the reasons behind the large failure rate of NAATI accreditation candidates.⁵²⁰

A recent study commissioned by NAATI entitled *Improvements to NAATI testing: Development of a conceptual overview for a new model for NAATI standards, testing and assessment* makes recommendations regarding the need for compulsory education for all interpreters and possible educational pathways to accreditation, which includes specialisation in health and other areas. It also recommends mandatory training for languages where there is no testing available, in which case a person may seek 'recognition'. The NAATI study recommends that those seeking recognition require at a minimum an Advanced Diploma or equivalent (pp 35–43).

It highlights the workforce issues inherent in the identification of the need for higher educational standards in relation to workforce supply, particularly in new-arrival languages and Aboriginal languages (pp 11–12).

Recommendation 5.14: The Commonwealth, states and territories should fund the National Accreditation Authority for Translators and Interpreters Inc to ensure timely testing of new-arrival languages for smaller language groups at professional and paraprofessional levels.

Recommendation 5.15: The Commonwealth, states and territories should consider investment in additional educational opportunities for new-arrival communities to ensure an adequate supply of interpreters with the introduction of improved NAATI accreditation systems.

5.3.7 Government initiatives to address industry issues

The Commonwealth and Victorian governments have implemented a number of actions to address workforce issues.

Victorian Government action includes:

- identifying as a priority strategy under the multicultural policy the development of a workforce strategy to improve the supply of interpreters when using government services, including the better use of technology⁵²¹
- training health and mental health interpreters in rural and regional Victoria; \$100,000 allocation over two years through the annual Budget and Expenditure Review Committee budget process partnered with Office of Multicultural Affairs and Citizenship (OMAC)/Department of Premier and Cabinet⁵²²
- increasing the number of quality interpreters and translators and enhancing the use of language services; \$2 million was allocated across a number of projects as a part of the 2011–12 Victorian budget⁵²³
- the OMAC, also offers scholarships worth \$2,000 to applicants of targeted language groups, enrolled in the Diploma of Interpreting at RMIT University⁵²⁴
- the OMAC professional development and internship program for interpreters and translators, which was developed and delivered by Monash University to provide professional development specific to the healthcare, legal and community sectors; 158 interpreters and translators have successfully completed the program.⁵²⁵

The National Accreditation Authority for Translators and Interpreters is undertaking a 'new interpreters project'.⁵²⁶ The project aims to increase the number of NAATI accredited or recognised interpreters in 'new and emerging' languages of demand in both metropolitan and selected regional areas around Australia.⁵²⁷ As at June 30 2011, a total of 95 accreditations and 92 recognitions had been issued since the commencement of the project in 2008.⁵²⁸

5.3.8 Suggested approaches to address supply issues

In the submissions received by this study, a number of suggestions were made to address translator and interpreter workforce shortages. These included:

- encourage interpreters to migrate to Australia by including them on the Skilled Occupation List for the skilled migration scheme; this would need to address shortages in required languages^{529, 530}
- sourcing interpreters in established languages who have dual Australian and other nationality citizenship, e.g. Australians living in countries that are currently experiencing economic difficulties such as

Greece or Italy may be encouraged to come to Australia and work as interpreters⁵³¹

- increasing award wages for in-house hospital interpreters⁵³²
- the development of regional networks of interpreters⁵³³
- clinical support services to be available to credentialed interpreters for briefing and debriefing to reduce work stress 'due to the issues that may be raised during a psychiatric consultation'⁵³⁴
- further Commonwealth and state investment for the training of new interpreters⁵³⁵
- a timely review and evaluation of interpreting services.⁵³⁶

There may be potential within Victoria to improve accessibility, meet demand for smaller language groups and develop a specialised healthcare interpreter workforce by sharing credentialed interpreters across regional or statewide interpreting service networks. The NSW Health Care Interpreter Service case study is included as an example of a regionalised interpreting service in Appendix 2. The Californian Health Care Interpreter Network is an example of a statewide interpreting service network in Appendix 3. It is not suggested that either jurisdiction provides better services than currently delivered in Victoria. These examples have been included rather to illustrate the potential for models of service delivery to address a number of issues currently experienced in the Victorian context. They warrant further study.

An effective response to the challenge of ensuring there is an appropriately skilled workforce of adequate size requires more comprehensive, action on a national basis. A review to achieve this is proposed in the next section.

A workforce and industry review

The Commonwealth, state and territory governments are the major funders, procurers and users of language services in Australia. They have a common interest in ensuring that there is workforce with appropriate skills and of sufficient size to meet the need for language services in health and other key areas. Greater coordination and collaboration between governments is likely to realise the potential for significant efficiencies and to promote the development and take-up of innovative models of service delivery.

There is therefore a compelling case for the Commonwealth, state and territory governments to undertake a broad review that encompasses:

- assessment of the current and projected need and demand for language services in key areas of government responsibility
- assessment of the current and projected availability of credentialed interpreters in relation to the need and demand for language services
- identification of key factors impacting on the recruitment, retention and accreditation of interpreters and translators and recommendation of

measures to encourage skilled people to enter and remain in the profession

- identification of models of service delivery, including use of technology, to promote more effective utilisation of the workforce.

Recommendation 5.16: The Commonwealth Government should lead a broad review to ensure that Australia has an interpreting and translating workforce and industry to sustainably meet current and projected requirements for language services in key areas of government responsibilities.

5.4 Clients

The onus should not be on people with low English language proficiency to ensure that health professionals engage credentialled interpreters. Access to interpreters can be facilitated if clients:

- are aware that such a service is available and may be accessed without cost
- are aware they are entitled to ask for an interpreter to be engaged if required
- are confident the interpreter will respect confidentiality.

Even if these circumstances are present, clients may for a variety of reasons prefer to rely on alternative sources of assistance or none.

5.4.1 Lack of awareness about interpreting services

Some health practitioners may not initiate the use of interpreters but will do so if requested by clients. A GP survey that asked doctors what would encourage interpreter use in their practice found that 24% of respondents believed the client needs to trigger interpreter use. Further, 68% of practices said they would arrange a credentialled interpreter if a patient requested one.⁵³⁷

Studies in a number of states have found many clients are unaware of the availability of credentialled interpreters in health settings. In a study of the carers of paediatric emergency department patients at a NSW hospital, it was found 29% were unaware of the hospital interpreter service, and some of the carers chose to use an ad hoc interpreter because they were not aware of other options.⁵³⁸ Client studies in Victoria⁵³⁹ and Western Australia⁵⁴⁰ found clients were unaware of credentialled interpreter services in the health sector more broadly. The Queensland 'Accessing Interpreters Working Group' found the confusing array of services made it 'hard for those who need interpreters to know

what to expect or what their entitlements or rights are'.⁵⁴¹ Hospital health practitioners have also reported that some clients are unfamiliar with interpreting services and therefore do not request credentialled interpreters.⁵⁴²

There is also concern that clients may be unaware they have a right to an interpreter.^{543, 544, 545, 546} As outlined in Chapter 1, the right to access an interpreter is stated in the brochure 'Summary of the Australian Charter of Healthcare Rights in Victoria', which is available in 25 languages. The Department of Health suggests that health services incorporate the brochure into their broader communications, and disseminate it to clients and the community.⁵⁴⁷

Around Australia, both governments and non-government agencies have implemented a variety of actions to improve public awareness about interpreting services and that clients are entitled to request such assistance.

The Queensland Government has developed the following client rights statement in 16 languages, which is available on their website for health services to incorporate into their communications.⁵⁴⁸



Interpreters

- you have a right to a professional interpreter if you need one, when you use a Queensland Health public service
- interpreters can be provided either in person or by phone at no charge
- it is Queensland Health policy to use friends and relatives only in emergency situations. If the friend or relative is less than 18 years old they should not be used as an interpreter under any circumstance
- please request a professional interpreter in advance so arrangements can be made for your appointment.

The Centre for Culture, Ethnicity and Health (CEH) has run two 'social marketing' campaigns to Italian and Vietnamese background communities after feedback that clients not proficient in English were expected by many health practitioners to request a credentialled interpreter. The CEH Vietnamese social marketing campaign culminated in a five-week period of radio announcements and the placement of a newspaper advertisement. Participants in focus groups indicated that the campaigns had increased awareness of the right to request an interpreter and how to do so, but it was unknown whether this directly translated into client requests.^{549, 550}

The DEECD conducted a similar campaign for Chinese and Arabic language users of maternal and child health services, in combination with cultural competency training for MCH nurses regarding interpreter use. This was successful, as there was found to be a 6–9% increase in demand for interpreting services.⁵⁵¹

In addition, there was an 'initiative to place "do you need an interpreter" posters in all MCH centres, alongside supported training and positive reinforcement as above ... Similar to promotion of vaccines. Helps to bring to the attention of both staff and clients. Likely to increase awareness and uptake.'⁵⁵²

Eastern Health disseminated a brochure in community languages providing information on available interpreting services and there was a 41% increase in interpreter usage in the first year of the publication's release, which was sustained in subsequent years.⁵⁵³

At Eastern Health, we have put significant effort into trying to communicate the entitlement of consumers to free interpreter services through the introduction of the 'multilingual interpreter brochure' and 'interpreter fact sheets' in 21 languages. The fact sheets were released with a statement developed to assist staff in overcoming patient and/or family reticence to using language services. Both the brochure and fact sheets are generic enough to be used in any government funded agency. These brochures and fact sheets have been adopted by numerous facilities nationally.⁵⁵⁴

The Australian Centre for the Study of Sexual Assault recommends that service providers include details of the interpreting service in all promotional materials. 'Ideally, the interpreter service would be featured in all promotional material produced by each service provider (in appropriate languages for the community as well as in English).'555

The South Eastern Melbourne Medicare Local acknowledges that client reticence plays a significant role in clients requesting interpreting services, but believes client awareness campaigns remain an important facilitator in accessing interpreting services.

The focus on clients to ask for the service will not improve matters significantly ... and what we appreciate as the cultural norms of many of these ethnic groups who 1. will not ask, 2. ask indirectly and 3. when they do ask directly and the GP feels it is not necessary, they are less likely to challenge that decision. However, it is still important to have resources to improve knowledge of the general community about the availability of services they and their health care provider can access. This may be through ethnic radio, newspaper, and health centre communications.⁵⁵⁶

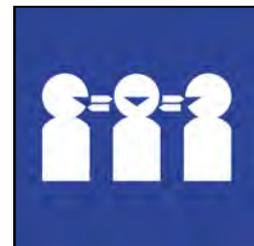
The Health West Partnership shares the view that client awareness campaigns to promote the availability of interpreting services would be of benefit and suggested AMES orientation sessions as a possible avenue.⁵⁵⁷ The Royal Australian and New Zealand College of Psychiatrists also recommended client awareness campaigns.

A communication strategy that will assist health professionals' and CALD communities' understanding of available interpreting services.⁵⁵⁸

The national interpreter symbol

The national interpreter symbol helps people identify where they can ask for language assistance when using a service. The national interpreter symbol is a national public information symbol developed as a joint partnership between Commonwealth and state and territory governments. It provides a simple way of indicating where people can ask for language assistance.⁵⁵⁹ The symbol was designed in accordance with Australian Standard 2342 ‘development, testing and implementation of information and safety symbols and symbolic signs’ and was tested in Victoria, Queensland, Western Australia and New South Wales with over 580 people of a CALD background.⁵⁶⁰ It was launched in Victoria in May 2006.⁵⁶¹

The interpreter symbol is available for download from the Victorian Office of Multicultural Affairs and Citizenship (OMAC) website, and stickers and similar resources have recently been made available on the OMAC website.^{562, 563}



The display of the national interpreter symbol may assist clients to request interpreting services, or at the very least raise awareness of their availability at general practices, community health centres and hospitals.

Interpreter cards

Victoria,⁵⁶⁴ Queensland⁵⁶⁵ and Western Australia have cards that clients not proficient in English can present to request interpreter assistance in the correct language.

A Western Australian study found their interpreter card had ‘gradually disappeared from ethnic communities and government institutions’, even though it was still promoted through a website. Less than 5% of participants surveyed were aware of the card and none had used it. Further, 60% of health service staff had heard of the card but only 13% had ever seen one.⁵⁶⁶

There has not been a formal evaluation of the effectiveness of the card in Victoria. Victorian cards were available from Centrelink and AMES offices and some local councils, migrant resource centres, public hospitals, schools and community agencies.⁵⁶⁷ Presently, the card is only available for download in 32 languages.⁵⁶⁸



TIS National also produces an 'I need an interpreter' card, which includes the telephone number for the TIS National service. Fee-free access to TIS National is generally limited to general practitioners, specialists and pharmacists working in private practice (see Chapter 3 for criteria for fee-free eligibility through TIS National).



TIS National conducts an annual client satisfaction report based on surveying both English-speaking and non-English-speaking clients. In 2011, 212 agency clients completed a survey and 200 non-English-speaking clients were interviewed by phone using an interpreter.



When asked if they had ever seen or been presented with a TIS National 'I need an interpreter' card, 38 per cent of English-speaking agency respondents said they had. Of those who had been presented with the card, 69 per cent indicated that the card had been issued to their client by the DIAC. When asked if they had engaged an interpreter when presented with the interpreter card, 82 per cent of respondents said they had.

However, only 6 per cent of non-English-speaking respondents indicated that they have an 'I need an interpreter' card. This figure was down from the 2010 survey when 16 per cent of respondents indicated they had a card. The cards had been provided to respondents by Australian Government agencies, community workers, Migrant Resource Centres, a hospital, a state government agency and friends. In the 2010 survey, of the non-English speakers who had an 'I need an interpreter' card, 75 per cent indicated that they were provided with an interpreter always or sometimes when they showed the card.⁵⁶⁹

The Royal Australian and New Zealand College of Psychiatrists submission suggested that there should be an investigation of the development of a national interpreter card 'which should be given to all patients who require interpreting services and which is distributed to various centres, such as Centrelink, Foundation House, AMES offices, local councils, migrant resource centres, public hospitals, schools and community agencies'.⁵⁷⁰ Prior to his appointment as Victorian Minister for Multicultural Affairs and Citizenship, Mr Nick Kotsiras indicated that it would be desirable Victoria to work with the other jurisdictions to introduce a nationally recognised interpreter card.⁵⁷¹

While the TIS National card is national in the sense that it can be presented at private practices across Australia, it is resource specific as it includes the telephone number for the TIS National service. Eligibility for fee-free services depends on the status of the service provider: if a client contacts TIS National to

initiate a call to a health practitioner the cost is borne by TIS National if the health practitioner is eligible and registered for fee-free services. However, if the health practitioner is not eligible for fee-free services the cost is borne by the practitioner, subject to their agreement to using an interpreter. A national card that is not resource specific may ensure the health practitioner uses the internal process for arranging language services, which would include other interpreting services with separate funding arrangements, e.g. commercial interpreting services are often tied to state funding.⁵⁷²

Recommendation 5.17: The Victorian Government should propose to Commonwealth, state and territory governments that a study be undertaken to identify the most effective approaches to a national interpreter card or similar mechanism.

5.4.2 Client reticence

A recent study of maternal and child health services in Melbourne reported that clients valued the service provided by credentialled interpreters and felt able to request their engagement:

Several Bhutanese, Iraqi and Assyrian Chaldean participants reported that when they felt that it was important for them to have an interpreter they asked for one because they did not want to misunderstand and health related information that might compromise their child health.⁵⁷³

However, a number of reports indicate that clients may be reticent to ask for interpreting services for a number of reasons, including:

- they are concerned that they might be charged for the service⁵⁷⁴
- they feel embarrassed or uncomfortable^{575, 576}
- they do not want to appear as a drain on government resources⁵⁷⁷
- they have had unsatisfactory experiences with interpreting services.⁵⁷⁸

Often clients report that they have requested interpreters but health practitioners have refused to provide them,^{579, 580, 581, 582, 583, 584} insisting the clients communicate without assistance or use family to interpret.⁵⁸⁵ The main reasons given to clients were:

- interpreting services are not available in a particular setting⁵⁸⁶
- the client was considered to be adequately proficient in English⁵⁸⁷
- the health practitioner does not work with interpreters.⁵⁸⁸

The experience of clients is confirmed by a study of GP practices, which found 30% of practices would not arrange a credentialled interpreter if requested.⁵⁸⁹ As the then Human Rights and Equal Opportunity Commission highlighted, this:

... suggests a failure of service providers to understand the repercussions of the refusal to engage interpreters to treat refugees ... many refugees are socially isolated and lack the necessary family and social supports to assist them through their illness. Also, language barriers and cultural barriers may also impede help seeking behaviour. For this particularly vulnerable group of consumers, to have overcome all these issues and then be turned away could result in no further attempts being made to access alternate service providers or receiving inadequate care.⁵⁹⁰

There is concern that clients may be unaware of complaints processes if things go wrong, for example, if their request for interpreting services is refused.⁵⁹¹ One study found a lack of complaints mechanisms related to a poor use of interpreting services.⁵⁹² Clients have said they require information about complaints mechanisms.⁵⁹³ The Federation of Ethnic Communities Council of Australia has recommended the 'government ensure that complaints mechanisms within the health care system are accessible and culturally safe to the extent that CALD consumers have confidence that the use of complaints processes will lead to just outcomes.'⁵⁹⁴

This was recommended in response to participants in a consultation reporting feelings of disempowerment in relation to complaints processes.

To begin with, some consultation participants reported that a lack of cultural competency amongst health care workers made the prospect of relating the sensitive details of their complaint intimidating and off putting. Participants also felt that their complaints were not taken seriously, particularly if they complained more than once.⁵⁹⁵

5.4.3 Client declines assistance of credentialled interpreter

Research suggests that the majority of clients prefer credentialled interpreters be engaged for health consultations (see 5.2.3).

However, clients may decline an offer made by a health practitioner to engage a credentialled interpreter or decline to request an interpreter although they know the service is available. In some cases, family members may decline interpreting service assistance on behalf of the client. 'This becomes particularly challenging in women's health services where a male partner who speaks English may refuse an interpreter on behalf of a woman, i.e. his partner who requires an interpreter.'⁵⁹⁶

There are a variety of reasons why clients may decline the assistance of credentialled interpreters. The following reasons have also been noted.

5.4.4 Confidentiality

'Using interpreters might also put them off because they worry that people will find out about it [a psychological disorder] and start gossiping. Here when "a needle falls" every Karen will know about it. You think that interpreters here are bound to confidentiality but I heard so many things back.'

Kokanovic, R., (2012), Pilot study on perinatal depression in refugee communities, Final Research Report, Beyondblue and Monash University, p 11.

Concerns regarding breaches of confidentiality, particularly for clients from small communities with new and emerging languages or rural communities, have been well documented.^{597, 598, 599, 600} The G21 Geelong Alliance has noted that 'People in smaller towns prefer not to use local interpreters as they are likely to be known to the client.'⁶⁰¹ Mental health practitioners have reported sharing client concerns about the ability of interpreters to maintain confidentiality within smaller communities.⁶⁰²

In an Australian study of 51 Iranian women, almost all the women said they would refuse access to a credentialled interpreter when discussing sexual matters.⁶⁰³ Their reticence reflected both embarrassment and concern that the interpreter would be known to their small community and their confidential information would therefore be divulged.⁶⁰⁴

Although the Australian Institute of Interpreters and Translators code of ethics requires interpreters to respect their clients' rights to privacy and confidentiality, clients and health practitioners raise concerns about credentialled interpreters adhering to the code.⁶⁰⁵ The Federation of Ethnic Communities Council of Australia has also commented on concerns regarding adherence to the code of ethics for credentialled interpreters.

Consultation participants felt that greater care needed to be taken to ensure that interpreters understand their obligations with regard to confidentiality and that CALD clients feel confident, in this regard, with the use of an interpreter.⁶⁰⁶

The Immigrant Women's Support Service in Queensland has advised for these reasons services should only engage credentialled interpreters.

IWSS strongly advocates for services to only use professional interpreters because lack of adherence to the principle of engaging professional interpreters might result in confidentiality breaches and misunderstandings. The stigma and consequences of being identified as the victim of sexual assault in some cultural groups could have impacts not only on the victim herself but the family and significant others. This may result in being ostracised from the community, which might otherwise be the only social support available at that time. Concerns in relation to confidentiality are nearly always present – particularly with smaller and emerging communities – and need to be addressed as a priority.⁶⁰⁷

The Royal Australian and New Zealand College of Psychiatrists suggested in its submission to this study the privacy and confidentiality concerns be addressed by the distribution of the code of ethics to both health practitioners and the CALD community in community languages.⁶⁰⁸

However, as noted elsewhere in this report, these issues may often be addressed by engaging a telephone interpreter from interstate or an interpreter from another country of birth who speaks the same language.

5.4.5 Gender

‘... booking for an interpreter was not always easy due to long waiting times. Therefore some women had to rely on their partners or family members to interpret for them. As reported in the interview results, some women relied on their husbands for interpreting but once again they were faced with another obstacle as husbands could not come with them to all the routine check-ups and antenatal visits due to work or study commitments.’

Hoang, Ha, (2008), Language and cultural barriers of Asian migrants in accessing maternal care in Australia, The International Journal of Language Society and Culture, Issue 26, p 58.

Clients may decline the assistance of a credentialled interpreter who is of a different gender.

A number of sources suggest that the gender of interpreters may be particularly significant for women, as the following examples illustrate:

Royal Australian and New Zealand College of Obstetricians and Gynaecologists:

While acknowledging the confidential nature of all medical interactions, as specialists involved in the provision of women’s health care, the importance of female interpreters cannot be understated, particularly those who are aware of the relevant cultural issues but who do not represent any perceived conflict of interest and, hence, will be accepted by the patient and enable a full and complete clinical consultation to be undertaken.⁶⁰⁹

Australian Psychological Society:

Gender issues are raised briefly in the discussion paper [Exploring Barriers and Facilitators to the Use of Qualified Interpreters in Health Discussion Paper, April 2012], particularly in relation to women talking with specialist doctors about sensitive issues. However, gender issues in counselling can be broader than this, and can include power relationship and safety issues, particularly in cultures where women may feel inhibited to speak in front of men, or have been treated insensitively by their male relatives in the past.

Women also may be unable or unwilling to articulate intimate or gender specific health needs with a male interpreter, particularly on issues to do with female genital mutilation, domestic violence and sexual abuse or rape.

Additionally, in some cultures, women are not encouraged to speak about personal issues in front of any man, let alone a stranger.⁶¹⁰

Federation of Ethnic Communities Council of Australia:

Cultural diversity in CALD people may serve to add further complexity to D/FV [domestic and family violence] situations. For example, it was pointed out by consultation participants that interpreters are often male and may have a different accent or language to the victim. This is problematic where the victim is female, as she may not feel safe confiding in a male interpreter where the perpetrator was male. Furthermore, in some cases, there may be cultural norms around the extent to which males and females interact with each other which would prevent the female victim from confiding in a male interpreter, and a male interpreter from acting in the best interests of the female victim.⁶¹¹

5.4.6 Political, religious and other sensitivities

The Centre for Culture, Ethnicity and Health noted that the ethnicity and religion of interpreters may affect how clients interact with interpreters.

The ethnicity and religion of the interpreter may be important to some clients, particularly if they come from countries where there has been political and civil unrest or conflict along religious lines. Note that ethnicity is not necessarily the same as country of birth (e.g. country of birth may be Iraq but ethnicity could be Kurdish).⁶¹²

The NSW Health Care Interpreter Service and the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) noted these issues for those who have survived war or organised violence.

Experiences of human rights violations can impact on a person's ability to trust others. This will be exacerbated if: the interpreter belongs to the ethnic, political or religious group that persecuted your patient or your patients family/friends ... they fear that the interpreter might inform the government of their home country about political criticism they make – putting friends and family at home in danger.⁶¹³

The Australian Psychological Society commented upon the importance of these issues in its submission.

The issue of racial or political tension between differing ethnic groups who speak the same language or similar dialects may need to be further highlighted in the report. For example, with asylum seekers an interpreter from the same language group may be asked to interpret, but when they meet or speak with the person requiring help, they become aware that they are from different ethnic or tribal groups who have a history of enmity or at least some level of distrust. This tension might not be apparent to the English-speaking counsellor or other health worker who cannot understand the language (although very uncomfortable body language, signs of fear or raised voices might indicate a problem). The English-speaking person is then not sure what is happening or being said, and whether the interpreter is accurately reporting all that was being exchanged with the

client. So this is an issue that needs to be raised and covered in training for counsellors or other workers on the use of interpreters ... Similarly to racial issues, religious tensions can also arise between differing groups and individuals, making it very uncomfortable for both the person needing the interpreter, as well as the interpreter. This can be especially disconcerting if the person is fearful of reprisals on themselves or their families from a differing political or religious group.⁶¹⁴

5.4.7 Interpreter service delays

Delays in securing interpreting services ultimately cause delays in appointments. In a study of nine Victorian liver clinics, it was found that CALD clients experienced the longest waiting times due to limited access to interpreting services, and the worst waiting times were reported to be where 'they do not have interpreters'.⁶¹⁵ Clients have commented if they do not identify as needing an interpreter they will be given an earlier appointment.⁶¹⁶

Faced with delayed appointments, clients may prefer to use family and friends to interpret, make do in English, not receive assistance, not request assistance or refuse assistance.^{617, 618, 619, 620} The Refugee Council of Australia has noted that a number of participants from their annual consultations have stated 'that clients are choosing not to request an interpreter because if they do it means they have to wait longer for an appointment'.⁶²¹

5.4.8 Negative experience with interpreter service

AMES noted that clients may decline an offer made by a health practitioner to engage a credentialled interpreter if they have had negative experiences with interpreting services.

Usually first impressions last long – the client's first visit to the service helps form their decision whether to go back to that service. If the experience is unsatisfactory or problematic (e.g. there is no interpreter or if there are issues with getting/using an interpreter) they may not return or if they do come back, pretend that they speak enough English instead of going through the initial unsatisfactory experience again.⁶²²

5.4.9 Client may overestimate their level of English proficiency

Clients may mistakenly believe their proficiency in English is adequate for certain situations and therefore decline the offer to engage a credentialled interpreter. In NSW, for example, a number of clients attending a hospital emergency department declined the offer to engage a credentialled interpreter because they

considered their language skills to be adequate, but found they were not able to properly understand the consultation.⁶²³ In another NSW study, 'There were many situations observed by researchers and accounts given by staff, of family members who believed they spoke English "well" but in reality faced significant challenges in understanding the information provided and expressing their views clearly.'⁶²⁴

Even when clients use everyday English, their language skills may be insufficient for complex communication in the health setting because their capacity to express themselves is limited and they cannot understand technical medical language and explanations, for example, a study of two Sydney-based hospitals found that 47% of the CALD clients had a problem understanding medical words.⁶²⁵ In these circumstances, clients' understanding of the medical assessment, diagnosis, treatment and care may be significantly compromised.^{626, 627, 628}

5.5 Strategies to address client concerns

A number of strategies have been identified to address concerns clients may have about credentialed interpreters being engaged in consultations involving gender, political, religious or cultural sensitivities.^{629, 630, 631, 632, 633, 634, 635 636, 637} In summary, these are:

- utilising telephone interpreters from another state or country of birth
- the repeated stressing of confidentiality, highlighting that credentialed interpreters are bound by the Australian Institute of Interpreters and Translators (AUSIT) Code of Ethics⁶³⁸
- 'In some circumstances it is advisable to book a female interpreter for a female client and a male interpreter for a male client. This especially applies for medical appointments or situations when sensitive or personal matters may need to be discussed (such as domestic violence or marital problems).'⁶³⁹
- asking the client if they have any ethnic, religious or political preferences for working with interpreters. 'TIS National can advise you about these to ensure the most appropriate interpreter is chosen.'⁶⁴⁰
- checking with the client their preferred language, as clients may speak a number of languages and avoid the possibility that other languages may be difficult because of traumatic associations
- checking with the client to see if any particular interpreters are either preferred or not appropriate.

The Peter MacCallum Cancer Centre has adopted a successful negotiation strategy when a client refuses the services of an interpreter. In such circumstances, the 'Language Services Coordinator with the assistance of the

interpreter consult, with the patient to better understand the reasons. After such a consultation, many patients accept that it is preferable to make use of the services of a qualified interpreter.⁶⁴¹ This strategy is in accordance with Victorian departmental language services policy, which advises staff to explore the reasons for the refusal of interpreter assistance and explain the consequences of not using a credentialed interpreter.⁶⁴²

VFST counsellors at times will check with clients after an appointment whether they were comfortable with the interpreting services provided. This may be done with a follow-up phone call with another interpreter if the counsellor notices an uneasiness or reticence to talk by the client.

The NSW Health Care Interpreter Service noted that both healthcare providers and clients are considered to be clients for interpreting purposes. It is stated that the option as well as the right to an interpreter applies equally to both parties.⁶⁴³ If the client continues to refuse the use of an interpreter, Victorian Government policy and procedures advise health practitioners to continue with the interview, documenting concerns relating to the language barrier, or to suspend or reschedule the interview.⁶⁴⁴

Chapter 6: Facilitators of the engagement of credentialed interpreters

Chapter 5 explored barriers to engagement of credentialed interpreters in healthcare settings. It is important to understand the interrelated factors that support effective interpreting services delivery in healthcare settings if systemic practice improvement is to be achieved. The measures outlined in this chapter relate variously to health practitioners and other staff, to the organisations in which they work and to clients themselves.

6.1 Health practitioners and support staff

6.1.1 Education and training

Health practitioners who have been trained to engage credentialed interpreters have been shown to be more aware of the importance of working with credentialed interpreters and more likely to engage them.^{645, 646, 647, 648, 649, 650} The provision of training on working with credentialed interpreters should therefore be considered to be a key element of contemporary healthcare practice.^{651, 652, 653, 654, 655, 656, 657}

The general view in submissions and consultations was that interpreter training should sit within a broader cultural competence training framework.^{658, 659, 660} As the Ethnic Communities Council of Victoria noted:

Good language service provision, is not just about 'interpreting', it is a multifaceted service with a focus on cultural competence, which is fundamental in the health context. Cultural competence requires a cultural shift within the hospital context; a full recognition that we are a diverse society with diverse needs, and that a 'one size fits all' approach is counterproductive. Cultural competence goes hand in hand with patient centred care and requires a whole of organisation responsiveness to the diversity of contemporary Australian society.⁶⁶¹

Similarly, St Vincent's Hospital observed that a health practitioner's cultural competence can significantly affect clinical encounters and health outcomes.

The content referred to here is the cultural competency of the health professional, the importance of their general cultural understanding of the ethnic communities that they extend care to (e.g. migrant history, health views and beliefs, variety of languages patient may be familiar with, cultural values relating to the patient role) and equally important, their ability to understand some of the

pitfalls in non-verbal communication (e.g. taking silences or a nod as consent). They may assume a patient has agreed to a health plan without realising this was done out of respect or because the patient was too embarrassed to admit they did not understand the instructions. A clinician's assessment of the level of a patient's health literacy and knowledge of flexible communication styles to address this is also crucial to an effective clinical encounter and a good health outcome.⁶⁶²

A Cochrane review is currently underway to 'assess the effects of cultural competence education interventions for health practitioners on patient-related outcomes, health practitioner outcomes, and healthcare organisation outcomes'.⁶⁶³ It is reasonable to assume this will include reference to provision of credentialled interpreting services.

6.1.2 Pre-service health practitioner education

There is a strong argument for modules about working with interpreters to be included in the curriculum for all practice-level health education, given the significant number of members of the Australian population whose English proficiency may be inadequate for effective communication in health settings.

If the acquisition of such fundamental skills is considered 'optional' then many healthcare professionals will not acquire skills that are required to work well with a substantial number of their clients. A study of first-year medical students at the University of Western Sydney found that a voluntary subject on working with interpreters had low participation rates, with the consequence that few students undertaking this course had been prepared to work with interpreters when they commenced practising.⁶⁶⁴

All TAFE students studying health-related courses are required to study a unit about how to 'work effectively with culturally diverse clients and co-workers'.⁶⁶⁵ The courses include nursing, pathology, health services assistance (personal care attendant), hospital pharmacy support, dental assisting, practice management and nutritional medicine.⁶⁶⁶ The unit covers compliance with duty of care policies of the organisation and communication through an 'an interpreter or other person'.⁶⁶⁷

However, the situation in other tertiary institutions varies considerably. A survey of nine tertiary institutions was undertaken as part of this study to capture inclusion of interpreting skills in health practice-ready curriculum. The survey enquired whether the institutions' courses covered working with interpreters, cultural competency and the impact of refugee trauma and torture. Six universities responded regarding 33 practice-ready courses covering all health disciplines.

Table 5 provides an overview of the responses.

Table 5: Survey of Victorian tertiary health courses

Course	Do you teach students how to work with interpreters?			Do you provide education in cultural competency?		
	Yes	No	Total	Yes	No	Total
Nursing and Midwifery	3	4	7	6	1	7
Health Sciences (including oral/dental)	3	1	4	4	0	4
Human Services	1	0	1	1	0	1
Nutrition and Dietetics	1	1	2	2	0	2
Physiotherapy	1	1	2	2	0	2
Occupational Therapy	2	1	3	3	0	3
Psychology and Social Work	1	6	7	7	0	7
Pharmacy	1	0	1	1	0	1
Speech Pathology	1	0	1	1	0	1
Ambulance and Paramedics	1	0	1	1	0	1
Radiography and Medical Imaging	0	2	2	2	0	2
Medicine	2	0	2	2	0	2
Total	17	16	33	32	1	33
Per cent	52%	48%	100%	97%	3%	100%

Respondents indicated that over half (52%) of courses include modules that teach students how to work with interpreters. Of these, just over half (53%) were reported to be compulsory; the status of the others is unknown. The most comprehensive components were in one institution's physiotherapy and occupational therapy courses where students attended either a three-hour or an all-day seminar with interpreting and translating students where issues pertaining to working with interpreters are explored and simulated interactions with interpreters are practised.

The coordinator of a course that does not include a component on working with interpreters explained that the rationale for not requiring students to complete such training was that it is unusual for clients not to have a family member interpreting for them.

While there are obviously many competing demands for subjects to be included within practice-ready courses, the inclusion of working with interpreters is clearly fundamental to good practice. It should not necessarily be a stand-alone unit, but could be included in subjects such as communication.

Recommendation 6.1: Victorian tertiary providers should ensure education on working with interpreters is a component of practice-ready health practitioner courses.

6.1.3 Professional development for clinical staff

Many health practitioners have not received training on working with interpreters during their courses or subsequently.^{668, 669, 670, 671, 672, 673} Training on working with credentialed interpreters should be provided to practising health professionals to equip those who have not received any training pre or post service and to refresh and develop the skills of those who have. The Refugee Council of Australia noted the importance of such training, especially in new settlement areas.

Training in regional and rural areas where refugees are settling for the first time is particularly important, and requires communication between the Department of Immigration and Citizenship and state health departments to enable forward planning.⁶⁷⁴

Professional development on working with credentialed interpreters is available from a number of sources, including:

- commercial language service providers⁶⁷⁵
- the Centre for Culture, Ethnicity and Health (CEH)⁶⁷⁶
- in-house by interpreting coordinators or other staff with skills in working with interpreters
- Medicare Locals
- accreditation colleges.

In NSW, the Health Care Interpreter Service delivers training about the interpreting service as part of an orientation for junior medical officers and more broadly as a part of corporate orientation sessions which are compulsory for all new employees, including clinicians of all disciplines except for doctors.⁶⁷⁷

In Victoria, CEH in 2007 piloted a TIS National Training Module for General Practices, entitled *Working effectively with professional interpreters in private general practice*. The module was accredited by the RACGP and attracted professional development points.⁶⁷⁸ In a questionnaire completed by 46 GPs, 21% indicated they would like training in effectively using an interpreter. The project identified a gap in training for general practitioners.⁶⁷⁹ In 2011–12, Mercy Hospital for Women and Werribee Mercy Hospital conducted regular training sessions for staff on the topic *Interpreting services and medico-legal risk: Know your responsibilities*. * Northern Health provides regular training sessions that are described in Appendix 1. St Vincent's Hospital also provides comprehensive training on cultural responsiveness and working with interpreters, as outlined here.

There is a very comprehensive and extensive training program at St Vincent's thanks to a designated professional cultural diversity trainer who, since 2009, provides onsite training workshops to all sites. An audio visual online cultural responsiveness training module is also available to all staff and is intended particularly for those who are unable to attend onsite training. Additionally,

onsite training is provided to all staff on request on all aspects of the rights of CALD clients, identifying interpreter need, working with an interpreter and the benefits and risks when one does/does not use one.⁶⁸⁰

The Refugee Health Program manager for the South Eastern Melbourne Medicare Local (SEMML) delivers training programs on how to use TIS National to doctors, nurses, receptionists and managers in general practice clinics in the SEMML region.

Issues here include: how to register each individual doctor to use the services, how to pre-book interpreters by telephone (specific number) or fax (specific number) or online (specific website) and how to quickly obtain a telephone interpreter using the Doctors Priority Line (generally within 90 seconds and faster than using a general phone number).⁶⁸¹

The SEMML considers Medicare Locals to be best placed to deliver training to GPs in both online and face-to-face modalities.

The mode of delivery of training should be varied using online as well as face-to-face methods so we can capture more health professionals who are time poor. Some learning outcomes can be best delivered online and others face-to-face. Training can be done more effectively through ML [Medicare Local] networks that link medical and allied health practitioners in community and hospital settings ensuring a focus on the patient journey through the various levels of health care. Training has been shown to increase usage of interpreting services in the GP group (CEH report).⁶⁸²

In Victoria, many community health services include skills in working with interpreters and working cross-culturally for new staff, such as Western Region Health Centre, and Dousta Galla Community Health Service.

The Royal Australasian College of Physicians is working with the Committee of Presidents of Medical Colleges to develop a series of six interactive eLearning modules to provide information and understanding about the following topics:

- centrality of culture in interpersonal relations
- major communication styles and channels used by different cultural groups in Australia
- the link between values, beliefs and behaviours and the differences between cultural groups in Australia
- cultural approaches to conflict and conflict resolution.⁶⁸³

It would be valuable for the material to include information on working with interpreters.

The cultural competency training component for maternal and child health (MCH) nurses formed a part of the Office for Multicultural Affairs and Citizenship 'cultural competence in professional practice' training program. The training program focused on the use of language services, improving cultural awareness and skills in cross-cultural communication.⁶⁸⁴ Approximately 255 participants,

22% of the MCH workforce, undertook the training.⁶⁸⁵ Together with client awareness campaign (see 5.4.1), this led to a 6–9% increase in interpreting services delivery.

The Municipal Association of Victoria noted significant value in further investing in the training of the MCH workforce and client awareness campaigns.

Staff at all levels who may be an access point for the engagement of interpreters should be provided with appropriate training.^{686, 687, 688}

In their submissions, AMES, St Vincent’s Hospital and Health West Partnership noted the importance of providing training to front-of-house staff.^{689, 690, 691} St Vincent’s Hospital detailed the type of skills administrative staff might require in addition to identifying that a patient requires an interpreter at first point of contact.

Once, established ... registering a language requires a level of expertise. For instance, data fields with drop-down menus in registration software may not list the patient’s language and dialect. Incorrectly identifying a patient’s language, particularly if they are from a new and emerging language community, causes delays in obtaining an interpreter and although there are DoH [Department of Health] posters which help to identify which language a patient speaks they are only useful if the patient is literate. Frontline staff should also be trained to have a basic understanding of world geography and cultures and be able to ask for further information if the language required is not clear, particularly if the patient is multilingual.⁶⁹²

Training should feature compulsorily as a component of annual staff performance reviews^{693, 694} or be connected to professional development points to increase the likelihood of participation.⁶⁹⁵ Some organisations have developed online training to increase participation for health practitioners who have little time to attend professional development sessions.^{696, 697, 698} In Chapter 2 it was proposed that the Royal Australian College of General Practice promote training on engaging credentialed interpreters for general practitioners, clinical staff and administrative staff in general practices by including this in their accreditation framework.

Recommendation 6.2: Health services should ensure that induction of all staff includes skills development related to policy and procedures for engaging and working with interpreters.

6.1.4 Issues to consider when developing or providing training

Guidance developed for health practitioners and the findings of this study recommend the inclusion of the following in learning and professional development on engaging working with interpreters:

- knowledge of available interpreting services
- understanding the reasons for working with credentialed interpreters
- the role of credentialed interpreters as distinct from cultural advocates^{699, 700}
- assessing the adequacy of clients' English proficiency for the clinical situation^{701, 702, 703}
- strategies for clients who refuse to use an interpreter, being mindful that they are entitled to do so^{704, 705, 706}
- identifying the language required^{707, 708}
- procedures for booking an interpreter^{709, 710}
- when to engage an interpreter: the Department of Human Services provides guidance on minimum critical points required for DHS-funded services and programs.⁷¹¹ advice on how to work effectively with interpreters before, during and after the consultation^{712, 713, 714, 715, 716, 717}
- considerations when working with clients of a refugee background taking into account the impact of trauma experiences^{718, 719, 720, 721}
- briefing and debriefing for the interpreter^{722, 723, 724, 725}
- strategies to employ when an interpreter is not available, especially in critical emergency situations^{726, 727}
- complaints mechanisms.^{728, 729}

6.1.5 Professional development tools

A number of professional development tools are available to support professional development.

- The Department of Immigration and Citizenship has produced a DVD about accessing interpreters through TIS National.⁷³⁰
- The Department of Human Services 'Making the Connection' multimedia resource and manual provide guidance for about how to best work with interpreters in a variety of work situations.⁷³¹
- The Department of Human Services has produced guidance for staff to deal with situations when a client refuses to use an interpreter and when an interpreter is not available.⁷³²
- VITS Language Link has produced an interactive training CD ROM on working with interpreters.⁷³³

Given the wealth of material available from multiple sources, it would be helpful for those seeking guidance to have a readily available site to locate what they require. One possibility is the Victorian Office for Multicultural Affairs and Citizenship 'Improving language services' web page.

Recommendation 6.3: The Victorian Office for Multicultural Affairs and Citizenship should consider including language services resources on its website, including organisational guides and professional development resources.

6.2 Health services

Organisational commitment to working with credentialled interpreters is a critical facilitator of good practice. This is the case in organisations of all types and scales, from small medical practices to major hospitals.⁷³⁴ This section outlines some of the ways in which organisational commitment is manifested, some of which may be pertinent to all organisations and others to only some.

6.2.1 Leadership

Chapter 5 describes the importance of health practitioners and other staff being aware of interpreting services and how to access them and – particularly in the case of clinicians – how to work with credentialled interpreters. Management needs to indicate to staff that they are expected to have or acquire the necessary knowledge and skills and allocate the time and funding to permit staff to attend training.⁷³⁵

In preparing this report, valuable information and advice was received from a number of staff members of organisations that are committed to the delivery of culturally competent health care, including the engagement of credentialled interpreters when required. These ‘local champions’, when supported by management, have demonstrated the ability to drive organisational improvements in effective interpreting services provision.⁷³⁶ However, it is important that culturally competent health care is not seen as other than routine business in the longer term.

In Europe, the ‘migrant friendly hospitals project’ was established with the aim – among others – of improving interpreting in clinical communication.⁷³⁷ The project included hospitals from 12 member states of the European Union.⁷³⁸ An important finding of the project was:

... clinical communication for migrants can be improved consistently only if: it is integrated into a hospitals general policy on diversity; it is sustained by becoming mainstream and not relying on local champions; and adequate political will and funding is assured.⁷³⁹

Mercy Health believes that ‘Strong leadership and management support (both symbolic and practical) is crucial in achieving positive outcomes in the provision of interpreting services.’⁷⁴⁰

6.2.2 Relationships between agencies

There has been a real improvement in health services and accessibility in the Dandenong region in the past five or six years. This is partly due to the Refugee Health Nurse program and the Refugee Health Network, but also it is because of leadership shown by Southern Health and champions within Southern Health, as well as by the State Government Health Department.

A Dandenong Service Provider Participant in the Refugee Council of Australia Annual Intake Submission Community Consultations 2011.

Developing relationships between key agencies may assist in working towards routine interpreter mediated health consultations. For example, Bendigo Health has found to be an important facilitator:

... the development and maintenance of a good working relationship with the main language service provider and the relevant contact person at the Department of Health regarding the language service credit line.⁷⁴¹

Health West Partnership also noted how important developing local relationships are in facilitating access to credentialed interpreters.⁷⁴²

In NSW, refugee health nurses work closely with the interpreter service. For example, 'In the Hunter region, Refugee Health sits with the multicultural health unit, where language services are also located. So that both Refugee Health and Multicultural health have the support from interpreters.'⁷⁴³ The development of relationships between the Refugee Health Nurses and the interpreting service is seen as important facilitator for increasing health practitioner awareness of interpreting services.

6.2.3 Employment of in-house interpreters

Health practitioners are more likely to engage interpreters who are employed by their organisation than those provided by external agencies. In one study, health practitioners gave the services of an in-house interpreter a 100% positive rating and provided no other better alternative. The positive rating was felt to be the result of: the established rapport, trust and continuity between the in-house interpreter and the clients; high level of training and ethical standards; professionalism; and competence.⁷⁴⁴ The healthcare experience, in terms of cultural issues and medical terminology are other notable strengths of in-house interpreters.⁷⁴⁵ Western Health has similarly reported in-house interpreters provide continuity of care, accessibility at short notice, cost-effectiveness and service efficiencies.⁷⁴⁶

G21 Geelong Region Alliance has reservations about the cost of in-house interpreting services. 'Some services have taken to employing their own

interpreters to guarantee they have someone, particularly for counselling. This comes at a huge cost to the service.⁷⁴⁷ However, this is not the experience of Western Health or Northern Health (Appendix 1). A more detailed cost-benefit analysis is required to assess the factors that may produce different outcomes, such as consistency of demand.

6.3 Interpreter equipment technologies

6.3.1 Telephone

'I try to use speakerphones to make the encounter less clunky and they are not widely enough available in many clinical areas, more so as they need to be in private spaces.'

Correspondence with a Regional Victorian Paediatrician

Availability of appropriate telephone equipment that is suitably situated (e.g. in consultation rooms or at the patient bedside in hospital settings) is a facilitator to engaging credentialled telephone interpreters.^{748, 749} As AMES has noted, telephone equipment may be available, but inappropriate for the environment; e.g. 'The emergency department is usually very crowded which makes it improper to be using a speakerphone for interpreting purposes.'⁷⁵⁰ Similarly, a NSW study reported: 'In the emergency department phones are often situated in the medical and nursing stations, where use for telephone interpreting with the patient poses its own difficulties in ensuring that patient information remains confidential. It also assumes that the patient or carer can leave the bedside.'⁷⁵¹

In recent research on access to maternal and child health (MCH) services in Melbourne by people of a refugee background, it was found that 'Telephone interpreters were used when necessary, although they are reported as problematic (mobile phones cutting out, telephones with no loudspeaker/hands free option or limited volume).'⁷⁵² Likewise, the Municipal Association of Victoria (MAV) has advised that the delivery of interpreter mediated consultations for home visits can be challenging as poor mobile coverage may necessitate using the client's landline which may also be unsuitable:

Some of the most vulnerable people using the MCH service live in high-rise accommodation where telephone reception is poor or variable. Clients may have telephone equipment without conference/speaker function. Again for many new arrivals it may be an alien experience to be using a telephone for a personal conversation.⁷⁵³

MAV further advised that an audit would be required to ascertain whether MCH services have access to appropriate telephone equipment, as there are 79 council organisations and approximately 10 other organisations contracted to

deliver MCH services and that points of service delivery vary; e.g. there is a mix of community-based facilities and temporary facilities.⁷⁵⁴

Ensuring appropriate telephone equipment is available is also critical in rural and regional locations, as the travel costs associated with engaging on-site interpreting services from Melbourne are prohibitive, and interpreting for all language groups will generally not be available locally. For example, the cost for a Melbourne-based interpreter to travel to Bendigo is \$277.20.⁷⁵⁵ Further, credentialed interpreters may be reluctant to travel to appointments as noted by Health West Partnership⁷⁵⁶ and G21 Geelong Region Alliance. For example, G21 Geelong Region Alliance noted:

In our region people report that they have 'given up' in most cases in getting face-to-face interpreters. Interpreters are not paid for travel time, or the time it takes to get to our region, so appointments are either not filled, or filled and then cancelled at the last minute when the interpreter gets an offer closer to home.⁷⁵⁷

The study of maternal and child health services mentioned previously also reported that nurses state that some interpreters 'were unwilling to travel long distances to get to MCH centres or people's homes'.⁷⁵⁸ Interpreter reluctance may be in part the out-of-pocket expenses for travel. However, it also represents a loss of income earning potential (Chapter 5). Where interpreters do choose to travel to appointments, it has been reported that the travel time can reduce the amount of interpretertime booked for the consultation. The Health West Partnership submission suggested an initiative where interpreters who are willing to travel to appointments could be easily identifiable to health services.⁷⁵⁹

Utilising technology that supports quality telephone interpreting will address barriers to using telephone interpreters. The RACGP Standards for general practices, which form a part of the accreditation process, include a standard on equipment for comprehensive care. However, this standard does not include guidelines for equipment to ensure quality telephone interpreting.⁷⁶⁰ Following are some examples of technologies.

'I liaised with a practice manager at a private psychiatric clinic around a first appointment for a client. The manager said the psychiatrists will work with interpreters, but that they would prefer it if the patient brings someone with them who can interpret. They did use the telephone interpreting service, but the clients feedback was that it didn't work very well, as the psychiatrist didn't use speaker phone, and so the handset was passed between them – a pretty ineffective way to use an interpreter. The client was very unhappy with the experience. I was informed that the phones do have speakers. So morale of the tale, being willing to use interpreters is one thing, using them effectively is another.'

Foundation House Counsellor Advocate

Dual-handset phone/three-way telephones

In the USA and UK, commercial organisation 'Language Line'⁷⁶¹ uses dual-handset phones, enabling sensitive information to be shared confidentially without using a speaker phone. The health practitioner and the client have their own handset which means there is no need to pass a handset back and forth between the health practitioner and the client. The dual-handset phone also has speakerphone capabilities to enable hands free consultations where confidentiality is not an issue and directly links to the commercial provider.^{762, 763} It has been reported that 'The ease with which the technology can be used is reflected in the increase of telephone interpreting as a widely used model by many health providers. Additionally and equally important is its cost-effectiveness in many health encounters which would otherwise cost double for a face-to-face encounter.'⁷⁶⁴

The NSW Health Care Interpreter Service noted that dual-handset phones are used in hospital wards to ensure the health practitioner and clients can choose to use a quiet room for privacy while they talk to the interpreter on the line.⁷⁶⁵

Three way phones were successfully piloted at Auburn Hospital, NSW to facilitate greater access to interpreter use and due to the success of the initiative they were provided to all emergency departments and birthing units within the former Sydney West Area Health Service.⁷⁶⁶

Wireless speaker telephones

The Polycom® SoundStation2W™ is a wireless conference phone that enables cordless roaming from the base station, allowing the phone to be used in rooms without phone lines.⁷⁶⁷ A single unit is in operation at Primary Care Connect Community Health Services where the base station is docked in the reception area. Staff book the cordless unit on the central electronic calendar and collect it



prior to the scheduled health consultation requiring telephone interpreting. The voice quality, loudness and microphone sensitivity are reported to be very good as the phone is successfully used to provide cordless speakerphone interpreting sessions between health practitioners and whole families.⁷⁶⁸

More generally, many telephones have speaker phone capability transferring the sound input to a microphone and output to a loudspeaker. The voice quality, volume and microphone sensitivity vary depending on the design, brand and model of the telephone. Health West Partnership recommended in its submission that organisations 'use a Cisco phone system where TIS phone calls can be placed on loudspeaker'.⁷⁶⁹ The Peter MacCallum Cancer Centre has

invested in appropriate and accessible telephone equipment. 'Dual use handsets are available on all the wards and most of the Outpatient Clinic rooms have speakerphones.'⁷⁷⁰

Mobile phones

Primary Care Connect Community Health Services purchased iPhones to be used in conjunction with speaker docks to successfully enable hands free off-site interpreting. Mobile call charges were not considered to be prohibitive under the organisation's telecommunication contract,⁷⁷¹ but that may not be so for organisations with other contracts.

Translation applications for portable hand-held devices.

A number of software speech-to-speech translation applications have been developed for portable hand-held devices and computers.

'MediBabble' is promoted as a free mobile medical translation application for iPhones that enables history taking and examination.⁷⁷² 'MediBabble' became available for download on the iTunes Store in April 2011 and 'uses touch screen software that allows health care providers to play medical questions and instructions out loud, so far in five languages'.⁷⁷³ It translates more than 2,500 closed-ended exam questions to elicit yes/no answers or gestures from the patient, for example, 'Do you get reoccurring lung infections?'⁷⁷⁴

The application was designed by a fourth-year medical student and developed by a team of University of California San Francisco (UCSF) faculty doctors who reviewed the 'accuracy and the cultural appropriateness' of the application.⁷⁷⁵

Two UCSF medical interpreters have since reviewed the application and found that no UCSF interpreters were consulted in the development of the device and they also question the cultural appropriateness of some questions, for example, 'Are you able to achieve orgasm during sexual intercourse?'⁷⁷⁶ Further, 'Plagued by problems with linguistic register, dialect variety, localisation and translation error, this application gives the provider a false assurance that he or she is being understood. A more thorough analysis of the real merits and the potential risks of this App are needed.'⁷⁷⁷

Google also has an iTunes application translating words and phrases between 60 languages; for most languages phrases can be spoken and corresponding translations can be heard.⁷⁷⁸ Jibbigo is another speech-to-speech translation iTunes application available in nine language pairs.⁷⁷⁹

In the absence of evidence-based peer-reviewed research, the use of translation software by health practitioners should be treated with caution.

6.3.2 Remote simultaneous interpretation

Traditional consecutive interpreting requires the interpreter to listen as the primary speaker speaks, and then interpret when the primary speaker has finished.⁷⁸⁰ In simultaneous interpretation, as the term suggests, the interpreter renders the primary speaker's statements into the language required by the audience(s) continuously as they are expressed. Simultaneous interpretation generally involves special equipment linking the parties involved. With remote simultaneous interpretation, the interpreter is linked to the parties – for example, a clinician and patient – from a remote site.

. A pilot study at the New York University School of Medicine found when remote interpreters are used the simultaneous method of interpretation is much quicker than traditional consecutive interpreting.⁷⁸¹ The use of the technology was reported to have other benefits.⁷⁸² However, at the time of writing it is unknown whether the technology has been effectively applied in other health settings.

6.3.3 Videoconferencing medical interpreter technology

Videoconferencing medical interpreter (VMI) technology links a remote credentialed interpreter to a client and a health practitioner via a video link so they can see and hear each other. The systems range from elaborate wireless freestanding equipment on trolleys to wheel to the point of care⁷⁸³ to web cameras in computers.⁷⁸⁴ VMI technology has recently become available to mobile devices through an application called Purple Video Remote Interpreter. It links a remote credentialed interpreter to a client and health practitioner.⁷⁸⁵

The use of VMI technology in two US hospitals has received positive appraisals. The Holy Name Hospital in New Jersey implemented VMI in 2003. An evaluation found that: it was more expensive than using telephone interpreters but much less expensive than using on-site interpreters; patients were comfortable with the system; there were fewer delays for interpreters; all important visual clues and body language which can be important in a health setting were able to be identified; and it could be easily replicated in other settings with the assistance of organisations' information technology staff.⁷⁸⁶

In 2005, the Rancho Los Amigos National Rehabilitation Centre implemented VMI.⁷⁸⁷ Introduction of VMI was reported to have increased access to credentialed interpreters. One month prior to the introduction of VMI, the service provided interpreters in 12 out of 195 cases, i.e. 6% of cases. In the month after the introduction of VMI, the service provided interpreters in 72 of 300 consults needing interpreters, i.e. 24% of cases.⁷⁸⁸ Rancho has used VMI technology to participate as a member of the Health Care Interpreter Network (see Appendix 3).⁷⁸⁹

A number of Victorian health service organisations utilise VMI, including Northern Health,⁷⁹⁰ Sunraysia Community Health Services (SCHS)⁷⁹¹ and Southern Health. Northern Health introduced VMI in 2009 and currently provides approximately 20 interpreting sessions per month by video, reporting that results are satisfactory and could be improved with infrastructure investments.⁷⁹² Southern Health reports benefits of faster access to credentialled interpreters and cost-effectiveness.⁷⁹³ SCHS has commented that their experience has been very good. However, 'it is underutilised as it is more difficult than the telephone modality in terms of interpreter availability, as the interpreter needs to be physically present in the interpreter service booth'.⁷⁹⁴

The NSW Health Care Interpreter Service (HCIS) has four services in NSW, two based in metropolitan Sydney and two based in regional/rural areas of NSW. Each of these HCIS sits within the local health district and provides interpreting services to public health facilities within their boundaries (Appendix 2). The HCIS submission to this study outlined their use of VMI in the provision of interpreting services.

Video conferencing is routinely used by Mental Health Review Tribunals and Magistrate hearings for involuntary psychiatry clients/patients with limited proficiency in English where healthcare interpreters are engaged as a matter of course, as well in rural areas where a particular language may not be available.⁷⁹⁵

The use of VMI could assist all service providers as it may increase the likelihood of the request for service being filled (where currently on-site requests often go unmet) because it reduces travel time and increases the time interpreters spend interpreting. Rural and outer metropolitan communities in particular will benefit because of the limited pool of on-site interpreters in those communities and the unwillingness of Melbourne-based interpreters to travel to these communities for appointments because of the associated out-of-pocket travel costs.⁷⁹⁶ The Royal Australian and New Zealand College of Psychiatrists, Bendigo Health and St Vincent's Hospital all expressed support for these developments in its submissions. St Vincent's noted:

There is a future direction which is currently being trialled by a number of health providers in Melbourne and Australia. It has enormous potential to ease availability issues and has been shown to be highly successful in countries such as the US and the UK, bearing in mind it is still ultimately reliant on the availability of an interpreter. Further promotion and acceptance of this mode of interpreting should be encouraged by seed funding by [the Department of Health].⁷⁹⁷

Specialists, consultant physicians or consultant psychiatrists who implement VMI technology may be able to take advantage of the Telehealth start-up instalment and a second instalment after the tenth valid Telehealth MBS claim, as well as MBS item numbers, if they also use VMI in consultations with clients in eligible

Telehealth areas.⁷⁹⁸ In practice, this could mean that the specialist and credentialed interpreter are co-located for the consultation in a Melbourne hospital and the client is based in a specified Telehealth area, which are generally rural, regional and outer metropolitan areas.

The Australian College of Rural and Remote Medicine submission noted the move towards Telehealth platforms for health practitioners.

Telephone interpreting would be familiar and adequate in many instances, however, there may well be need for qualified interpreters to facilitate Telehealth (video or web based) enabled services ... We note that the government is providing financial support to doctors (GPs and Specialists) to become Telehealth enabled so this may well become an increasing feature of health consultations into the future.⁷⁹⁹

Given that the MBS funding exists, and there is health sector support to maximise technology to deliver interpreter mediated health consultations, it would be timely if the Commonwealth and Victorian governments could investigate opportunities for Telehealth to deliver VMI to clients of low English proficiency in any projects being considered for implementation.

Recommendation 6.4: The Commonwealth Department of Health and Ageing and the Victorian Government should explore the potential for Telehealth and similar videoconferencing services to deliver cost-effective interpreting services.

6.4 Service planning and data collection

6.4.1 Demographic data

Demographic data from various sources can be accessed to assist health services to plan to meet the language needs of clients in their catchment areas with low English proficiency. The data can indicate the presence of significant numbers of people who may require language assistance and also the languages.⁸⁰⁰ For example:⁸⁰¹

- the Australian Bureau of Statistics, e.g. the census for proficiency in spoken English, country of birth and preferred language
- the Department of Immigration and Citizenship, e.g. settlement database: <http://www.immi.gov.au/settlement>
- client files may include preferred language and other possibly pertinent characteristics such as age and gender
- language service providers may hold data on requests for interpreting services by language and region.

The NSW Health Care Interpreter Service noted that they access ABS, DIAC, inpatient, outpatient and emergency department data for service planning and projecting demand.⁸⁰²

Demographic data can be used to compare the expected demand for and use of interpreting services.^{803, 804} Projecting demand for interpreting services using all available data is especially important in budgeting for interpreting services.

Bendigo Health noted that some factors may interfere with accurately projecting demand for services based on client files:

Often due to barriers such as language, culture or fear, the country of origin and number of people are underestimated, which statistically gives a false (under) impression of the need for interpreter services in this region.⁸⁰⁵

Medical Locals are well placed to assist health services to plan to meet the language needs of clients with low English proficiency in their catchment areas.

There are five Medicare Local strategic objectives, which include the 'identification of the health needs of local areas and development of locally focused and responsive services' (Objective 3). To achieve this objective Medicare Locals are expected to have appropriate data collection and analysis expertise to 'maintain a population health database including community health and wellbeing measures, provide input to population health profiles and undertake population needs assessment and planning'.⁸⁰⁶

The guidelines for the establishment and initial operation of Medicare Locals set out six selection criteria against which applications for Medicare Local funding are assessed. One specifies that applicants must have:

... demonstrated knowledge of the population base, health service architecture and infrastructure, utilisation and other demographic characteristics and health priorities in the proposed catchment area (this should indicate evidence from which this knowledge is drawn).⁸⁰⁷

Successful applicants enter into a Medicare Locals Deed with the Department of Health and Ageing (DoHA).⁸⁰⁸ Schedule 3 of the Deed commencing 2011–12 requires Medicare Locals to provide a needs assessment report outlining local needs-based population health planning, having regard to a template provided by the department.

At present the template does not require details on the number of people in the area who were born overseas, whether they are of CALD background, or levels of English proficiency. Medicare Locals are required to annually review and update the annual needs assessment report. DoHA has let a tender for the development of a template that will be used from 2014 onwards for comprehensive needs assessments. The development of the new template and accompanying resources should include English proficiency, in terms of access to services.⁸⁰⁹

Recommendation 6.5: The Australian Government should ensure that the needs assessment reports prepared by Medicare Locals include data about English proficiency and languages other than English of the populations in their areas, in order to indicate possible demand for interpreters.

6.4.2 Monitoring demand for and use of interpreters

The collection and analysis of data about the demand for and provision of interpreting services (both on-site and telephone) provides organisations with the necessary tools to monitor the delivery of interpreting services, such as wait times for interpreting services, the quality and safety of treatment for individual clients (e.g. those in acute care requiring complex interventions), and whether:

- screening tools for interpreting services are effective
- clients who require interpreting services are provided with them
- staff are engaging interpreters at critical moments in care
- telephone interpreting services are being fully utilised
- there is unsatisfied demand
- quality improvement activities for interpreter access are successful.^{810, 811}

The Victorian Government has standards for data collection on interpreting and translating for funded agencies which cover client demographics, expenditure, in-house staff and services provided by language service providers.⁸¹² New reporting requirements for quality of care reports⁸¹³ will assist service providers to monitor demand for and use of interpreters.

The NSW Health Care Interpreter Service collects data on utilisation of interpreters per language, which then is used as a tool for planning the recruitment of staff (in-house) interpreters and/or freelance interpreters.⁸¹⁴

A US learning network around the delivery of language services in the hospital setting developed a set of five performance measures that could be used by hospitals interested in quality improvement for language services. These are:

- screening for preferred language
- clients receiving language services from qualified language service providers
- client wait time
- time spent interpreting
- interpreter delay time.

The network hospitals then tested over 200 strategies for quality improvement in the delivery of language services. There was significant improvement in language service delivery for the 10 participating hospitals across the performance measures.⁸¹⁵

Having dedicated time for senior and administrative staff within their roles to support access to interpreting services, by monitoring and reporting on service provision, quality and improvement has been found to improve access to interpreting services by Bendigo Health.⁸¹⁶

6.5 Interpreter booking systems

Complex or inefficient booking systems can impact on the engagement of interpreting services.⁸¹⁷ The lack of service coordination in relation to booking interpreters can also be a source of frustration.⁸¹⁸ Health West Partnership noted that poor service coordination between health services and interpreting services can impair the ability to meet demand.

Interpreters are often unable to wait when appointments or outpatient clinics run late. It is acknowledged that late appointments are a health system issue; however there is a lack of alignment between inflexible booking systems, i.e. health service appointment schedules and interpreter bookings and schedules.⁸¹⁹

It follows that 'Good practice in language services delivery in the health and community sector is characterised by established and efficient interpreter booking systems.'⁸²⁰

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

Designating a specific staff member with responsibility for the organisational operation of the interpreting service is regarded as an example of best practice,⁸²¹ and has been adopted by (among others) Northern Health, the Royal Women's Hospital and Western Health.⁸²² Recently, the Dental Hospital introduced a new system of booking all interpreters via an interpreter bookings officer. It is reported that 'Interpreters, patients and staff like the new system because they know who to contact and where to go for any interpreter issues. It saves everyone time and money.'⁸²³

Western Health recently introduced the 'dr. notes' system specifically tailored for their needs. The 'dr. notes' system replaced a manual system where paper-based requests would be entered into Excel and then forwarded to in-house or agency interpreters. The 'dr. notes' system is reportedly working well; no bookings have been lost since its introduction. Other reported benefits include:

- it is easy for staff to use
- there are fewer errors
- it has the capacity to generate reports
- it is more efficient.⁸²⁴

Mercy Health has reported an increase in interpreting services following the development and implementation of the interpreter booking report in the statewide HealthSMART integrated patient and client management system.

The report identifies all outpatients who require an interpreter and their appointment details. This system is complemented by a number of other strategies, but the point of difference is that it eliminates the reliance on receiving requests for an interpreter. Instead, it allows the Interpreter Bookings Coordinator to identify and book interpreters as required. Implementation of these strategies has seen the provision of interpreting services to maternity patients increase from 79.8% in 2008/09 to 97% in 2010/11. Currently a similar report is being trialled to assist in identifying inpatients who require an interpreter.⁸²⁵

St Vincent's Hospital noted the importance of appropriate interpreter booking and management software systems.

In addition to an initial contact and registration system to establish whether an interpreter is required, an interpreter booking and management software system is needed for the bulk and complexity of interpreter bookings. Many organisations now use some form of database to facilitate bookings and related costs, collect language productivity data and run reports on booking outcomes and unmet demand. Data entry of episodes of care should include outcomes of interpreter bookings categorised, for example as: appointment cancelled by patient; appointment cancelled by agency, or health provider; patient did not attend; interpreter did not attend (punctuality is also recorded); interpreter unavailable – family interpreted and the like.⁸²⁶

6.5.1 Block booking interpreters

A number of health services in Victoria that have high demand for particular languages book on-site interpreters in those languages for regular sessions of time; for instance ISIS Primary Care block book the same Chin Burmese interpreter for one day each week.⁸²⁷

The Greater Dandenong Community Health Service found block booking interpreters for regular sessions of time for their clinics was cost-efficient.

Two block booked interpreters are used at Greater Dandenong Community Health Service (Southern Health), a Burmese interpreter for the MY Health Clinic and a Cambodian interpreter for the Well Women's Clinic. For September, October and November 2011, the use of these block booked interpreters was tracked to ascertain usage. Usage of these interpreters was high over this period. When comparing the cost of block booked interpreters to the cost of booking individual interpreters instead to provide the same service, using block booked interpreters facilitated a significant saving of \$8,308.50 over the period.⁸²⁸

Primary Care Connect Community Health Services opportunistically block books, using colour coding in Outlook (e.g. Arabic – green, Dari – blue) when they book interpreters, so that other staff can synchronise appointments that arise for those language groups with the scheduled interpreter appointments.⁸²⁹

The Royal Dental Hospital of Melbourne uses a mixture of block booking regular sessions of time and opportunistically block booking appointments as they arise.

A single booking officer now coordinates all interpreter bookings with patient appointments. Interpreters of the most commonly used languages at the hospital are allocated weekly appointment blocks, and wherever possible, patients who speak these languages are given appointments on these days. Patients speaking other languages are grouped in blocks of two or more wherever possible.⁸³⁰

In NSW, block booking has also been found to be effective.

Block bookings or ‘permanent clinics’ as they are called among staff, have worked well for high demand languages at busy clinics such as antenatal clinic, chest clinic, sexual health clinic, physiotherapy, dental clinic just to name a few.⁸³¹

Block booking minimises travel for the interpreter providing more interpreted hours and less travel time. It is also more cost-effective for the organisation as each on-site booking is charged for 90 minutes irrespective of the consultation length, therefore if consultations typically take 30 minutes, the interpreter can see three clients for the cost of one on-site booking. Furthermore, it enhances access to the health service when community members become aware an interpreter in their language is regularly available on a dedicated day.^{832, 833, 834, 835}

However, a number of issues have been raised regarding the practice of block booking. Firstly, block booking can raise equity issues for other health services competing for available interpreters, particularly in new and emerging languages.⁸³⁶ Secondly, the very nature of block booking requires clients to come to a service at the same time as others from the same background; some clients may prefer not to be identified by those of their own community due to stigma or embarrassment.⁸³⁷

6.6 Policies and procedures

As noted in Chapter 2, the Victorian Government has implemented policies and frameworks to guide and support funded agencies to become more culturally responsive, including:

- *The Cultural Responsiveness Framework: Guidelines for Victorian health services*
- Home and Community Care program Diversity Planning and Practice Strategy
- the departmental *Language Services Policy*.

The adoption of policies and procedures on engaging credentialled interpreters are important elements of organisational commitment.^{838, 839} ‘The promotion and uptake of the policies and procedures by staff throughout the organisation is just as critical.’⁸⁴⁰ Research confirms that staff awareness of organisational policies increases the likelihood of them working with credentialled interpreters.⁸⁴¹ In NSW, a standardised interpreter procedure was rolled out across all emergency departments and birthing units in the Sydney West Area Health Service to assist staff with accessing and booking interpreters as well as recording information.⁸⁴²

Policies and procedures should encompass the organisation’s values and expectations, complaints mechanisms and government policy where applicable, as well as detailed procedural guidelines, for example, booking procedure and guidelines on use of on-site or telephone interpreters. These should be referenced in cultural responsiveness or quality improvement plans. Both private and public health service providers should be encouraged to develop policies for communicating with clients with low English proficiency, and the accreditation standards are a good mechanism for this (see Chapter 2).

Recommendation 6.6: All health services should have policies and procedures in place for the engagement of and working with credentialled interpreters.

6.7 Internal reviews

Mr Trong Chau Nguyen moved to Australia from Vietnam in 2004. Two years later, he was diagnosed with type 2 diabetes. Mr Nguyen learnt a lot about managing his diabetes from his Vietnamese-speaking doctor and interpreters at (North) Richmond Community Health Centre. But having someone to call for advice or information in Vietnamese in between regular appointments would be very helpful ... ‘Sometimes a question comes to mind and I do not have an appointment at the health centre so I can just call the InfoLine.’ [via an interpreter]

Diabetes Australia – Vic, (2012), New diabetes information line speaks your language, Media Release.

Organisations that have undertaken internal reviews of language services report positive outcomes such as the identification of areas for improvement of current procedures and budgetary efficiencies. For example, Primary Care Connect Community Health Services in 2008 used the ‘Language Services Toolkit’⁸⁴³ in a move towards implementing procedures for best practice.⁸⁴⁴ In 2010, ISIS

Primary Care had an internal review that culminated in improved efficiencies and a review of policies.⁸⁴⁵ In 2010, Western Region Health Centre (WRHC) also had an internal review, which identified areas for improvement within the organisation.⁸⁴⁶ The Royal Women's Hospital recently set up a taskforce focused on language service delivery which will seek to improve budget efficiencies and address identified barriers to the use of interpreters.⁸⁴⁷ The Diabetes Australia Victoria Multilingual Infoline (1300 801 164) evolved from an internal evaluation and review conducted in 2010 of a service which was established in 2006 and upgraded in 2009. The review took place as a result of lower than expected levels of uptake of interpreting services. The review found that complications arose from having individual numbers for nine different languages. This led to the launch of the current single dedicated phone line for all callers who prefer to use an interpreter (Appendix 5).

A number of barriers were identified in the Chapter 5 that highlight that there are critical points within health services where the clients' need for interpreting services may not be identified and addressed. For example:

- clients not identified as requiring an interpreter at the point of initial contact with a service
- patient management systems not allowing the specification of new and emerging languages
- referral documentation not including a client's interpreter needs, or the language required
- lack of awareness of interpreting services by health practitioners
- lack of appropriate telephone equipment in areas where it is required.

The development of a self-assessment checklist that highlights the key areas management should routinely monitor and review may help organisations significantly improve service delivery.

Recommendation 6.7: The Victorian Government should support health services to review interpreting services, and to trial innovations and other quality improvements in interpreting services delivery.

Appendix 1: Northern Health interpreting services

Note: The information provided in this appendix was provided to Foundation House by Northern Health unless otherwise noted.

In the early to mid-2000s, Northern Health clinicians used interpreters inconsistently, or often used unqualified interpreters or family members to communicate with patients with low English proficiency; there was minimal training of staff members, and little use of translated information. Moreover, staff reported that their use of interpreters was negatively affected by the length of time involved in organising an interpreter.⁸⁴⁸

Northern Health has since made significant investments to elevate the important role language services play in the delivery of health care to clients with low English proficiency, with the creation of the Transcultural and Language Services Department (TALS) in 2007.

Initially the TALS department was tasked with centralising language services across Northern Health's five major public healthcare campuses: Broadmeadows Health Service, the Northern Hospital, Bundoora Extended Care Centre, Craigieburn Health Service, and Panch Health Service. This involved reviewing and updating policies and strategic plans with a view to improving cultural competence at the five campuses.

Subsequently the TALS department concentrated on employment strategies bringing the number of EFT in-house interpreters and translators from four in 2007 to 15.1 in 2012. As a minimum requirement, all staff have NAATI professional accreditation (Level 3). Additionally, 14 out of 17 staff have tertiary language degrees and four out of 17 staff have postgraduate qualifications.

TALS also introduced four separate one-hour transcultural training sessions for all staff, including medical, allied health and admin staff; additionally TALS delivered targeted presentations also for senior management, including the board, the Executive Committee, Human Resources, and the Quality Department. Sessions covered topics including:

- the impact of cultural competence on health services
- when, why and how to book a professional interpreter
- how to work with an interpreter
- diversity in the health context
- established and emerging communities
- working with Muslim patients

- intergenerational conflict
- why children should not be used as interpreters.

The TALS department also entered into a memorandum of understanding with Monash and RMIT universities so that their language students may complete their practicum in the acute or sub-acute context; to play their part in shaping the future interpreting and translating workforce.

Further, the TALS department successfully advocated for all research projects undertaken at Northern Health involving clients, to include 25% of the total number of clients in the research project to be from a non-English-speaking background, to accurately reflect the client population at Northern Health. Researchers also typically consult with the TALS department to determine the cultural appropriateness of the project and budget for interpreter and translation costs as a part of the research project.

It should be noted that at Northern Health, the top nine languages attract approximately 85% of all demand. However, many smaller languages are growing at a much faster rate.

The benefits

The creation of the TALS department at Northern Health in recognition of the important role that credentialled interpreters play has ultimately improved patient care and reduced medico-legal risks, but it has also provided significant return for investment to the hospital.

There has been a demonstrated improvement to the level of accessibility for credentialled interpreters as the occasions where interpreting services have been requested but unable to be met have reduced from over 5% in 2008 to 1.9% in 2012.

There has been a reduction in the average length of stay for low-English-proficiency clients from 9.14 days in the first half 2007 to 5.9 days in the first half of 2012 which has resulted in significant cost-efficiencies for the hospital.

The TALS department is lifting the profile of interpreting within the hospital, requests for interpreting services increased from 15,000 in the 2007 calendar year to 43,202 in 2011 (see Table a1 below). This is in part a reflection of the inherent value of the services provided. More so however, the rise in requests for interpreting services may be indicative of previously unrevealed demand, or demand previously not identified. Table a2 below illustrates that the rise in requests for service is not based on a growth in demand from the catchment's population, as there has been a negligible increase in percentage of clients born in non-English-speaking countries in the total number of appointments at

Northern Health. Demand for the Northern Health catchment for language services was 18.2% of total appointments in 2011–12 financial year, a 6.5% increase from what was 11.7% in the 2008–09 financial year – with only negligible increases (0.6%) in the proportion of appointments for patients born in non-English-speaking countries over the same period.

Table a1: The benefits of investing in interpreting services at Northern Health

Factor	Jan-Jun 2007	Jul-Dec 2007	Jan-Jun 2008	Jul-Dec 2008	Jan-Jun 2009	Jul-Dec 2009	Jan-Jun 2010	Jul-Dec 2010	Jan-Jun 2011	Jul-Dec 2011	Jan-Jun 2012
In-house EFTs	4		5		8		10.6		12.1		15.1
Interpreter requests	7,000	8,000	9,000	12,487	15,014	18,458	19,022	19,295	20,645	22,557	23,439
Training sessions	0		30		60		77		92		95
Number of translated words in-house	0		0		33,303		50,202		70,083		89,960
Unable to provide			5%+		4.40%		3.50%		3.40%		1.90%
Average NES length of stay	9.14	8.85	8.75	8.47	8.31	7.94	7.55	6.85	6.07	6.5	5.9

Table a2: Financial years 2008–09 to 2011–12, a focus on unrevealed demand

Factor	Jul-Dec 2008	Jan-Jun 2009	Total 2008–09 FY	Jul-Dec 2009	Jan-Jun 2010	Total 2009–10 FY	Jul-Dec 2010	Jan-Jun 2011	Total 2010–11 FY	Jul-Dec 2011	Jan-Jun 2012	Total 2010–11 FY
Total appointments			233,839			248,074			234,618			251,526
Interpreter Requests and % of total appointments	12487	15014	27,501 (11.7%)	18458	19022	37,480 (15.1%)	19295	20645	39,940 (17%)	22557	23439	45,996 (18.2%)
Patients born in NES Countries and % total appointments			100,133 (42.8%)			108,207 (43.6%)			100,849 (43%)			109,212 (43.4%)

Source: Zucchi, E. (2012), *Beyond Interpreting: the Case for a Language Services Discipline in the Health Context*, Culturally & Linguistically Diverse Communities Conference, Sydney.

Northern Health has reported additional benefits, including:

- lower unit costs for delivering interpreting services internally than relying on external providers

- increased clinician cultural competence
- more efficient use of clinician time
- developing trust in the healthcare system with clients of low English proficiency
- the ability to translate documents in-house which led to the development of a translations database that is accessible to all staff containing over 500 documents translated in the top seven languages used by clients with low English proficiency at the hospital.

Appendix 2: NSW Health Care Interpreter Service

Note: The information in this appendix was provided directly by the NSW Health Care Interpreter Service.

There are four Health Care Interpreter Service units (HCIS) in NSW or Health Language Services (HLS) as some are called. Two are based in metropolitan Sydney and the other two in regional/rural areas. Each of these HCIS sits within the structure of a local health district (LHD) and provides interpreter services to the public health facilities in its designated boundaries.

HCISs have been present in the NSW public health environment since 1977 and there is a level of awareness among CALD clients about the service. HCIS is a free service to health providers and clients, 24 hours a day and 7 days a week. Dedicated hotlines are allocated for public hospital emergency departments, birth units and intensive care units. There is one phone number to call at all times and for any type of interpreter booking request. In addition, booking requests for interpreters can be made via email, e-orders (through patients' electronic medical record) or fax.

Each HCIS has their own centralised booking system for the whole of the LHD they service. Coordinating the allocation and prioritisation of assignments is carried out from this hub usually called the 'booking office' or the 'call centre'.

Each of the HCIS employs full-time and part-time staff interpreters on a permanent or temporary basis depending on the emerging trends in demand for specific languages. The existing four HCIS are the largest employers of staff interpreters in Australia. Depending on the number and the size of the LHDs that individual HCIS cover, the number of employed staff interpreters ranges from around 20 to 91 interpreters.

In addition, and as a supporting mechanism, each of the HCIS maintains their own panels of contract (freelance) or sessional interpreters who are engaged in periods of increased demand and for those languages not covered by staff interpreters. The number of interpreters on the freelance panels varies constantly as recruitment is an ongoing activity. It is estimated that numbers can range from 250 to 450 interpreters at any one time. TIS is used as a backup in cases where HCIS has been unable to provide an interpreter either from the staff interpreter or the freelance pool.

The benefits

Having a network of shared interpreter services for public health facilities in NSW has shown to have numerous benefits, including:

- cost-efficiencies
- improved response rates to requests for service
- well trained interpreters through ongoing training delivered through the NSW Professional Development Committee (PDC) dedicated to delivering healthcare interpreter specific training programs
- ongoing experience in practising medical interpreting leading to a specialised workforce (although this has been largely unexplored and unrecognised)
- successful quality insurance mechanisms as trained assessors from the HCIS conduct on the job observations to provide both opportunities to support interpreters and identify performance gaps which can translate into designing relevant training programs (further clients can lodge a complaint in their own language or through the patient representative)
- sophisticated data collection and reporting, including: number of occasions of service per language, per facility and/or specified departments in a facility (which then is used as a tool for planning the recruitment of staff interpreters and/or freelance interpreters); unmet interpreter requests per language; and the disaggregation of the 'failure to utilise' resources by:
 - (a) healthcare provider failed to attend (HCP FTA)
 - (b) patient failed to attend (PT FTA)
 - (c) seen without an interpreter (SWI), i.e. interpreter has been provided but the patient was seen before the requested time of the appointment
 - (d) healthcare provider failed to cancel (HCP FTC)
 - (e) waiting time, i.e. the time the interpreter waited before the patient was seen.

Appendix 3: Californian Health Care Interpreter Network

The Health Care Interpreter Network (HCIN) was established as a not-for-profit cooperative of Californian public hospitals sharing interpreter services.⁸⁴⁹ The network operates via a mobile video unit that is wheeled to the point of care at the time of need, which enables both telephone and video interpreting. The interpreter request is initiated automatically when the health practitioner pushes a button. Requests are first routed to in-house interpreters. If they are unavailable, the request is then routed to the network of participating hospitals and subsequently to a commercial interpreter provider.⁸⁵⁰

When they join the network, hospitals incur start-up costs for the necessary equipment. They pay annual fees to participate in the network at levels based on the number of services they receive.⁸⁵¹ Membership fees cover three scenarios: 'full' membership for hospitals with staff interpreters; 'junior' membership for high need and no in-house interpreters; and 'lite' membership for hospitals with only occasional need for interpreters. Californian hospitals and community-based clinics are eligible to join the network.⁸⁵²

Funding support came from multiple sources, including the US Government, philanthropic foundations and consumer organisations.⁸⁵³

There are at least four other interpreter networks across the US: Illinois Video Interpreter Network; Kaiser Permanente Interpreter Network; University of New Mexico Hospitals; and MedStar Interpreter Network.^{854, 855}

The benefits

'The Health Care Interpreter Network has now routed over 631,000 calls from its beginning in late 2005 through August 2011 and has provided over 4 million connected minutes of health interpretation. The annual number of routed calls has exploded from 1,543 in 2005 to 229,035 in calendar year 2010 with an anticipated 275,000 routed calls in 2011.'⁸⁵⁶

The HCIN network has reported a number of benefits, including:

- a large uptake in the use of interpreter services after the implementation of the network
- it increased the interpreted hours provided (as interpreters are not required to change locations)
- it lowered costs
- it increased access to new-arrival languages

- the capacity to designate high priority for a call, so that an emergency call can jump to the top of the queue
- the ability for interpreter requests to be answered in less than 3 minutes, with an average connection time of 22 seconds^{857, 858}

However, it was found face-to-face interpreters may still be preferable to both physicians and clients, and there were additional costs associated with training health practitioners on how to use the equipment.⁸⁵⁹

Appendix 4: The Victorian Health Innovation and Reform Council

In March 2012, the Victorian Minister for Health established an independent advisory body, the Health Innovation and Reform Council (the council) to guide health service improvement across the state. The council was set up in accordance with the *Health Services Amendment (Health Innovation and Reform Council) Act 2011*.⁸⁶⁰

Among its tasks, the council is to ‘advise on the implementation and ongoing review of the Victorian Health Priorities Framework 2012–2022, Victorian state health planning and specifically implementation priorities and implementation approach’.⁸⁶¹ One of the priorities under the framework is ‘Improving every Victorian’s health status and health experience’ and an implementation action is ensuring interpreters are available where needed.⁸⁶² Another task set before the council is to advise on ‘research for the purpose of more effective clinical and policy decision making’.⁸⁶³

The minister has given the council two initial priority terms of reference: reviewing hospital readmission rates and associated practice to provide advice on clinical, quality and operational improvements; and consider and advise on innovative models of care that can be provided through Telehealth services, particularly in rural and regional areas.⁸⁶⁴ Each of these can contribute to facilitating the engagement of credentialled interpreters in the provision of health services.

Appendix 5: Diabetes Australia Vic – Case Study

Diabetes Australia – Vic (DA–Vic) launched its new Multilingual Infoline (1300 801 164) during ‘Cultural Diversity Week’ in March 2012. The initiative stems from the organisation’s cultural diversity strategy.⁸⁶⁵

The Multilingual Infoline connects callers with the help of an interpreter (in over 170 different languages) to services and information on diabetes prevention, support, management and the National Diabetes Services Scheme (NDSS).

The Infoline evolved from an internal evaluation and review conducted in 2010 of an existing service which was initially established in 2006 and later upgraded in 2009. The review took place as a result of lower levels than expected of uptake of interpreter services. The review found that complications arose from having individual numbers for nine different languages. This led to the launch of the current single dedicated phone line for all callers who prefer to use an interpreter.

Within two months of launching the new Multilingual Infoline, DA–Vic is receiving the same number of calls that were being recorded on the previous system.

The Multilingual Infoline was launched with a client and health practitioner awareness campaign, which included:

- promotional materials developed: magnets and posters
- media releases for local and CALD media outlets
- targeting health professionals through general practice newsletters, symposiums and forums
- pharmacies and other access points for the National Diabetes Services Scheme
- mail out through database contacts for CALD consumer organisations, local government and community health centres
- website and social media
- translated letters sent to DA–Vic members in five community languages and an article published in the DA–Vic membership newsletter
- promotion through the Bilingual Health Educator (BHE) program. DA–Vic runs a type 2 diabetes awareness session utilising BHEs who can speak over nine languages
- promotion through community events such as Brimbank Festival 2012 as well as community newsletters.

The Multilingual Infoline was also promoted internally to DA–Vic staff, which included:

- announcements at monthly staff meetings
- staff email announcing the new service and resources
- the cultural diversity program attended customer service team meetings to explain the new system and how it works step by step
- a cultural diversity morning tea where the new service was highlighted
- promotion on the intranet home page
- distribution of a ‘Do you need an interpreter?’ poster to all staff that could be pinned up near their phone – with the steps of how to access TIS
- liaison with human resources to ensure that all new staff members receive the poster in their orientation pack.

Notes

Glossary

¹ National Accreditation Authority for Translators and Interpreters, personal communication, June 2012.

Executive summary

² Australian Bureau of Statistics. (2006). *Proficiency in Spoken English / Language by age for time series, Cat. No. 2068.0*, 2006 Census Tables – Victoria (State).

² Phillips, C. & Travaglia, J. (2011). Low levels of uptake of free interpreters by Australian doctors in private practice: secondary analysis of national data. *Australian Health Review*, 35(4).

Chapter 1: Reasons to engage credentialed interpreters

⁴ Department of Health. (2009). *Cultural responsiveness framework – Guidelines for Victorian Health Services*. Melbourne: Victoria, p. 18.

⁵ Australian Human Rights Commission. (2010). *In our own words African Australians: a review of human rights and social inclusion issues*. Sydney, New South Wales, p. 18.

⁶ Heaney, C. & Moreham, S. (2002). Use of interpreter services in a metropolitan healthcare system. *Australian Health Review*, 25(3), p. 38.

⁷ Berner, S. (2010). Health care interpreters – vital partners in client care. Diversity Health Institute. *Diversite*, 2, p.7.

⁸ Jacobs, E. et al. (2001). Impact of interpreter services on delivery of health care to limited English proficient clients. *Journal of General Internal Medicine*, 16(7), p. 468.

⁹ Bolton, P., Hammond, S. & Leung, J. (2002). Issues in quality use of medicines in two non-English speaking background communities. *Australian Journal of Primary Health*, 8(3), p. 79.

¹⁰ Centre for Culture, Ethnicity and Health. (2006). *Language Services in Victoria's Health System: Perspectives of Culturally and Linguistically Diverse Consumers*. Melbourne, Victoria: Brough, C., p. 34.

¹¹ Flores, G. (2005). The impact of medical interpreter services on the quality of health care: a systematic review. *Medical Care Research and Review*, 62, p. 255.

¹² Karliner, L., Jacobs, E., Chen, A. & Mutha, S. (2007). Do professional interpreters improve clinical care for clients with limited English proficiency? A systematic review of the literature. *Health Services Research*, 42(2), p. 743.

¹³ Flores, G. et al. (2003). Errors in Medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics*, 111(1), p. 6.

¹⁴ Australian Institute of Interpreters and Translators. *Accreditation*. Accessed 6 June, 2013, from

http://www.ausit.org/AUSIT/About/Our_Industry/Accreditation/AUSIT/About/Our_Industry_Sub.aspx?hkey=5c2348c3-de01-4c2e-bcd5-70ac1b5c94ee.

¹⁵ National Accreditation Authority for Translators and Interpreters. (2012). *Accreditation by Testing Information Booklet, Version 1.18*. Canberra: Australian Capital Territory.

1.1 Quality of care

¹⁶ Timmins, C. (2002). The impact of language barriers on the health care of Latinos in the United States: a review of the literature and guidelines for practice. *Journal of Midwifery and Women's Health*, 47(2), p. 80.

¹⁷ Flores, G. (2005). The impact of medical interpreter services on the quality of health care: a systematic review. *Medical Care Research and Review*, 62, p. 255.

¹⁸ Renzaho, A. (2007). Ischaemic heart disease and Australian immigrants: the influence of birthplace and language skills on treatment and use of health services. *Health Information Management Journal*, 36(2), p. 26.

¹⁹ Ferguson, W. & Candib, L. (2002). Culture, language and the doctor client relationship. *Family Medicine*, 34(5), p. 353.

²⁰ Flores, G., (2005), op. cit., p. 258.

²¹ Eastern Access Community Health. (2011). *Refugee Health Nurse Program Evaluation Project 2011*. Melbourne, Victoria: p. 22.

²² Australian Psychological Society submission to Foundation House's Exploring barriers and facilitators to the use of qualified interpreters in health, discussion paper, June 2012.

²³ Flores, G. (2005). op. cit., p. 255.

²⁴ Karliner, L., Jacobs, E., Chen, A. & Mutha, S. (2007). Do professional interpreters improve clinical care for clients with limited English proficiency? A systematic review of the literature. *Health Services Research*, 42(2), p. 748.

1.2 Client safety

²⁵ Eastern Access Community Health. (2011). *Refugee Health Nurse Program Evaluation Project 2011*. Melbourne, Victoria: p. 23.

²⁶ Blennerhassett, J. & Hilbers, J. (2011). Medicine management in older people from non-English speaking backgrounds. *Journal of Pharmacy Practice and Research*, 41(1), p. 36.

²⁷ Timmins, C. (2002). The impact of language barriers on the health care of Latinos in the United States: a review of the literature and guidelines for practice. *Journal of Midwifery and Women's Health*, 47(2), p. 80.

²⁸ Divi, C. et al. (2007). Language proficiency and adverse events in US hospitals: a pilot study. *International Journal for Quality in Health Care*, 19(2), p. 60.

²⁹ Cohen, A. et al. (2005). Are language barriers associated with serious medical events in hospitalised pediatric clients? *Pediatrics*, 116(3), p. 575.

³⁰ Zimbudzi, E., Thompson, S. & Terrill, B. (2010). How accessible are interpreter services to dialysis patients of Non-English Speaking Background? *Australasian Medical Journal*, 1(3), p. 208.

³¹ Thomas, P., Beckmann, M. & Gibbons, K. (2010). The effect of cultural and linguistic diversity on pregnancy outcome. *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 50, p. 421.

³² Johnstone, M. & Kanitsaki, O. (2006). Culture, language and client safety: making the link. *International Journal for Quality in Health Care*, 18(5), p. 383.

³³ Kalanj., B. (2007). Qualified interpreters improve health literacy and client safety. *Client Education Management*, 14(7), p. 74.

³⁴ Garrett, P. (2009). Healthcare interpreter policy: policy determinants and current issues in the Australian context. *Interpreting and Translations*, 1(2), p. 44.

1.3 Access to health care

- ³⁵ Cooke, R., Murray, S., Carapetis, J., Rice, J., Mulholland, N. & Skull, S. (2004). Demographics and utilization of health services by paediatric refugees from East Africa: implications for service planning and provision. *Australian Health Review*, 27(2), p. 40.
- ³⁶ Timmins, C. (2002). The impact of language barriers on the health care of Latinos in the United States: a review of the literature and guidelines for practice. *Journal of Midwifery and Women's Health*, 47(2), p. 80.
- ³⁷ MacKinnon, V. (1998). Language difficulties and health consequences for older Italian-Australians in Ascot Vale. *Australian Journal of Primary Health*, 4(4), p. 34.
- ³⁸ Henderson, S. & Kendall, E. (2011). Culturally and linguistically diverse peoples' knowledge of accessibility and utilisation of health services: exploring the need for improvement in health service delivery. *Australian Journal of Primary Health*, 17, p. 195.
- ³⁹ Fuller, J. & Ballantyne, A. (2000). Immigrants and equitable health care delivery in rural areas. *Australian Journal of Rural Health*, 8, p. 190.
- ⁴⁰ Davidson, N., Skull, S., Calache, H., Chesters, D. & Chalmers, J. (2007). Equitable access to dental care for an at risk group: a review of services for Australian refugees. *Australian and New Zealand Journal of Public Health*, 31(1), p. 73.
- ⁴¹ Renzaho, A. (2008). Re-visioning cultural competence in community health services in Victoria. *Australian Health Review*, 32(2), pp. 227-229.
- ⁴² Ward, B., Anderson, K. & Sheldon, M. (2005). Patterns of home and community care service delivery to culturally and linguistically diverse residents of rural Victoria. *Australian Journal of Rural Health*, 13, p. 350.
- ⁴³ Derose, K. & Baker, D. (2000). Limited English proficiency and Latinos' use of physician services. *Medical Care Research and Review*, 57(1), p. 76.
- ⁴⁴ Fiscella, K. et al. (2002). Disparities in health care by race, ethnicity and language among the insured. *Medical Care*, 40(1), p. 52.
- ⁴⁵ Eastern Access Community Health. (2011). *The pregnancy and birth experience of women from refugee backgrounds living in the Outer East of Melbourne*. Melbourne, Victoria: Nicolaou, M., p. 13.
- ⁴⁶ Hoang, H. (2008). Language and cultural barriers of Asian migrants in accessing maternal care in Australia. *The International Journal of Language Society and Culture*, 26, pp. 55-57.
- ⁴⁷ Sarver, J. & Baker, D. (2000). Effect of language barriers on follow up appointments after an emergency department visit. *Journal of General Internal Medicine*, 15, p. 261.
- ⁴⁸ Australian Institute of Health and Welfare. (2010). *Australia's Health 2010*. Canberra, Australian Capital Territory: p. 273.
- ⁴⁹ Jacobs, E. et al. (2006). The need for more research on language barriers in health care: a proposed research agenda. *The Milbank Quarterly*, 84(1), p. 116.
- ⁵⁰ Riggs, E. et al. (2012). Accessing maternal and child health services in Melbourne, Australia: reflections from refugee families and service providers. *BMC Health Services Research*, 12, p. 117.
- ⁵¹ Ehsani, J., Vu, T. & Karvelas, M. (2006). Exploring the need for hepatology nurses and allied health professionals in Victorian liver clinics. *Australian Health Review*, 30(2), p. 211.
- ⁵² Dolman, J. et al. (1996). A survey of health agency responses to non-English speaking women's health needs in South Australia. *Australian and New Zealand Journal of Public Health*, 20(2), p. 158.
- ⁵³ Jacobs, E. et al. (2001). Impact of interpreter services on delivery of health care to limited English proficient clients. *Journal of General Internal Medicine*, 16(7), p. 472.

-
- ⁵⁴ Flores, G. (2005). The impact of medical interpreter services on the quality of health care: a systematic review. *Medical Care Research and Review*, 62, p. 280.
- ⁵⁵ Bernstein, J. et al. (2002). Trained medical interpreters in the emergency department: effects on services, subsequent changes and follow up. *Journal of Immigrant Health*, 4(4), p. 174.
- ⁵⁶ Bischoff, A. et al. (2003). Language barriers between nurses and asylum seekers: their impact on symptom reporting and referral. *Social Science and Medicine*, 57, p. 510.
- ⁵⁷ Jacobs, E. et al. (2004). Overcoming language barriers in health care: costs and benefits of interpreter services. *American Journal of Public Health*, 95(5), p. 866.
- ⁵⁸ Cooke, R., Murray, S., Carapetis, J., Rice, J., Mulholland, N. & Skull, S. (2004), op. cit., p. 43.

1.4 Unnecessary health expenditure

- ⁵⁹ Kosmider, S. et al. (2010). Predictors of clinic non-attendance: opportunities to improve patient outcomes in colorectal cancer. *Internal Medicine Journal, Royal Australasian College of Physicians*, 40, p. 760.
- ⁶⁰ Flores, G. (2005). The impact of medical interpreter services on the quality of health care: a systematic review. *Medical Care Research and Review*, 62, p. 291.
- ⁶¹ Mahmoud, I., Hou, X-Y., Chu, K. & Clark, M. (2011). Is language a barrier for quality care in hospitals? A case series from an Emergency Department of a teaching hospital in Brisbane. *Australasian Epidemiologist*, 18, pp. 6–9.
- ⁶² Renzaho, A. (2007). Ischaemic heart disease and Australian immigrants: the influence of birthplace and language skills on treatment and use of health services. *Health Information Management Journal*, 36(2), p. 26.
- ⁶³ Flores, G. (2005). op. cit., pp. 291–292.
- ⁶⁴ Lindholm, M. et al. (2012). Professional language interpretation and inpatient length of stay and readmission rates. *Journal General Internal Medicine*, 27(10), pp. 1294-95.
- ⁶⁵ Baptise, A. et al. (2004). The effect of English language proficiency on length of stay and in hospital mortality. *Journal General Internal Medicine*, 19(3), p. 221.
- ⁶⁶ Renzaho, A. (2007). op. cit., p. 26.
- ⁶⁷ Mahmoud, I., Hou, X-Y., Chu, K. & Clark, M. (2011). op. cit., pp. 6–9.
- ⁶⁸ Renzaho, A. (2007). op. cit., p. 26.
- ⁶⁹ Flores, G. (2005). op. cit., p. 292.
- ⁷⁰ Bernstein, J. et al. (2002). Trained medical interpreters in the emergency department: effects on services, subsequent changes and follow up. *Journal of Immigrant Health*, 4(4), p. 171.
- ⁷¹ Department of Health. (2010). *Language services in health care policy consultations: discussion paper*. Government of Western Australia: p. 13.
- ⁷² Jacobs, E. et al. (2004). Overcoming language barriers in health care: costs and benefits of interpreter services. *American Journal of Public Health*, 95(5), p. 867.
- ⁷³ Whitehouse Office of Management and Budget. (2002). *Report to Congress, Assessment of the total benefits and costs of implementing executive order # 13166: Access to services for persons with limited English proficiency*, p. 16.
- ⁷⁴ Lindholm, M. et al. (2012). Professional language interpretation and inpatient length of stay and readmission rates. *Journal General Internal Medicine*, 27(10), pp. 1294-95.
- ⁷⁵ Zucchi, E. (2011). Strategies to reduce the length of stay in hospital on non-English speaking clients, FECCA National Conference Advancing Multiculturalism, Northern Health.
- ⁷⁶ Ku, L. & Flores, G. (2005). Pay now or pay later: providing interpreting services in health care. *Health Affairs*, 24(2), p. 442.

⁷⁷ Jacobs, E. et al. (2006). The need for more research on language barriers in health care: a proposed research agenda. *The Milbank Quarterly*, 84(1), p. 122.

⁷⁸ Victorian Foundation for Survivors of Torture. (2009). Access to specialist services by refugees in Victoria: a report prepared for the Department of Human Services by the Victorian Refugee Health Network. Melbourne, Victoria: Kulkens, M.

⁷⁹ Department of Health. (2009). *Cultural responsiveness framework: Guidelines for Victorian health services*. Melbourne, Victoria: p. 19.

1.5 Stress on families

⁸⁰ Centre for Culture, Ethnicity and Health. (2006). *Language Services in Victoria's Health System: Perspectives of Culturally and Linguistically Diverse Consumers*. Melbourne, Victoria: Brough, C., p. 15.

⁸¹ Lehna, C. (2005). Interpreter services in pediatric nursing. *Pediatric Nursing*, 31(4), p. 293.

⁸² Renzaho, A. (2008). Re-visioning cultural competence in community health services in Victoria. *Australian Health Review*, 32(2), p. 229.

⁸³ Australian Centre for the Study of Sexual Assault. (2011). *Supporting women from CALD backgrounds who are victims/survivors of sexual violence: challenges and opportunities for practitioners*. Canberra, Australian Capital Territory: Allimant, A. & Ostapiej-Piatkowski, B., pp. 8-9.

⁸⁴ Seidelman, R. & Bachner, Y. (2010). That I won't translate! Experiences of a family medical interpreter in a multicultural environment. *Mount Sinai Journal of Medicine*, 77, p. 391.

⁸⁵ Pelling, N. (2005). The use of interpreters in psychotherapy. *Psychotherapy in Australia*, 12(1), p. 71.

⁸⁶ deJongh, K. (2005). *The 2005 Sir William Kilpatrick Churchill Fellowship: To research hospital language service systems and analyse policy frameworks and strategies to deliver quality health interpreting/translation services to multicultural communities*, p. 34. Accessed 6 June, 2013, from <http://churchilltrust.com.au/fellows/detail/2933/karella+de-jongh>.

⁸⁷ Seidelman, R. & Bachner, Y. (2010). op. cit., p. 390.

⁸⁸ Morrone, A. (2008). Mr. Lion won't eat his vegemite sandwiches. *Health Issues*, 95, p. 32.

⁸⁹ Gray, B., Hilder, J. & Donalson, H. (2011). Why do we not use trained interpreter for all patients with limited English proficiency? Is there a place for using family members. *Australian Journal of Primary Health*, 17, p. 246.

⁹⁰ Jacobs, B., Kroll, L. & Green, J. (1995). The hazards of using a child as an interpreter. *Journal of the Royal Society of Medicine*, 88, p. 474.

⁹¹ Centre for Culture, Ethnicity and Health. (2006). op. cit., p. 19.

⁹² Renzaho, A. (2008). op. cit., p. 229.

⁹³ Henderson, S. & Kendall, E. (2011). Culturally and linguistically diverse peoples' knowledge of accessibility and utilisation of health services: exploring the need for improvement in health service delivery. *Australian Journal of Primary Health*, 17, p. 197.

Chapter 2: Standards, policies and laws

2.1 National charters and frameworks

⁹⁴ Victorian Department of Health. Australian Charter of Healthcare Rights in Victoria. Retrieved 8 March, 2012, from <http://www.health.vic.gov.au/patientcharter>.

⁹⁵ Australian Commission on Safety and Quality in Health Care. *The Australian Charter of Healthcare Rights: a guide for healthcare providers*. Retrieved 20 June, 2012, from

<http://www.safetyandquality.gov.au/wp-content/uploads/2012/01/17500-HealthCareguide.pdf>.

⁹⁶ Ibid.

⁹⁷ Australian Commission on Safety and Quality in Health Care. *The Australian Charter of Healthcare Rights: Roles in Realising the Australian Charter of Healthcare Rights*. Retrieved 20 June, 2012, from <http://www.safetyandquality.gov.au/wp-content/uploads/2012/01/17388-roles.pdf>.

⁹⁸ <http://www.health.gov.au/internet/safety/publishing.nsf/Content/NSQF> accessed on 17/5/2012

⁹⁹ Australian Commission on Safety and Quality in Health Care. *Australian Framework for Safety and Quality in Health Care*. Retrieved 17 May, 2012, from <http://www.safetyandquality.gov.au/our-work/national-perspectives/australian-safety-and-quality-framework-for-health-care>.

<http://www.healthissuescentre.org.au/documents/items/2012/02/405529-upload-00001.pdf>

¹⁰⁰ Australian Commission on Safety and Quality in Health Care. *Australian Framework for Safety and Quality in Health Care*. Retrieved 17 May, 2012, from <http://www.safetyandquality.gov.au/our-work/national-perspectives/australian-safety-and-quality-framework-for-health-care>.

¹⁰¹ Australian Commission on Safety and Quality in Health Care. *Australian Safety and Quality Framework for Health Care - Putting the Framework into Action: Getting Started, Activities for the Health Care Team*, p. 3. Retrieved 17 May, 2012, from <http://www.safetyandquality.gov.au/wp-content/uploads/2011/01/ASQFHC-Guide-Healthcare-team.pdf>.

¹⁰² Ibid, p. 3.

¹⁰³ Australian Commission on Safety and Quality in Health Care. *Australian Safety and Quality Framework for Health Care - Putting the Framework into Action: Getting Started, Activities for Managers*, p. 3. Retrieved 17 May, 2012, from <http://www.safetyandquality.gov.au/wp-content/uploads/2011/01/ASQFHC-Guide-Managers.pdf>.

¹⁰⁴ Australian Commission on Safety and Quality in Health Care. *Australian Safety and Quality Framework for Health Care - Putting the Framework into Action: Getting started, Activities for Health Service Executives and Boards*, p. 2. Retrieved 17 May, 2012, from <http://www.safetyandquality.gov.au/wp-content/uploads/2011/01/ASQFHC-Guide-Executive.pdf>.

¹⁰⁵ Australian Commission on Safety and Quality in Health Care. *Australian Safety and Quality Framework for Health Care - Putting the Framework into Action: Getting Started, Activities for Policy Makers*, p. 4. Retrieved 17 May, 2012, from <http://www.safetyandquality.gov.au/wp-content/uploads/2011/01/ASQFHC-Guide-Policymakers.pdf>.

2.2 Commonwealth Government

¹⁰⁶ Commonwealth Ombudsman. (2009). *Use of Interpreters*. Retrieved date unknown, http://www.ombudsman.gov.au/files/investigation_2009_03.pdf & Commonwealth Ombudsman. (2009) *Factsheet 4 – Use of Interpreters*. Retrieved date unknown, from <http://www.ombudsman.gov.au/docs/fact-sheets/onlineFactSheet4-interpreters.pdf>

¹⁰⁷ <http://www.immi.gov.au/about/reports/access-equity/2008/html>.

¹⁰⁸ Commonwealth of Australia. (2011). *Access and Equity in Government Services Report 2008–2010*, p. 12. Retrieved 8 March, 2012, from <http://www.immi.gov.au/about/reports/access-equity/2010/access-equity-report-2010.pdf>.

¹⁰⁹ Commonwealth of Australia. (2012). Access and equity for multicultural Australia – access and equity panel 2012. Retrieved 8 November, 2012, from <http://www.immi.gov.au/living-in-australia/a-multicultural-australia/government-approach/government-services/AandEreport.pdf>.

¹¹⁰ Ibid, p. 2.

2.3 Victorian Government

¹¹¹ Australian Commission on Safety and Quality in Health Care. (2012). *The Australian Charter on Healthcare Rights in Victoria*, p. 12. Retrieved date unknown, from [http://docs.health.vic.gov.au/docs/doc/A828F4D7161E1D77CA2578AA007DDA38/\\$FILE/1105029_ACHCR_A5_FA_web.pdf](http://docs.health.vic.gov.au/docs/doc/A828F4D7161E1D77CA2578AA007DDA38/$FILE/1105029_ACHCR_A5_FA_web.pdf).

¹¹² Victorian Department of Health. Australian Charter on Healthcare Rights in Victoria. Retrieved 20 June, 2012, from <http://www.health.vic.gov.au/patientcharter/publications/index.htm>.

¹¹³ Department of Health. (2011). *Victorian Health Priorities Framework 2012–2022: Metropolitan Health Plan*. Melbourne: Victoria, pp. 50-54.

¹¹⁴ Department of Health. (2009). *Cultural responsiveness framework: Guidelines for Victorian health services*. Melbourne: Victoria, pp. 6-27.

¹¹⁵ Victorian Multicultural Commission. (2010). *Using interpreting services: Victorian Government Policy and Procedures*, p. 4 & p. 10. Retrieved date unknown, from <http://www.multicultural.vic.gov.au/images/stories/pdf/2383%20vmc%20interpreter%20manual%20web.pdf>.

¹¹⁶ Department of Human Services. (2005). *Language Services Policy*. Melbourne: Victoria, p. 8.

¹¹⁷ Department of Health. (2009). *Cultural responsiveness framework: Guidelines for Victorian health services*. Melbourne: Victoria, p. 20.

¹¹⁸ Victorian Department of Health. Diversity planning and practice. Accessed 28 August, 2012, from http://www.health.vic.gov.au/hacc/projects/diversity_framework.htm.

¹¹⁹ Department of Health. (2011). *Strengthening diversity planning and practice: a guide for Victorian Home and Community Care Services*. Melbourne: Victoria, p. 15.

¹²⁰ Victorian Multicultural Commission. (2010). *Using interpreting services – Victorian Government Policy and Procedures*, p. 4. Retrieved date, from <http://www.multicultural.vic.gov.au/images/stories/pdf/2383%20vmc%20interpreter%20manual%20web.pdf>.

¹²¹ Department of Health. *Information Sheet: May 2011*. Accessed 18 June, 2012, from <http://docs.health.vic.gov.au/docs/doc/Information-sheet:-May-2011>.

¹²² Victorian Department of Health. (2010). *The Mental Health Bill Exposure Draft*. Accessed 30 July, 2012, from http://www.health.vic.gov.au/mentalhealth/archive/mhactreview/mental_health_bill2010.pdf.

¹²³ Victorian Transcultural Psychiatry Unit. (2010). 'Protecting the rights of culturally and linguistically diverse consumers and carers' *submission to the Mental Health Bill Exposure Draft*. Retrieved 18 June, 2012, from http://www.health.vic.gov.au/mentalhealth/archive/mhactreview/ed_submissions/submissions-2011/health-service-providers/eds94-stolk-dr-yvonne-mcdonough-ms-sue-chopra-dr-prem.pdf.

¹²⁴ Ibid.

¹²⁵ Mental Health Council of Australia. (2005). *Not for service: experiences of injustice and despair in mental health care in Australia*. Deakin West: Australian Capital Territory, p. 147.

¹²⁶ Transcultural Mental Health Centre submission to the *Australian Senate Inquiry into Suicide*, 2009.

2.4 Professional codes of conduct and assessment standards

¹²⁷ Medical Board of Australia. (2009). *Good Medical Practice: A Code of Conduct for Doctors in Australia*. Retrieved 7 May, 2012, from www.medicalboard.gov.au/documents/default.aspx?record=WD10%2F1277&dbid=AP&checksum=eNjZOZ%2FajN7oxjvHX.

¹²⁸ Australian Medical Council Limited. *Good Medical Practice – A Code of Conduct for Doctors in Australia*. Accessed 21 May, 2012, from <http://www.amc.org.au/index.php/about/good-medical-practice>.

¹²⁹ National Health and Medical Research Council. (2004). *Communication with patients: advice for medical practitioners*, p. 12. Retrieved 7 May, 2012, from http://www.nhmrc.gov.au/_files_nhmrc/file/publications/synopses/e58.pdf.

¹³⁰ The Royal Australian and New Zealand College of Obstetricians and Gynaecologists response to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

¹³¹ Ibid.

¹³² The Australian Psychological Society. *Code of Ethics*. Retrieved 28 August, 2012 from http://www.psychology.org.au/Assets/Files/Code_Ethics_2007.pdf.

¹³³ Australian Health Practitioner Regulatory Agency. *The National Boards*. Accessed date unknown, from <http://www.ahpra.gov.au/Health-Professions.aspx>

2.5 Health and community services

¹³⁴ <http://www.qic.org.au/secretariat.html>, accessed on 22/4/2013.

¹³⁵ Quality Improvement Council. (2010). *QIC Health and Community Services Standards 6th Edition*. Available from <http://www.qic.org.au/publications.html>.

¹³⁶ Australian Commission on Safety and Quality in Health Care. (2011). *National Safety and Quality Health Service Standards ACSQHC*. Retrieved 12 February, 2013 from <http://www.safetyandquality.gov.au/wp-content/uploads/2011/01/NSQHS-Standards-Sept2011.pdf>.

¹³⁷ Australian Commission on Safety and Quality in Health Care. *Hospital Accreditation Workbook*. Retrieved 12 February, 2013 from <http://www.safetyandquality.gov.au/publications/hospital-accreditation-workbook-2>.

¹³⁸ Australian Commission on Safety and Quality in Health Care. (2011). *National Safety and Quality Health Service Standards*, p. 4. Retrieved 12 February, 2013 from <http://www.safetyandquality.gov.au/wp-content/uploads/2011/01/NSQHS-Standards-Sept2011.pdf>.

¹³⁹ Australian Commission on Safety and Quality in Health Care. *Hospital Accreditation Workbook*, p. 80. Retrieved 12 February, 2013, from <http://www.safetyandquality.gov.au/publications/hospital-accreditation-workbook-2>.

¹⁴⁰ Commonwealth Department of Health and Ageing. *Publications*. Accessed 8 February, 2013, from <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-servst10>.

¹⁴¹ Ibid.

¹⁴² RACGP Standards for general practices (4th edition)

<http://www.racgp.org.au/your-practice/standards/standardsforgeneralpractices/standard1-2/1-2-3/>, accessed 7 February 2013.

2.6 International human rights framework

¹⁴³ General Comment No. 14 (2000) "The right to the highest attainable standard of health," E/C.12/2000/4.

¹⁴⁴ Ibid 12(b)(i).

¹⁴⁵ Ibid (12b)(ii).

¹⁴⁶ United Nations Office for the High Commission for Human Rights. The Right to Health - Fact Sheet No.31. Retrieved 20 June, 2012, from <http://www.ohchr.org>.

¹⁴⁷ Ibid, p. 4.

¹⁴⁸ Ibid, p. 18.

Chapter 3: Funding of interpreter services

3.1 Commonwealth Government

¹⁴⁹ Department of Immigration and Citizenship. (2003). *Report of the Review of Settlement Services for Migrants and Humanitarian Entrants – Chapter 12: The Translating & Interpreting Service*, p. 277 & p. 280. Retrieved 24 May, 2011, from http://www.immi.gov.au/media/publications/settle/_pdf/chap12web.pdf.

¹⁵⁰ Department of Immigration and Citizenship. Free services through TIS National. Accessed 6 June, 2013, from http://www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/free-services.htm.

¹⁵¹ Department of Immigration and Citizenship, Settlement Branch, personal communication, 17 February 2012.

¹⁵² Department of Immigration and Citizenship. (2013) *Portfolio Budget Statements 2013-14*. Retrieved 13 June, 2013, from <http://www.immi.gov.au/about/reports/budget/budget13/budget13pbs.htm>.

¹⁵³ Department of Immigration and Citizenship. (2011). *Annual Report 2010–11*. Belconnen: Australian Capital Territory, p. 226.

¹⁵⁴ Department of Immigration and Citizenship, Settlement Branch, personal communication, 17 February 2012.

¹⁵⁵ Multicultural Mental Health Australia. (2011). *MNHA e-Bulletin*, p. 13. Retrieved 6 June 2013, from <http://www.mhima.org.au/news-and-events/newsletter-archive>.

¹⁵⁶ Department of Families, Housing, Community Services and Indigenous Affairs, Mental Health Branch, personal communication, 23 November, 2011.

¹⁵⁷ Department of Health and Ageing. (2012). *Operational Guidelines for the Access to Allied Psychological Services Component of The Better Outcomes in Mental Health Care Program, 2012*, p. 5. Retrieved 6 June, 2013, from <http://www.aasw.asn.au/document/item/2932>

¹⁵⁸ Ibid, p. 7.

3.2 Victorian Government

¹⁵⁹ Victorian Multicultural Commission. (2010). *Using interpreting services: Victorian Government Policy and Procedures*, p. 6. Retrieved 6 June, 2013, from <http://www.multicultural.vic.gov.au/images/stories/pdf/2383%20vmc%20interpreter%20manual%20web.pdf>.

¹⁶⁰ Victorian Auditor General. *Victorian Auditor General's Report, Audit Summary of Delivery of Nurse on Call*, p. viii, tabled in Parliament 15 September, 2010.

¹⁶¹ <http://www.education.vic.gov.au/earlychildhood/support/mchline.htm> accessed on date unknown.

¹⁶² Victorian Department of Education and Early Childhood Development, personal communication, 8 March, 2012.

¹⁶³ Victorian Department of Justice, personal communication, 13 February, 2012.

¹⁶⁴ Victorian Department of Justice, personal communication, 13 February, 2012.

¹⁶⁵ <http://health.vic.gov.au/casemix/about.htm> accessed on 23/7/2012

-
- ¹⁶⁶Victorian Department of Health. (2011). *Part three – technical guidelines*. Retrieved 23 July, 2012, from [http://docs.health.vic.gov.au/docs/doc/07730A56386CE006CA25794F001C9473/\\$FILE/pfg-part3.pdf](http://docs.health.vic.gov.au/docs/doc/07730A56386CE006CA25794F001C9473/$FILE/pfg-part3.pdf).
- ¹⁶⁷ <http://health.vic.gov.au/casemix/about.htm> accessed on 23/7/2012
- ¹⁶⁸ Victorian Department of Health. (2011). *Part three – technical guidelines*. Retrieved 23 July, 2012, from [http://docs.health.vic.gov.au/docs/doc/07730A56386CE006CA25794F001C9473/\\$FILE/pfg-part3.pdf](http://docs.health.vic.gov.au/docs/doc/07730A56386CE006CA25794F001C9473/$FILE/pfg-part3.pdf).
- ¹⁶⁹ <http://health.vic.gov.au/casemix/about.htm> accessed on 23/7/2012
- ¹⁷⁰ Victorian Department of Health. (2011). *Part three – technical guidelines*. Retrieved 23 July, 2012, from [http://docs.health.vic.gov.au/docs/doc/07730A56386CE006CA25794F001C9473/\\$FILE/pfg-part3.pdf](http://docs.health.vic.gov.au/docs/doc/07730A56386CE006CA25794F001C9473/$FILE/pfg-part3.pdf).
- ¹⁷¹ Victorian Department of Health. National Health Reform – Victoria’s Approach. Accessed 17 July, 2012, from <http://www.health.vic.gov.au/healthreform>.
- ¹⁷² http://www.coag.gov.au/docs/national_health_reform_agreement.pdf accessed on 17/7/2012
- ¹⁷³ Health Policy Solutions. (2011). Activity based funding for Australian public hospitals: Towards a Pricing Framework. Retrieved 17 July, 2012, from [http://www.ihsa.gov.au/internet/ihsa/publishing.nsf/Content/EB8EFD07DF85BC70CA25798300033BE1/\\$File/IHPA%20Draft%20Pricing%20Framework_long%20version.pdf](http://www.ihsa.gov.au/internet/ihsa/publishing.nsf/Content/EB8EFD07DF85BC70CA25798300033BE1/$File/IHPA%20Draft%20Pricing%20Framework_long%20version.pdf).
- ¹⁷⁴ Victorian Department of Health, personal communication, 11 September, 2012.
- ¹⁷⁵ Victorian Government Department of Human Services. *Guidelines for the Department of Human Services Language Services Credit Line*. Accessed 23 August, 2012, from <http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/policies,-guidelines-and-legislation/language-services-credit-line-guidelines>.
- ¹⁷⁶ Ibid.
- ¹⁷⁷ <http://www.education.vic.gov.au/officeforchildren>
- ¹⁷⁸ Victorian Department of Education and Early Childhood Development, personal communication, 8 March, 2012.
- ¹⁷⁹ Victorian Department of Education and Early Childhood Development. (2009). Office for Children Language Services Credit Line. Retrieved 6 June, 2013, from <http://www.eduweb.vic.gov.au/edulibrary/public/earlychildhood/childrenservices/languagecreditle.pdf>.
- ¹⁸⁰ 2012–13 Victorian State Budget, Budget Paper 3: Service Delivery, p. 22.
- ¹⁸¹ Department of Health comments to Foundation House’s *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ¹⁸² *On Call Interpreters and Translators Agency Pty Ltd v Commissioner of Taxation* (No 3) [2011] FCA 366 (13 April 2011).
- ¹⁸³ Australian Taxation Office. *Decision Impact Statement, On Call Interpreters and Translators Agency Pty Ltd v Commissioner of Taxation*. Accessed 6 June, 2013, from <http://law.ato.gov.au/atolaw/view.htm?DocID=LIT/ICD/VID409of2009/00001>.
- ¹⁸⁴ Australian Taxation Office. Superannuation Guarantee Ruling SGR 2005/1. Accessed 6 June, 2013, from <http://law.ato.gov.au/atolaw/view.htm?docid=SGR/SGR20051/NAT/ATO/00001>.
- ¹⁸⁵ Victorian Government. *Victorian Budget Overview 2011–12*, p. 22.

Chapter 4 Communication approaches between health practitioners and clients

4.1 Language diversity in Victoria

¹⁸⁶ Australian Bureau of Statistics. (2012). *2011 Census of Population and Housing, Expanded Community Profile, Based on Usual Residence*, Cat. No. 2005.0, tables X05e & X05f.

¹⁸⁷ Australian Bureau of Statistics. (2006). *Proficiency in Spoken English/Language by age for time series*, Cat. No. 2068.0, 2006 Census Tables – Victoria (State).

¹⁸⁸ Australian Bureau of Statistics. (2012). *2011 Census of Population and Housing, Expanded Community Profile, Based on Usual Residence*. Cat. No. 2005.0, tables X05e & X05f.

¹⁸⁹ Australian Bureau of Statistics. *Population Composition – language spoken in Australia*. Accessed 16 July, 2012, from <http://www.abs.gov.au/ausstats/abs@.nsf/2f762f95845417aeca25706c00834efa/d67b7c95e0e8a733ca2570ec001117a2!OpenDocument>.

4.2 Modes of communication between health practitioners and clients

¹⁹⁰ Phillips, C. & Travaglia, J. (2011). Low levels of uptake of free interpreters by Australian doctors in private practice: secondary analysis of national data. *Australian Health Review*, 35(4).

¹⁹¹ Atkin, N. (2008). Getting the message across: professional interpreters in general practice. *Australian Family Physician*, 37(3), p. 176.

¹⁹² Huang, Y-T. & Phillips, C. (2009). Telephone interpreters in general practice: bridging the barriers to their use. *Australian Family Physician*, 38(6), p. 444.

¹⁹³ Bonacruz Kazzi, G. & Cooper, C. (2003). Barriers to the use of interpreters in emergency room paediatric consultations. *Journal of Paediatric Child Health*, 39, p. 260.

¹⁹⁴ Centre for Culture, Ethnicity and Health. (2006). *Language Services in Victoria's Health System: Perspectives of Culturally and Linguistically Diverse Consumers*. Melbourne, Victoria: Brough, C., p. 22.

¹⁹⁵ Sypek, S., Clugston, G. & Phillips, C. (2008). Critical health infrastructure for refugee resettlement in rural Australia: case study of four rural towns. *Australian Journal of Rural Health*, p. 352.

¹⁹⁶ http://www.vtptu.org.au/resources/bilingual_directory.html

¹⁹⁷ Atkin, N. (2008). op. cit., p. 176.

¹⁹⁸ AMA Victoria. Doctor Search. Accessed 6 June, 2013, from http://www.amavic.com.au/dr_search.

¹⁹⁹ Find a Pharmacy. Basic Search. Accessed 6 June, 2013, from www.findapharmacy.com.au.

²⁰⁰ Centre for Culture, Ethnicity and Health. (2008). *Bilingual Staff Research Project Report*. Melbourne, Victoria.

²⁰¹ Phillips, C., & Travaglia, J. (2010). op. cit.

²⁰² Dr Thomas Schulz submission to Foundation House's Exploring barriers and facilitators to the use of qualified interpreters in health, discussion paper, May 2012.

²⁰³ The Royal Women's Hospital. (2011). *Quality of Care Report 2010–11*. Melbourne, Victoria, p. 35.

²⁰⁴ Royal Women's Hospital, personal communication, 23 January, 2012.

²⁰⁵ <http://trainingsupport.skills.vic.gov.au/curriculum/Display.cfm?courseCode=3686> accessed on 17/4/2012

²⁰⁶ Huang, Y-T. & Phillips, C. (2009). op. cit., p. 444.

-
- ²⁰⁷ Eastern Access Community Health. (2011). *Refugee Health Nurse Program Evaluation Project 2011*. Melbourne, Victoria: p. 22.
- ²⁰⁸ Atkin, N. (2008). op. cit., p 175.
- ²⁰⁹ Victorian Auditor General. (2011). *Maternity Services Capacity*. Melbourne, Victoria, p. 71.
- ²¹⁰ Hoang, H. (2008). Language and cultural barriers of Asian migrants in accessing maternal care in Australia. *The International Journal of Language Society and Culture*, 26, p. 58.
- ²¹¹ Eastern Access Community Health. (2011). *The pregnancy and birth experience of women from refugee backgrounds living in the Outer East of Melbourne*. Melbourne, Victoria: Nicolaou, M., p 16.
- ²¹² Adult Multicultural Education Services comments to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ²¹³ Garrett, P., Forero, R., Dickson, H. & Klinken Whelan, A. (2008b). How are language barriers bridged in acute hospital care? The tale of two methods of data collection. *Australian Health Review*, 32(4), p. 759.
- ²¹⁴ Bonacruz Kazzi, G. & Cooper, C. (2003). op. cit., p. 261.
- ²¹⁵ Zimbudzi, E., Thompson, S. & Terrill, B. (2010). How accessible are interpreter services to dialysis patients of Non-English Speaking Background? *Australasian Medical Journal*, 1(3), p. 208.
- ²¹⁶ Garrett, P., Forero, R., Dickson, H. & Whelan, A. (2008a). Communication and healthcare complexity in people with little or no English: the communication complexity score. *Ethnicity and Health*, 13(3), p. 211.
- ²¹⁷ Eastern Access Community Health. (2011). *Refugee Health Nurse Program Evaluation Project 2011*. Melbourne, Victoria: p. 21.
- ²¹⁸ Centre for Culture, Ethnicity and Health. (2006). op. cit., p. 4.
- ²¹⁹ Hoang, H. (2008). Language and cultural barriers of Asian migrants in accessing maternal care in Australia. *The International Journal of Language Society and Culture*, 26, p. 57.
- ²²⁰ Heaney, C. & Moreham, S. (2002). Use of interpreter services in a metropolitan healthcare system. *Australian Health Review*, 25(3), p. 41.
- ²²¹ Atkin, N. (2008). op. cit., p. 174.
- ²²² Blennerhassett, J. & Hilbers, J. (2011). Medicine management in older people from non-English speaking backgrounds. *Journal of Pharmacy Practice and research*, 41(1), p. 35.
- ²²³ Heaney, C. & Moreham, S. (2002). Use of interpreter services in a metropolitan healthcare system. *Australian Health Review*, 25(3), p. 41.
- ²²⁴ Lee, T., Lansbury, G. & Sullivan, G. (2005). Health care interpreters: A physiotherapy perspective. *Australian Journal of Physiotherapy*, 51, p. 163.
- ²²⁵ Centre for Culture, Ethnicity and Health. (2006). op. cit., p. 4.
- ²²⁶ Zimbudzi, E., Thompson, S. & Terrill, B. (2010). op. cit., p. 208.
- ²²⁷ Bonacruz Kazzi, G. & Cooper, C. (2003). op. cit., p. 261.
- ²²⁸ Beyondblue and Monash University. (2012). Pilot study on perinatal depression in refugee communities: final research report. Melbourne, Victoria: Kokanovic, R. p. 13.
- ²²⁹ Eastern Access Community Health. (2011). *The pregnancy and birth experience of women from refugee backgrounds living in the Outer East of Melbourne*. Melbourne, Victoria: Nicolaou, M., p 14.
- ²³⁰ Riggs, E. et al. (2012). Accessing maternal and child health services in Melbourne, Australia: reflections from refugee families and service providers. *BMC Health Services Research*, 12, p. 117.
- ²³¹ Heaney, C. & Moreham, S. (2002). op. cit., p. 41.

-
- ²³² Centre for Culture, Ethnicity and Health. (2006). op. cit., p. 31.
- ²³³ National Accreditation Authority for Translators and Interpreters. (2011). *Annual Report 2010–11*. Canberra, Australian Capital Territory, p. 3.
- ²³⁴ http://www.naati.com.au/company_info.html
- ²³⁵ National Accreditation Authority for Translators and Interpreters. (2012). *Improvements to NAATI testing: Development of a conceptual overview for a new model for NAATI standards, testing and assessment*. University of New South Wales: Hale, S. et al.
- ²³⁶ National Accreditation Authority for Translators and Interpreters. (2011). *Annual Report 2011–12*. Canberra, Australian Capital Territory, pp. 15-27.
- ²³⁷ Department of Immigration and Citizenship. Department of Immigration and Citizenship portfolio budget statements 2012–13, p. 75. Accessed 6 June, 2013, from <http://www.immi.gov.au/about/reports/budget/budget12/pbs/2012-13-pbs-full.pdf>.
- ²³⁸ Budget Measures 2011–12, Budget Paper Number 2, Expense Measures – Immigration and Citizenship Portfolio.

4.3 Service delivery models

- ²³⁹ Fuller, J. & Ballantyne, A. (2000). Immigrants and equitable health care delivery in rural areas. *Australian Journal of Rural Health*, 8, p. 190.
- ²⁴⁰ Department of Human Services Southern Metropolitan Region. (2009). *Understanding the client experience: Refugees accessing and utilising the health system in Australia*. Melbourne, Victoria, p. 7.
- ²⁴¹ Kuo, D. & Fagan, M. (1999). Satisfaction with methods of Spanish interpretation in an ambulatory care clinic. *Journal of General Internal Medicine*, 14, p. 548.
- ²⁴² Riggs, E. et al. (2012). Accessing maternal and child health services in Melbourne, Australia: reflections from refugee families and service providers. *BMC Health Services Research*, 12, p. 117.
- ²⁴³ Australian Psychological Society submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, June 2012.
- ²⁴⁴ Health West Partnership submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ²⁴⁵ Department of Immigration and Citizenship (Victorian Office). (2012). *Settlement Planning Update*, March 2012.
- ²⁴⁶ Jones, D. & Gill. P. (1998). Breaking down language barriers. *British Medical Journal*, 316, p. 1776.
- ²⁴⁷ Fuller, J. & Ballantyne, A. (2000). Immigrants and equitable health care delivery in rural areas. *Australian Journal of Rural Health*, 8, p. 190.
- ²⁴⁸ Christine Phillips, Medical Director, Companion House, personal communication, 22 April, 2012.
- ²⁴⁹ Gray, B., Hilder, J. & Donalson, H. (2011). Why do we not use trained interpreter for all patients with limited English proficiency? Is there a place for using family members. *Australian Journal of Primary Health*, 17, p. 245.
- ²⁵⁰ St Vincent's submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ²⁵¹ Victorian Multicultural Commission. (2010). *Using interpreting services: Victorian Government policy and procedures*. Melbourne, Victoria, p. 17.
- ²⁵² Ibid.
- ²⁵³ Victorian Interpreting and Translating Services. *We speak your language: a guide to cross cultural communication*. Melbourne, Victoria: p. 21.
- ²⁵⁴ St Vincent's Hospital Chief Interpreter, personal communication, 24 May, 2012.

-
- ²⁵⁵ National Resource Centre for Ethnic Minority Health. (2008). *Now we're talking: Interpreting guidelines for staff of NHS Scotland*. Health Scotland, Edinburgh: p. 29–31.
- ²⁵⁶ Garrett, P. (2009). Healthcare interpreter policy: policy determinants and current issues in the Australian context. *Interpreting and Translations*, 1(2), p. 45.

Chapter 5: Barriers to the engagement of credentialed interpreters

5.1 Inadequate funding

- ²⁵⁷ Department of Immigration and Citizenship, personal communication, 17 February, 2012.
- ²⁵⁸ Allied health professionals are able to provide Medicare funded services, if they receive referrals from GPs and care is managed by the GP through the implementation of either: a mental health care plan; GP management plan; or team care arrangement see: Department of Health and Ageing. (2010). *MBS Item Numbers by Profession*. Retrieved 6 June, 2013, from [http://www.health.gov.au/internet/main/publishing.nsf/Content/FFE0581E65EF1E68CA2574F500824BFF/\\$File/MBS%20items%20numbers%20by%20profession.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/FFE0581E65EF1E68CA2574F500824BFF/$File/MBS%20items%20numbers%20by%20profession.pdf).
- ²⁵⁹ Australian General Practice Network submission to the *Senate Community Affairs References Committee*, 2011, p. 14.
- ²⁶⁰ Multicultural Mental Health Australia submission to the *Inquiry into Multiculturalism in Australia*, 2011, p. 21.
- ²⁶¹ Department of Health and Ageing. (2010). *MBS Item Numbers by Profession*. Retrieved 6 June, 2013, from [http://www.health.gov.au/internet/main/publishing.nsf/Content/FFE0581E65EF1E68CA2574F500824BFF/\\$File/MBS%20items%20numbers%20by%20profession.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/FFE0581E65EF1E68CA2574F500824BFF/$File/MBS%20items%20numbers%20by%20profession.pdf).
- ²⁶² Department of Immigration and Citizenship, personal communication, 17 February, 2012.
- ²⁶³ Wright, B. (2011). Is there really equitable access to mental health services across all sectors? *Culture and Psychology Australian Psychological Society IG Newsletter*, p. 4.
- ²⁶⁴ Khawaja, N. (2011), Letter from the national convener. *Culture and Psychology Australian Psychological Society Newsletter*, p. 2.
- ²⁶⁵ Community Health Action Group. (2004). *Lost in translation: a discussion paper on interpreting issues in health care settings in Queensland*: p. 14.
- ²⁶⁶ Australian Psychological Society submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, June 2012.
- ²⁶⁷ Ibid.
- ²⁶⁸ Refugee Council of Australia submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ²⁶⁹ South Eastern Melbourne Medicare Local submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ²⁷⁰ Ibid, p. 22.
- ²⁷¹ Ibid, p. 36.
- ²⁷² The Pharmacy Guild of Australia submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ²⁷³ Ibid.

-
- ²⁷⁴ Davidson, N., Skull, S., Calache, H., Chesters, D. & Chalmers, J. (2007). Equitable access to dental care for an at risk group: a review of services for Australian refugees. *Australian and New Zealand Journal of Public Health*, 31(1), p. 79.
- ²⁷⁵ Stanton, J., Kaplan, I. & Webster, K. (1999) Role of Australian Doctors in the refugee health care. *Current Therapeutics*, p. 26.
- ²⁷⁶ Johnson, D., Ziersch, A. & Burgess, T. (2008). op. cit., p. 5.
- ²⁷⁷ Brisbane Inner South Division of General Practice. (2001). *The refugee consumer voice: how to ensure it makes a difference*. Brisbane, Queensland: p. 7.
- ²⁷⁸ Pelling, N. (2005). The use of interpreters in psychotherapy. *Psychotherapy in Australia*, 12(1), p. 69.
- ²⁷⁹ Lee, T., Lansbury, G. & Sullivan, G. (2005). Health care interpreters: A physiotherapy perspective. *Australian Journal of Physiotherapy*, 51, p. 163.
- ²⁸⁰ Codrington, R., Iqbal, A. & Segel., J. (2011). Lost in translation? Embracing the challenges of working with families of a refugee background. *The Australian and New Zealand Journal of Family Therapy*, 32(2), p. 140.
- ²⁸¹ Lee, T., Lansbury, G. & Sullivan, G. (2005). op. cit., p. 163.
- ²⁸² Atkin, N. (2008). Getting the message across: professional interpreters in general practice. *Australian Family Physician*, 37(3), p. 175.
- ²⁸³ Royal Children's Hospital, personal communication, date unknown.
- ²⁸⁴ Thorton, J. et al. (2009). Families with limited English proficiency receive less information and support in interpreted intensive care unit family conferences. *Critical Care Medicine*, 37(1), p. 92.
- ²⁸⁵ Kravitz, R. et al. (2000). Comparing the use of physician time and health care resources among patients speaking English, Spanish and Russian. *Medical Care*, 38(7), p. 729.
- ²⁸⁶ Flores, G. (2005). The impact of medical interpreter services on the quality of health care: a systematic review. *Medical Care Research and Review*, 62, p. 281.
- ²⁸⁷ RACGP, (2010), Standards for General Practices 4th Edition, p 10.
- ²⁸⁸ Department of Health and Ageing. Search the MBS. Accessed 6 June, 2013, from <http://www9.health.gov.au/mbs/search.cfm?q=23&sopt=l>.
- ²⁸⁹ Refugee Council of Australia submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ²⁹⁰ Australian Institute of Interpreters and Translators comments to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ²⁹¹ For example see Brunswick medical centre <http://www.eastbrunswickmedical.com.au/index.php?sectionID=881&pageID=1003> or Mediscreen Clinic Hawthorn East <http://www.mediscreenclinic.com.au/fees-and-billing1> accessed on 14/9/2012.
- ²⁹² Dr Thomas Schulz submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ²⁹³ National Health and Medical Research Council. (2004). *Communication with patients - advice for medical practitioners*. Retrieved 7 May, 2012 from http://www.nhmrc.gov.au/_files_nhmrc/file/publications/synopses/e58.pdf.
- ²⁹⁴ Johnson, D., Ziersch, A. & Burgess, T. (2008). I don't think general practice should be the front line: experiences of general practitioners working with refugees in South Australia. *Australia and New Zealand Health Policy*, 5(20), p. 5.
- ²⁹⁵ Huang, Y-T. & Phillips, C. (2009). Telephone interpreters in general practice: bridging the barriers to their use. *Australian Family Physician*, 38(6), p. 445.
- ²⁹⁶ Stanton, J., Kaplan, I. & Webster, K. (1999). Role of Australian Doctors in the refugee health care. *Current Therapeutics*, p. 26.

-
- ²⁹⁷ Heaney, C. & Moreham, S. (2002). Use of interpreter services in a metropolitan healthcare system. *Australian Health Review*, 25(3), p. 41.
- ²⁹⁸ Zimbudzi, E., Thompson, S. & Terrill, B. (2010). How accessible are interpreter services to dialysis patients of Non-English Speaking Background? *Australasian Medical Journal*, 1(3), p. 210.
- ²⁹⁹ Codrington, R. et al. (2011). *Lost in translation? Embracing the challenges of working with families of a refugee background*. The Australian and New Zealand Journal of Family Therapy, 32(2), p. 134.
- ³⁰⁰ Atkin, N. (2008), op. cit., p. 175.
- ³⁰¹ Huang, Y-T. & Phillips, C. (2009). op. cit., p. 446.
- ³⁰² Centre for Culture, Ethnicity and Health. (2007). *Report to the Victorian Multicultural Commission: working effectively with professional interpreters in private general practice*. North Richmond, Victoria.
- ³⁰³ Health West Partnership submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ³⁰⁴ Department of Health and Ageing. Search the MBS. Accessed 12 September, 2012 from <http://www9.health.gov.au//mbs/search.cfm?q=10990&sopt=l>.
- ³⁰⁵ Dr Joanne Gardiner, Melbourne based GP working in community health, personal communication, 14 September, 2012.
- ³⁰⁶ Dr Kate Molinari, a Canberra-based GP, lecturer at Australian National University and medical editor of The Australian Family Physician who liaised with official agencies in Norway and Dr Christine Phillips, Medical Director Companion House and senior research at Australian National University, personal communication on 12 September, 2012.
- ³⁰⁷ Davidson, N., Skull, S., Calache, H., Chesters, D. & Chalmers, J. (2007). Equitable access to dental care for an at risk group: a review of services for Australian refugees. *Australian and New Zealand Journal of Public Health*, 31(1), pp. 75–76.
- ³⁰⁸ Council of Social Services NSW. (2009). *Report of the NSW oral health alliance: access to dental services amongst clients of non-government human service organisations*, p. 15. Retrieved 11 September, 2012, from <http://www.cpsa.org.au/files/090402-DentalSurveyReport.pdf>.
- ³⁰⁹ Davidson, N., Skull, S., Calache, H., Chesters, D. & Chalmers, J. (2007). Equitable access to dental care for an at risk group: a review of services for Australian refugees, *Australian and New Zealand Journal of Public Health*, 31(1), pp. 75-76.
- ³¹⁰ Department of Health Ageing. Health Budget 2012 – 2013. Accessed 6 August, 2012, from <http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2012-hmedia02.htm>.
- ³¹¹ The Hon Tanya Plibersek MP Minister for Health, Media Release, 29 August, 2012. Accessed 11 September, 2012, from [http://www.health.gov.au/internet/ministers/publishing.nsf/Content/BEB596CE56CBCF33CA257A690006E268/\\$File/TP074.pdf](http://www.health.gov.au/internet/ministers/publishing.nsf/Content/BEB596CE56CBCF33CA257A690006E268/$File/TP074.pdf).
- ³¹² Western Region Health Centre and Victorian Multicultural Commission. (2010). *Language Services Report, Executive Summary*. Melbourne, Victoria.
- ³¹³ Renzaho, A. (2008). Re-visioning cultural competence in community health services in Victoria. *Australian Health Review*, 32(2), p. 227.
- ³¹⁴ Davidson, N., Skull, S., Calache, H., Chesters, D. & Chalmers, J. (2007). op. cit., p. 76.
- ³¹⁵ Victorian Transcultural Psychiatry Unit submission to the Senate Select Committee on Mental Health's *Inquiry into the provision of mental health services in Australia*, 2005, p. 9.
- ³¹⁶ Brisbane Inner South Division of General Practice. (2001). *The refugee consumer voice: how to ensure it makes a difference*. Brisbane, Queensland: p. 7.

-
- ³¹⁷ Victorian Multicultural Commission. (2008). *All of Us: Victoria's Multicultural Affairs Policy*. Melbourne, Victoria, p. 13.
- ³¹⁸ Western Region Health Centre and Victorian Multicultural Commission. (2010). *Language Services Report, Executive Summary*. Melbourne, Victoria.
- ³¹⁹ ISIS Primary Health, personal communication, date unknown.
- ³²⁰ Refugee Council of Australia response to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ³²¹ Renzaho, A. (2008). op. cit., p. 228.
- ³²² Australian College of Optometry. Do I qualify? Accessed 15 February, 2012, from <http://www.vco.org.au/eye-care-services/eye-care-in-melbourne/do-i-qualify>.
- ³²³ Garrett, P., Forero, R., Dickson, H. & Klinken Whelan, A. (2008b). How are language barriers bridged in acute hospital care? The tale of two methods of data collection. *Australian Health Review*, 32(4), p. 759.
- ³²⁴ Bonacruz Kazzi, G. & Cooper, C. (2003). Barriers to the use of interpreters in emergency room paediatric consultations. *Journal of Paediatric Child Health*, 39, p. 260.
- ³²⁵ Garrett, P., Forero, R., Dickson, H. & Whelan, A. (2008a). Communication and healthcare complexity in people with little or no English: the communication complexity score. *Ethnicity and Health*, 13(3), p. 210.
- ³²⁶ Mahmoud, I., Hou, X-Y., Chu, K. & Clark, M. (2011). Is language a barrier for quality care in hospitals? A case series from an Emergency Department of a teaching hospital in Brisbane. *Australasian Epidemiologist*, 18, p. 8.
- ³²⁷ G21 Geelong Region Alliance response to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012
- ³²⁸ Centre for Culture, Ethnicity and Health. (2006). *Language Services in Victoria's Health System: Perspectives of Culturally and Linguistically Diverse Consumers*. Melbourne, Victoria: Brough, C., p. 18.
- ³²⁹ Refugee Council of Australia. (2010). *Australia's refugee and humanitarian program 2010-11: community views on current challenges and future directions*. Surrey Hills, New South Wales, p. 78.
- ³³⁰ Garrett, P., Forero, R., Dickson, H. & Whelan, A. (2008a). op. cit., p. 210.
- ³³¹ Melbourne Health. (2011). *Quality of Care Report 2011*. Melbourne, Victoria: p. 35.
- ³³² Blennerhassett, J. & Hilbers, J. (2011). Medicine management in older people from non-English speaking backgrounds. *Journal of Pharmacy Practice and research*, 41(1), p. 35.
- ³³³ Heaney, C. & Moreham, S. (2002). op. cit., p. 41.
- ³³⁴ The Royal Women's Hospital. (2011). *Quality of Care Report 2010-11*. Melbourne, Victoria: p. 35.
- ³³⁵ Victorian Transcultural Psychiatry Unit submission to the Senate Select Committee on Mental Health's *Inquiry into the provision of mental health services in Australia*, 2005, p. 22.
- ³³⁶ Garrett, P., Forero, R., Dickson, H. & Whelan, A. (2008a). op. cit., pp. 211-214.
- ³³⁷ Garrett, P., Forero, R., Dickson, H. & Whelan, A. (2008a). op. cit., p. 211-214.
- ³³⁸ Centre for Culture, Ethnicity and Health. (2006). op. cit., p. 20.
- ³³⁹ Community Health Action Group. (2004). Lost in translation: a discussion paper on interpreting issues in health care settings in Queensland: p. 13.
- ³⁴⁰ Peter MacCallum Cancer Centre submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ³⁴¹ Mercy Health submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ³⁴² Eastern Health submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

-
- ³⁴³ Refugee Council of Australia submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ³⁴⁴ Victorian Transcultural Psychiatry Unit. (2008). *Access to mental health services in Victoria: a focus on ethnic communities*. Fitzroy, Victoria: Stolk, I., Minas, H. & Klimidis, S., p 6.
- ³⁴⁵ Hassett, A., George, K. & Harrigan, S. (1998). Admissions of elderly patients from English-speaking and non-English speaking backgrounds to an inpatient psychogeriatric unit. *Australian and New Zealand Journal of Psychiatry*, 33, p. 580.
- ³⁴⁶ Department of Health. (2011). *Dental Health Program: guide to funding and accountability reform*. Melbourne, Victoria.
- ³⁴⁷ Australian College of Optometry. Do I qualify? Accessed 15 February, 2012, from <http://www.vco.org.au/eye-care-services/eye-care-in-melbourne/do-i-qualify>.
- ³⁴⁸ Australian College of Optometry, personal communication, date unknown.
- ³⁴⁹ Sunraysia Community Health Service, personal communication, 12 June, 2012.
- ³⁵⁰ Bendigo Health submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ³⁵¹ Municipal Association of Victoria comments to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ³⁵² Adult Multicultural Education Services response to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ³⁵³ Ibid.
- ³⁵⁴ The Allen Consulting Group. (2002). Report to the Department of Premier and Cabinet, Victorian Office of Multicultural Affairs: a needs analysis of language services. Melbourne, Victoria: p. 9.

5.2 Staff awareness and service protocols

- ³⁵⁵ Huang, Y-T. & Phillips, C. (2009). Telephone interpreters in general practice: bridging the barriers to their use. *Australian Family Physician*, 38(6), p. 443.
- ³⁵⁶ Atkin, N. (2008). Getting the message across: professional interpreters in general practice. *Australian Family Physician*, 37(3), p. 175.
- ³⁵⁷ Adult Multicultural Education Services response to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ³⁵⁸ Johnson, D., Ziersch, A. & Burgess, T. (2008). I don't think general practice should be the front line: experiences of general practitioners working with refugees in South Australia. *Australia and New Zealand Health Policy*, 5(20), p. 5.
- ³⁵⁹ Phillips, C. (2010). Using interpreters a guide for GPs. *Australian Family Physician*, 39(4), p. 193.
- ³⁶⁰ Ibid.
- ³⁶¹ Zimbudzi, E., Thompson, S. & Terrill, B. (2010). How accessible are interpreter services to dialysis patients of Non-English Speaking Background? *Australasian Medical Journal*, 1(3), p. 209.
- ³⁶² Johnson, D., Ziersch, A. & Burgess, T. (2008). op. cit., p. 5.
- ³⁶³ Huang, Y-T. & Phillips, C. (2009). op. cit., p. 445.
- ³⁶⁴ Huang, Y-T. & Phillips, C. (2009). op. cit., p. 445.
- ³⁶⁵ Sypek, S., Clugston, G. & Phillips, C. (2008). Critical health infrastructure for refugee resettlement in rural Australia: case study of four rural towns. *Australian Journal of Rural Health*, 16, p. 353.

-
- ³⁶⁶ Blennerhassett, J. & Hilbers, J. (2011). Medicine management in older people from non-English speaking backgrounds. *Journal of Pharmacy Practice and research*, 41(1), p. 34.
- ³⁶⁷ Heaney, C. & Moreham, S. (2002). Use of interpreter services in a metropolitan healthcare system. *Australian Health Review*, 25(3), p. 41.
- ³⁶⁸ Multicultural Mental Health Australia submission to the *Inquiry into Multiculturalism in Australia*, 2011, p. 28.
- ³⁶⁹ Queensland Accessing Interpreters Working Party. (2008). *A matter for interpretation: the case for access to high quality accredited interpreting and translating services and cultural competence in Queensland services working with culturally and linguistically diverse people*. West End, Queensland: p. 8.
- ³⁷⁰ Renzaho, A. (2008). Re-visioning cultural competence in community health services in Victoria. *Australian Health Review*, 32(2), p. 228.
- ³⁷¹ Heaney, C. & Moreham, S. (2002). op. cit., p. 42.
- ³⁷² Department of Immigration and Citizenship, Settlement Branch, personal communication, 17 February, 2012
- ³⁷³ Phillips, C. & Travaglia, J. (2011). Low levels of uptake of free interpreters by Australian doctors in private practice: secondary analysis of national data. *Australian Health Review*, 35(4).
- ³⁷⁴ Data set provided directly by the Settlement Policy Section of the Department of Immigration and Citizenship on 8 December, 2011.
- ³⁷⁵ Phillips, C. & Travaglia, J. (2011). op. cit.
- ³⁷⁶ Australian Bureau of Statistics. *Census of Population and Housing, 2006 and 2011, compiled and presented in profile.id by .id. the population experts*. Accessed 17 April, 2013, from <http://profile.id.com.au/australia/speaks-english>.
- ³⁷⁷ Commonwealth Department of Health and Ageing, *Medicare Statistics, 2010–11, Table 1: National Figures, Number of Services for Broad Service Type: Non-referred attendances GP/VR GP*. Accessed 17 April, 2013, from <http://www.health.gov.au/internet/main/publishing.nsf/Content/Annual-Medicare-Statistics>.
- ³⁷⁸ Refugee Council of Australia. (2009). *Australia's refugee and humanitarian program 2009–10*. Surrey Hills, New South Wales, p. 71.
- ³⁷⁹ Centre for Culture, Ethnicity and Health. (2006). *Language Services in Victoria's Health System: Perspectives of Culturally and Linguistically Diverse Consumers*. Melbourne, Victoria: Brough, C., p. 20.
- ³⁸⁰ Renzaho, A. (2008). Re-visioning cultural competence in community health services in Victoria. *Australian Health Review*, 32(2), p. 228.
- ³⁸¹ The Pharmacy Guild of Australia submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ³⁸² Gray, B., Hilder, J. & Donalson, H. (2011). Why do we not use trained interpreter for all patients with limited English proficiency? Is there a place for using family members. *Australian Journal of Primary Health*, 17, p. 244.
- ³⁸³ Giacomelli, J. (1997). A review of health interpreter services in a rural community: a total quality management approach. *Australian Journal of Rural Health*, 5, p. 162.
- ³⁸⁴ Atkin, N. (2008). Getting the message across: professional interpreters in general practice. *Australian Family Physician*, 37(3), p. 175.
- ³⁸⁵ Centre for Culture, Ethnicity and Health. (2006). op. cit.
- ³⁸⁶ St Vincent's submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012
- ³⁸⁷ Eastern Health submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

-
- ³⁸⁸ Victorian Multicultural Commission. (2010). *Using interpreting services: Victorian Government policy and procedures*. Melbourne, Victoria, p. 15.
- ³⁸⁹ Mulas, C. (2011). The ABC of interpreting – supporting staff in emergency departments. *Diversit-e*, 2, p. 9.
- ³⁹⁰ Goulburn Valley Primary Care Partnership. (2003). Quality language service provision: a practical toolkit for rural primary health care providers, p. 20. Retrieved 28 May, 2012, from [http://nps718.dhs.vic.gov.au/rrhacs/hacc/ch.nsf/images/Language_services_toolkit/\\$file/language%20services%20toolkit.pdf](http://nps718.dhs.vic.gov.au/rrhacs/hacc/ch.nsf/images/Language_services_toolkit/$file/language%20services%20toolkit.pdf).
- ³⁹¹ Victorian Transcultural Psychiatry Unit. (2006). *Guidelines for working effectively with interpreters in mental health settings*. Fitzroy, Victoria: Miletic, T. et al., p. 14.
- ³⁹² Queensland Government, Queensland Health. (2007). *Working with interpreters guidelines*, p. 5.
- ³⁹³ Karliner, L. et al. (2008). Identification of limited English proficient patients in clinical care. *Journal of General Internal Medicine*, 23(10), p. 1558.
- ³⁹⁴ Jacobs, E. (2008). A better measure of patients need for interpreter services. *Journal of General Internal Medicine*, 23(10), p. 1724.
- ³⁹⁵ Centre for Culture, Ethnicity and Health. Assessing the need for an interpreter. Accessed 6 June, 2013, from http://www.ceh.org.au/downloads/CEH_TipSheet2_Assessing_need_for_interpreter.pdf.
- ³⁹⁶ Californian Academy of Family Physicians. (2005). *Addressing language access issues in your practice: a toolkit for physicians and their staff members*, p. 7.
- ³⁹⁸ Phillips, C. (2010). op. cit.
- ³⁹⁹ Australian Institute of Interpreters and Translators comments to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012
- ⁴⁰⁰ Huang, Y-T. & Phillips, C. (2009). op. cit., p. 443.
- ⁴⁰¹ Centre for Culture, Ethnicity and Health. (2007). *Report to the Victorian Multicultural Commission: working effectively with professional interpreters in private general practice*. North Richmond, Victoria.
- ⁴⁰² Garrett, P., Forero, R., Dickson, H. & Klinken Whelan, A. (2008b). How are language barriers bridged in acute hospital care? The tale of two methods of data collection. *Australian Health Review*, 32(4), p. 760.
- ⁴⁰³ Centre for Culture, Ethnicity and Health. (2006). op. cit., p. 13.
- ⁴⁰⁴ Blennerhassett, J. & Hilbers, J. (2011). Medicine management in older people from non-English speaking backgrounds. *Journal of Pharmacy Practice and Research*, 41(1), p. 35.
- ⁴⁰⁵ Friedman-Rhodes, E. & Hale, S. (2010). Teaching Medical Students to work with interpreters. *The Journal of Specialised Translation*, 14, p. 125.
- ⁴⁰⁶ Department of Health. (2010). *Language services in health care policy consultations: discussion paper*. Government of Western Australia: p. 10.
- ⁴⁰⁷ Atkin, N. (2008), op. cit., p. 175.
- ⁴⁰⁸ Hale, S. (2007). *Community Interpreting*. Palgrave Macmillan, p. 146.
- ⁴⁰⁹ Australian Psychological Society submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, June 2012.
- ⁴¹⁰ The Association of Professional Engineers, Scientists and Managers Australia. (2012). *Lost in translation: barriers to building a sustainable Australian translating and interpreting industry*. Melbourne, Victoria: p. 8.

-
- ⁴¹¹ NSW Health Care Interpreter Service response to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁴¹² Huang, Y-T. & Phillips, C. (2009). op. cit., p. 443-5.
- ⁴¹³ Bonacruz Kazzi, G. & Cooper, C. (2003). Barriers to the use of interpreters in emergency room paediatric consultations. *Journal of Paediatric Child Health*, 39, p. 260.
- ⁴¹⁴ Zimbudzi, E., Thompson, S. & Terrill, B. (2010). op. cit., p. 210.
- ⁴¹⁵ Garrett, P., Forero, R., Dickson, H. & Klinken Whelan, A. (2008b). op. cit., p. 761.
- ⁴¹⁶ White, L. & Chalmers, S. (2011). Responding to cultural diversity at two Sydney based children's hospitals. *Journal of Paediatrics and Child Health*, 47, p. 790.
- ⁴¹⁷ Southern Health. (2011). *Quality of Care Report 2010-2011*, p. 34.
- ⁴¹⁸ Renzaho, A. (2008). op. cit., p. 228.
- ⁴¹⁹ Eastern Access Community Health. (2011). *The pregnancy and birth experience of women from refugee backgrounds living in the Outer East of Melbourne*. Melbourne, Victoria: Nicolaou, M., p 12.
- ⁴²⁰ White, L. & Chalmers, S. (2011). op. cit., p. 792.
- ⁴²¹ G21 Geelong Region Alliance response to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁴²² Eastern Health response to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁴²³ Commonwealth Ombudsman. (2009) *Factsheet 4 – Use of Interpreters*. Retrieved 6 June, 2013, from <http://www.ombudsman.gov.au/docs/fact-sheets/onlineFactSheet4-interpreters.pdf>.
- ⁴²⁴ Centre for Culture, Ethnicity and Health. (2006). op. cit., p. 30.
- ⁴²⁵ Government of Western Australia. (2010). op. cit., p 15.
- ⁴²⁶ Primary Care Connect Community Health Services, personal communication, 20 December, 2012
- ⁴²⁷ Goulburn Valley Primary Care Partnership. (2003). *Quality language service provision – a practical toolkit for rural primary health care providers*, p. 18. Retrieved 28 May, 2012, from [http://nps718.dhs.vic.gov.au/rrhacs/hacc/ch.nsf/images/Language_services_toolkit/\\$file/language%20services%20toolkit.pdf](http://nps718.dhs.vic.gov.au/rrhacs/hacc/ch.nsf/images/Language_services_toolkit/$file/language%20services%20toolkit.pdf).
- ⁴²⁸ RACGP, (2010), *Standards for General Practices 4th Edition*, p 49.
- ⁴²⁹ Peter MacCallum Cancer Centre submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁴³⁰ Centre for Culture Ethnicity and Health. *Language Services: Good Practice in the Victorian health and community sector*. North Richmond, Victoria: p. 13.
- ⁴³¹ NSW Health Care Interpreter Service comments to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁴³² Health West Partnership submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁴³³ Eastern Access Community Health. (2011). op. cit., p. 17.
- ⁴³⁴ Municipal Association of Victoria comments to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁴³⁵ Adult Multicultural Education Services submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁴³⁶ Auditor General Victoria. (2006). *Access to specialist medical outpatient care*. Victorian Government Printer: p. 90.

⁴³⁷ Bendigo Health submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

⁴³⁸ Health West Partnership submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

5.3 Interpreters

⁴³⁹ Auditor General Victoria. (2011). *Maternity services: capacity*. Victorian Government Printer, p. 71.

⁴⁴⁰ Blennerhassett, J. & Hilbers, J. (2011). Medicine management in older people from non-English speaking backgrounds. *Journal of Pharmacy Practice and Research*, 41(1), p. 35.

⁴⁴¹ Centre for Culture, Ethnicity and Health. (2006). *Language Services in Victoria's Health System: Perspectives of Culturally and Linguistically Diverse Consumers*. Melbourne, Victoria: Brough, C., p. 21.

⁴⁴² Bolton, P., Hammond, S. & Leung, J. (2002). Issues in quality use of medicines in two non-English speaking background communities. *Australian Journal of Primary Health*, Vol. 8(3), p. 78.

⁴⁴³ Hoang, H. (2008). Language and cultural barriers of Asian migrants in accessing maternal care in Australia. *The International Journal of Language Society and Culture*, 26, p. 58.

⁴⁴⁴ Queensland Accessing Interpreters Working Party. (2008). *A matter for interpretation: the case for access to high quality accredited interpreting and translating services and cultural competence in Queensland services working with culturally and linguistically diverse people*. West End, Queensland: p. 8.

⁴⁴⁵ Lee, T., Lansbury, G. & Sullivan, G. (2005). Health care interpreters: A physiotherapy perspective. *Australian Journal of Physiotherapy*, 51, p. 163.

⁴⁴⁶ Bonacruz Kazzi, G. & Cooper, C. (2003). Barriers to the use of interpreters in emergency room paediatric consultations. *Journal of Paediatric Child Health*, 39, p. 262.

⁴⁴⁷ Community Health Action Group. (2004). Lost in translation: a discussion paper on interpreting issues in health care settings in Queensland: p. 17.

⁴⁴⁸ Gray, B., Hilder, J. & Donalson, H. (2011). Why do we not use trained interpreter for all patients with limited English proficiency? Is there a place for using family members. *Australian Journal of Primary Health*, 17, p. 244.

⁴⁴⁹ White, L. & Chalmers, S. (2011). Responding to cultural diversity at two Sydney based children's hospitals. *Journal of Paediatrics and Child Health*, 47, p. 792.

⁴⁴⁹ Southern Health. (2011). *Quality of Care Report 2010-2011*, p. 34.

⁴⁵⁰ Zimbudzi, E., Thompson, S. & Terrill, B. (2010). How accessible are interpreter services to dialysis patients of Non-English Speaking Background? *Australasian Medical Journal*, 1(3), p. 209.

⁴⁵¹ Department of Human Services (Southern Metropolitan Region). (2009). *Understanding the client experience: refugees accessing and utilising the health system in Australia*, p. 7.

⁴⁵² The Allen Consulting Group. (2002). Report to the Department of Premier and Cabinet, Victorian Office of Multicultural Affairs: a needs analysis of language services. Melbourne, Victoria: p. 9.

⁴⁵³ Bonacruz Kazzi, G. & Cooper, C. (2003). op. cit., p. 262.

⁴⁵⁴ The Allen Consulting Group. (2002). op. cit., p. 9.

⁴⁵⁵ Sunraysia Community Health Services. (2011). *Quality of Care Report 2010-2011*, p. 32.

⁴⁵⁶ Fuller, J. & Ballantyne, A. (2000). Immigrants and equitable health care delivery in rural areas. *Australian Journal of Rural Health*, 8, p. 190.

-
- 457 Victorian Transcultural Psychiatry Unit submission to the Senate Select Committee on Mental Health's *Inquiry into the provision of mental health services in Australia*, 2005, p. 19.
- 458 The Allen Consulting Group. (2002). op. cit., p. 9.
- 459 Queensland Accessing Interpreters Working Party. (2008). op. cit., p. 8.
- 460 Victorian Transcultural Psychiatry Unit. (2005). op. cit., p. 19.
- 461 Centre for Culture, Ethnicity and Health. (2006). op. cit., p. 4.
- 462 Zimbudzi, E., Thompson, S. & Terrill, B. (2010). op. cit., p. 209.
- 463 The Allen Consulting Group. (2002). op. cit., p. 9.
- 464 Phillips, C. & Travaglia, J. (2011). Low levels of uptake of free interpreters by Australian doctors in private practice: secondary analysis of national data. *Australian Health Review*, 35(4).
- 465 Heaney, C. & Moreham, S. (2002). Use of interpreter services in a metropolitan healthcare system. *Australian Health Review*, 25(3), p. 40.
- 466 Community Health Action Group. (2004). op. cit., p. 18.
- 467 Multicultural Mental Health Australia submission to the *Inquiry into Multiculturalism in Australia*, 2011, p. 28.
- 468 Peter MacCallum Cancer Centre submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- 469 Adult Multicultural Education Services comments to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- 470 Centre for Culture, Ethnicity and Health. (2006). op. cit., p. 17.
- 471 Australian College of Rural and Remote Medicine comments to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- 472 Dr Thomas Schulz submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- 473 Bendigo Health submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- 474 Dr John Scopel submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- 475 Eastern Health submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- 476 Health West Partnership submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- 477 Mercy Health submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- 478 Peter MacCallum Cancer Centre submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- 479 Pharmacy Guild of Australia submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- 480 Department of Immigration and Citizenship (Victorian Office). (2011). *Settlement Planning Update – September 2011*.
- 481 Data set provided directly by the Settlement Policy Section of the Department of Immigration and Citizenship on 8 December, 2011.
- 482 Ibid.
- 483 Ibid.
- 484 The Allen Consulting Group. (2002). op. cit., p. 6.

-
- ⁴⁸⁵ Department of Health. (2009). *Cultural responsiveness framework: guidelines for Victorian health services*. Melbourne, Victoria: p. 27.
- ⁴⁸⁶ Department of Health. (2010). *Quality of care reports: guidelines and minimum reporting requirements for 2010–11*. Melbourne, Victoria.
- ⁴⁸⁷ Victorian Office of Multicultural Affairs. (2006). *Pathways to interpreting and translating: executive summary*. Department for Victorian Communities. Melbourne, Victoria: Wilson, R. et al., pp. 9-15.
- ⁴⁸⁸ Correspondence with the Victorian Multicultural Commission on 17/4/2012.
- ⁴⁸⁹ Western Health's comments to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁴⁹⁰ Parliament of Australia. House of Representatives Committees. *Inquiry into Multiculturalism in Australia*. Accessed 6 June, 2013, from http://www.aph.gov.au/Parliamentary_Business/Committees/House_of_Representative_s_Committees?url=mig/multiculturalism/report.htm.
- ⁴⁹¹ Ibid, p. 158.
- ⁴⁹² The Association of Professional Engineers, Scientists and Managers Australia. (2012). *Lost in translation: barriers to building a sustainable Australian translating and interpreting industry*. Melbourne, Victoria: p. 9.
- ⁴⁹³ Ibid.
- ⁴⁹⁴ Victorian Office of Multicultural Affairs. (2006). *Pathways to interpreting and translating: executive summary*. Department for Victorian Communities. Melbourne, Victoria: Wilson, R. et al., pp. 9-15.
- ⁴⁹⁵ Victorian Multicultural Commission, personal communication, 17 April, 2012.
- ⁴⁹⁶ St Vincent's Melbourne submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁴⁹⁷ Ibid.
- ⁴⁹⁸ Department of Health. (2008). *Delivering a healthy WA: review of language services in the WA health system final report*. Systems reviews project development, Director Generals Division. Perth, Western Australia: p. 19.
- ⁴⁹⁹ St Vincent's submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁵⁰⁰ The Association of Professional Engineers, Scientists and Managers Australia. (2012). *Lost in translation: barriers to building a sustainable Australian translating and interpreting industry*. Melbourne, Victoria: p. 9.
- ⁵⁰¹ Department of Health. (2008). *Delivering a healthy WA: review of language services in the WA health system final report*. Systems reviews project development, Director Generals Division. Perth, Western Australia: p. 19.
- ⁵⁰² Northern Health, personal communication, 19 July, 2012.
- ⁵⁰³ St Vincent's submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁵⁰⁴ The Association of Professional Engineers, Scientists and Managers Australia. (2012). op. cit.
- ⁵⁰⁵ The Association of Professional Engineers, Scientists and Managers Australia APESMA. (2012). op. cit., p. 14.
- ⁵⁰⁶ Green, H., Sperlinger, D. & Carswell, K. (2012). Too close to home? Experiences of Kurdish refugee interpreters working in UK mental health services. *Journal of Mental Health*, 21(3), pp. 227-235.
- ⁵⁰⁷ The Association of Professional Engineers, Scientists and Managers Australia. (2012). op. cit., p. 9.
- ⁵⁰⁸ Adult Multicultural Education Services submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

-
- ⁵⁰⁹ The Association of Professional Engineers, Scientists and Managers Australia. (2012). op. cit., p. 20.
- ⁵¹⁰ Ibid.
- ⁵¹¹ The Association of Professional Engineers, Scientists and Managers Australia. (2012). op. cit., p. 8.
- ⁵¹² Mr Sundaar Nadeson, Vice Chair Australian Institute of Interpreters and Translators, personal communication, 8 May, 2012.
- ⁵¹³ St Vincent's submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁵¹⁴ Victorian Office of Multicultural Affairs. (2006). *Pathways to interpreting and translating: executive summary*. Department for Victorian Communities. Melbourne, Victoria: Wilson, R. et al., p. 9.
- ⁵¹⁵ Ibid, p. 13.
- ⁵¹⁶ Adult Multicultural Education Services comments to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁵¹⁷ Mercy Health submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁵¹⁸ National Accreditation Authority for Translators and Interpreters. Accreditation by testing – Information booklet. Accessed 27 July, 2012, from http://www.naati.com.au/PDF/Booklets/Accreditation_by_Testing_booklet.pdf.
- ⁵¹⁹ Health West Partnership submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁵²⁰ Victorian Office of Multicultural Affairs. (2006). *Pathways to interpreting and translating: executive summary*. Department for Victorian Communities. Melbourne, Victoria: Wilson, R. et al., p. 14.
- ⁵²¹ Victorian Multicultural Commission. (2008). *All of Us: Victoria's Multicultural Affairs Policy*. Melbourne, Victoria, p. 21.
- ⁵²² Victorian Department of Premier and Cabinet and Victorian Department of Health, personal communication, date unknown.
- ⁵²³ Victorian Budget 2011–12, The Hon Nicholas Kotsiras MP, Minister for Multicultural Affairs and Citizenship. *Coalition Govt ensures more funding for interpreting and translating services*, 3 May, 2011.
- ⁵²⁴ Victorian Multicultural Submission. *Interpreter training and scholarships*. Accessed 6 June, 2013, from <http://www.multicultural.vic.gov.au/projects-and-initiatives/improving-language-services/interpreter-scholarships>.
- ⁵²⁵ Office of Multicultural Affairs and Citizenship. (2011). Victorian Government Initiatives and reporting in multicultural affairs 2010–11. Melbourne, Victoria: p. 27.
- ⁵²⁶ Department of Immigration and Citizenship. *Professional Development for Interpreters*. Accessed 6 June, 2013, from http://www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/information-interpreters/pro-development.htm.
- ⁵²⁷ Department of Immigration and Citizenship comments to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, 30 April, 2012.
- ⁵²⁸ National Accreditation Authority for Translators and Interpreters. (2011). *Annual Report 2010–11: the key to language diversity*, p 9.
- ⁵²⁹ Mercy Health submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012
- ⁵³⁰ Health West Partnership submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012
- ⁵³¹ Ibid.

⁵³² St Vincent's submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

⁵³³ Health West Partnership submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012

⁵³⁴ Royal Australian and New Zealand College of Psychiatrists submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

⁵³⁵ Refugee Council of Australia submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

⁵³⁶ The Royal Australian and New Zealand College of Psychiatrists submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

⁵³⁷ Atkin, N. (2008). Getting the message across: professional interpreters in general practice. *Australian Family Physician*, 37(3), p. 175.

5.4 Clients

⁵³⁸ Bonacruz Kazzi, G. & Cooper, C. (2003). Barriers to the use of interpreters in emergency room paediatric consultations. *Journal of Paediatric Child Health*, 39, p. 260.

⁵³⁹ Centre for Culture, Ethnicity and Health. (2006). *Language Services in Victoria's Health System: Perspectives of Culturally and Linguistically Diverse Consumers*. Melbourne, Victoria: Brough, C., p. 4.

⁵⁴⁰ Ethnic Communities Council of Western Australia. (2007). *A report on interpreters and the West Australian public health service*. Perth, Western Australia: Chan-Furness, N. & Atkinson, A., p. 28.

⁵⁴¹ Queensland Accessing Interpreters Working Party. (2008). *A matter for interpretation: the case for access to high quality accredited interpreting and translating services and cultural competence in Queensland services working with culturally and linguistically diverse people*. West End, Queensland: p. 8.

⁵⁴² Zimbudzi, E., Thompson, S. & Terrill, B. (2010). How accessible are interpreter services to dialysis patients of Non-English Speaking Background? *Australasian Medical Journal*, 1(3), p. 208.

⁵⁴³ Eastern Access Community Health. (2011). *Refugee Health Nurse Program Evaluation Project 2011*. Melbourne, Victoria: p. 21.

⁵⁴⁴ Mental Health Council of Australia. (2005). *Not for service: experiences of injustice and despair in mental health care in Australia*. Deakin West: Australian Capital Territory, p. 243.

⁵⁴⁵ Department of Human Services (Southern Metropolitan Region). (2009). *Understanding the client experience: refugees accessing and utilising the health system in Australia*, p. 10.

⁵⁴⁶ Department of Health. (2010). *Language services in health care policy consultations: discussion paper*. Government of Western Australia: p. 11.

⁵⁴⁷ Victorian Department of Health. *Australian Charter of Healthcare Rights in Victoria – disseminating the brochure*. Accessed 20 June, 2012, from <http://www.health.vic.gov.au/patientcharter/services/disseminating.htm>.

⁵⁴⁸ Queensland Government. Client right for an interpreter. Accessed 20 June, 2012 from http://www.health.qld.gov.au/multicultural/interpreters/qhis_client_rght.asp.

⁵⁴⁹ Centre for Culture, Ethnicity and Health. Increasing requests for qualified interpreters. Accessed 6 June, 2013, from <http://www.ceh.org.au/about/projects/pages/italian-seniors.aspx>.

⁵⁵⁰ Centre for Culture, Ethnicity and Health. (2011). *Your health is too important for misunderstandings: report on a pilot consumer social marketing project to the*

Vietnamese community in Melbourne to increase the awareness of, and demand for, qualified interpreters. Melbourne, Victoria: Veljanovski, S.

⁵⁵¹ Department of Education and Early Childhood Development, personal communication, date unknown.

⁵⁵² Adult Multicultural Education Services comments to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

⁵⁵³ Centre for Culture Ethnicity and Health. *Language Services: Good Practice in the Victorian health and community sector.* North Richmond, Victoria: p. 114.

⁵⁵⁴ Eastern Health submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

⁵⁵⁵ Australian Centre for the Study of Sexual Assault. (2011). *Supporting women from CALD backgrounds who are victims/survivors of sexual violence: challenges and opportunities for practitioners.* Canberra, Australian Capital Territory: Allimant, A. & Ostapiej-Piatkowski, B., p. 12.

⁵⁵⁶ South Eastern Melbourne Medicare Local submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

⁵⁵⁷ Health West Partnership submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

⁵⁵⁸ The Royal Australian and New Zealand College of Psychiatrists submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

⁵⁵⁹ <http://www.multicultural.qld.gov.au/multicultural/services-and-resources/translating-and-interpreting-services/national-interpreter-symbol> accessed on 26/7/2012

⁵⁶⁰ Community Relations Commission for a Multicultural NSW. *Guidelines for Use.* Accessed 6 June, 2013, from http://www.crc.nsw.gov.au/services/language_services/national_interpreter_symbol/guidelines.

⁵⁶¹ Victorian Multicultural Commission. National Interpreter Symbol. Accessed 4 April, 2013, from <http://www.multicultural.vic.gov.au/projects-and-initiatives/improving-language-services/interpreter-card-and-symbol>.

⁵⁶² Ibid.

⁵⁶³ Victorian Multicultural Commission. National Interpreter Symbol. Accessed 10 September, 2012, from <http://www.multicultural.vic.gov.au/projects-and-initiatives/improving-language-services/interpreter-card-and-symbol>.

⁵⁶⁴ Victorian Multicultural Commission. Victorian Interpreter Card. Accessed 6 June, 2013, from <http://www.multicultural.vic.gov.au/projects-and-initiatives/improving-language-services/victorian-interpreter-card>.

⁵⁶⁵ <http://www.communities.qld.gov.au/multicultural/services-resources/translating-interpreting-services/card.page> accessed date unknown.

⁵⁶⁶ Ethnic Communities Council of Western Australia. (2007). *A report on interpreters and the West Australian public health service.* Perth, Western Australia: Chan-Furness, N. & Atkinson, A., p. 21.

⁵⁶⁷ Victorian Office of Multicultural Affairs. Victorian Interpreter Card. Retrieved 6 June, 2013, from <http://www.multicultural.vic.gov.au/images/stories/pdf/ic-english.pdf>.

⁵⁶⁸ Victorian Multicultural Commission. Victorian Interpreter Card. Accessed 6 June, 2013, from <http://www.multicultural.vic.gov.au/projects-and-initiatives/improving-language-services/victorian-interpreter-card>.

⁵⁶⁹ Information provided by TIS National.

-
- ⁵⁷⁰ The Royal Australian and New Zealand College of Psychiatrists submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁵⁷¹ Victorian Hansard (2008, May 7). *Multicultural Affairs Interpreter Card*. Accessed 24 October, 2011, from Parliament of Victoria Hansard.
- ⁵⁷² Department of Immigration and Citizenship, personal communication, 8 December, 2011.
- ⁵⁷³ Riggs, E. et al. (2012). Accessing maternal and child health services in Melbourne, Australia: reflections from refugee families and service providers. *BMC Health Services Research*, 12, p. 117.
- ⁵⁷⁴ Eastern Health submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁵⁷⁵ Centre for Culture, Ethnicity and Health. (2006). op. cit., p. 17.
- ⁵⁷⁶ Adult Multicultural Education Services comments to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁵⁷⁷ Centre for Culture, Ethnicity and Health. (2006). op. cit., p. 23.
- ⁵⁷⁸ Adult Multicultural Education Services comments to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁵⁷⁹ Mental Health Council of Australia. (2005). *Not for service: experiences of injustice and despair in mental health care in Australia*. Deakin West: Australian Capital Territory, p. 143.
- ⁵⁸⁰ Refugee Council of Australia. (2010). *Australia's refugee and humanitarian program 2010–11: community views on current challenges and future directions*. Surrey Hills, New South Wales, p. 78.
- ⁵⁸¹ Victorian Refugee Health Network submission to *Australian Parliament Joint Standing Committee on Migration*, 2011, p. 4.
- ⁵⁸² Garrett, P., Forero, R., Dickson, H. & Klinken Whelan, A. (2008b). How are language barriers bridged in acute hospital care? The tale of two methods of data collection. *Australian Health Review*, 32(4), p. 761.
- ⁵⁸³ Centre for Culture, Ethnicity and Health. (2006). Op. cit.
- ⁵⁸⁴ Community Health Action Group. (2004). *Lost in translation: a discussion paper on interpreting issues in health care settings in Queensland*: p. 14.
- ⁵⁸⁵ Centre for Culture, Ethnicity and Health. (2006). op. cit., p. 22.
- ⁵⁸⁶ Centre for Culture, Ethnicity and Health. (2006). op. cit., p. 17.
- ⁵⁸⁷ Centre for Culture, Ethnicity and Health. (2006). op. cit., p. 22.
- ⁵⁸⁸ Humans Rights and Equal Opportunity Commission. (2005). op. cit., p. 147.
- ⁵⁸⁹ Atkin, N. (2008). Getting the message across: professional interpreters in general practice. *Australian Family Physician*, 37(3), p. 175.
- ⁵⁹⁰ Humans Rights and Equal Opportunity Commission. (2005). op. cit., p. 585.
- ⁵⁹¹ Brisbane Inner South Division of General Practice. (2001). *The refugee consumer voice: how to ensure it makes a difference*. Brisbane, Queensland: p. 7.
- ⁵⁹² Renzaho, A. (2008). Re-visioning cultural competence in community health services in Victoria. *Australian Health Review*, 32(2), p. 228.
- ⁵⁹³ Centre for Culture, Ethnicity and Health. (2006). op. cit., p. 4.
- ⁵⁹⁴ Federation of Ethnic Communities' Council of Australia. (2012). *Opening the door to access and equity: FECCA Access and Equity Report 2011–2012*, submission paper, p. 46.
- ⁵⁹⁵ Ibid.
- ⁵⁹⁶ Mercy Health submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012

-
- ⁵⁹⁷ Colucci, E., Minas, H., Szwarc, J., Paxton, G. & Guerra, C. (2012). *Barriers to and facilitators of utilisation of mental health services by young people of refugee background*. Foundation House, University of Melbourne, Centre for Multicultural Youth and Royal Children's Hospital: p. 14.
- ⁵⁹⁸ Codrington, R. et al. (2011). Lost in translation? Embracing the challenges of working with families of a refugee background. *The Australian and New Zealand Journal of Family Therapy*, 32(2), p. 136.
- ⁵⁹⁹ Sypek, S., Clugston, G. & Phillips, C. (2008). Critical health infrastructure for refugee resettlement in rural Australia: case study of four rural towns. *Australian Journal of Rural Health*, 16, p. 352.
- ⁶⁰⁰ Zimbudzi, E., Thompson, S. & Terrill, B. (2010). op. cit., p. 208.
- ⁶⁰¹ G21 Geelong Region Alliance comments to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012
- ⁶⁰² Multicultural Mental Health Australia submission to the *Inquiry into Multiculturalism in Australia*, 2011, p. 28.
- ⁶⁰³ Richters, J. & Khoei., E. (2008). Concepts of sexuality and health among Iranian women in Australia. *Australian Family Physician*, 37(3), p. 192.
- ⁶⁰⁴ Ibid, p. 192.
- ⁶⁰⁵ http://www.ausit.org/files//code_of_ethics/ethics.pdf
- ⁶⁰⁶ Federation of Ethnic Communities' Council of Australia. (2012). Opening the door to access and equity: FECCA Access and Equity Report 2011–2012, submission paper, p. 46.
- ⁶⁰⁷ Australian Centre for the Study of Sexual Assault. (2011). *Supporting women from CALD backgrounds who are victims/survivors of sexual violence: challenges and opportunities for practitioners*. Canberra, Australian Capital Territory: Allimant, A. & Ostapiej-Piatkowski, B., p. 12.
- ⁶⁰⁸ The Royal Australian and New Zealand College of Psychiatrists submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁶⁰⁹ The Royal Australian and New Zealand College of Obstetricians and Gynaecologists submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012
- ⁶¹⁰ Australian Psychological Society submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, June 2012.
- ⁶¹¹ Federation of Ethnic Communities' Council of Australia. (2012). Opening the door to access and equity: FECCA Access and Equity Report 2011–2012, submission paper, p. 48.
- ⁶¹² Centre for Culture, Ethnicity and Health. (2010). *Arranging an interpreter tip sheet: language service series*. Retrieved 29 August, 2012, from http://www.ceh.org.au/downloads/CEH_TipSheet3_Arranging_an_interpreter.pdf.
- ⁶¹³ NSW Health Care Interpreter Service & NSW Service for the Treatment and Rehabilitation of Torture and Trauma. (2011). *Guidelines for working with interpreters for counselling & health care staff working with refugees*. Accessed 28 August, 2012 from http://www.sswahs.nsw.gov.au/sswahs/refugee/pdf/Resource/FactSheet/FactSheet_14.pdf.
- ⁶¹⁴ Australian Psychological Society submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, June 2012.

-
- ⁶¹⁵ Ehsani, J., Vu, T. & Karvelas, M. (2006). Exploring the need for hepatology nurses and allied health professionals in Victorian liver clinics. *Australian Health Review*, 30(2), p. 215.
- ⁶¹⁶ Centre for Culture, Ethnicity and Health. (2006). op. cit., p. 21.
- ⁶¹⁷ Centre for Culture, Ethnicity and Health. (2006). op. cit., pp. 3-21.
- ⁶¹⁸ Auditor General Victoria. (2011). *Maternity services: capacity*. Victorian Government Printer, p. 71.
- ⁶¹⁹ Hoang, H. (2008). Language and cultural barriers of Asian migrants in accessing maternal care in Australia. *The International Journal of Language Society and Culture*, 26, p. 58.
- ⁶²⁰ Centre for Culture, Ethnicity and Health. (2006). op. cit., pp. 21-34.
- ⁶²¹ Refugee Council of Australia submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁶²² Adult Multicultural Education Services submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁶²³ Bonacruz Kazzi, G. & Cooper, C. (2003). op. cit., p. 262.
- ⁶²⁴ White, L. & Chalmers, S. (2011). Responding to cultural diversity at two Sydney based children's hospitals. *Journal of Paediatrics and Child Health*, 47, p. 792.
- ⁶²⁵ Ibid, p. 790.
- ⁶²⁶ Ibid. p. 792.
- ⁶²⁷ Garrett, P., Forero, R., Dickson, H. & Whelan, A. (2008a). Communication and healthcare complexity in people with little or no English: the communication complexity score. *Ethnicity and Health*, 13(3), p. 204.
- ⁶²⁸ White, L. & Chalmers, S. (2011). op. cit., p. 790.

5.5 Strategies to address client concerns

- ⁶²⁹ NSW Community Relations Commission. (2002). *Use of interpreters in domestic violence and sexual assault cases: a guide for service providers*, p. 12. Accessed 24 May, 2012 from http://www.crc.nsw.gov.au/publications/documents/interpreters_domestic_violence.
- ⁶³⁰ Australian Centre for the Study of Sexual Assault. (2011). *Supporting women from CALD backgrounds who are victims/survivors of sexual violence: challenges and opportunities for practitioners*. Canberra, Australian Capital Territory: Allimant, A. & Ostapiej-Piatkowski, B., p. 11.
- ⁶³¹ Codrington, R. et al. (2011). Lost in translation? Embracing the challenges of working with families of a refugee background. *The Australian and New Zealand Journal of Family Therapy*, 32(2), p. 136.
- ⁶³² Colucci, E., Minas, H., Szwarc, J., Paxton, G. & Guerra, C. (2012). *Barriers to and facilitators of utilisation of mental health services by young people of refugee background*. Foundation House, University of Melbourne, Centre for Multicultural Youth and Royal Children's Hospital: p. 15.
- ⁶³³ deJongh, K. (2005). *The 2005 Sir William Kilpatrick Churchill Fellowship: To research hospital language service systems and analyse policy frameworks and strategies to deliver quality health interpreting/translation services to multicultural communities*, p. 10. Accessed 6 June, 2013, from <http://churchilltrust.com.au/fellows/detail/2933/karella+de-jongh>.
- ⁶³⁴ Wenk-Ansohn, M. & Gurriss, N. (2011). Intercultural encounters in counseling and psychotherapy – communication with the help of interpreters. *Torture*, 21, p. 183.
- ⁶³⁵ Hadziabdic, E. et al. (2009). Migrants perceptions of using interpreters in health care. *International Nursing Review*, 56, p. 461.

-
- ⁶³⁶ Centre for Culture, Ethnicity and Health. (2010). *Arranging an interpreter tip sheet: language service series*. Accessed 29 August, 2012, from http://www.ceh.org.au/downloads/CEH_TipSheet3_Arranging_an_interpreter.pdf.
- ⁶³⁷ Fuller, J. & Ballantyne, A. (2000). Immigrants and equitable health care delivery in rural areas. *Australian Journal of Rural Health*, 8, p. 190.
- ⁶³⁸ Available from http://ausit.org/national/?page_id=110 accessed on 17/9/2012.
- ⁶³⁹ Department of Immigration and Citizenship. Bridge the communication gap brochure. Accessed 10 September, 2012, from http://www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/publications-forms.htm.
- ⁶⁴⁰ Ibid.
- ⁶⁴¹ Peter MacCallum Cancer Centre submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁶⁴² Department of Human Services. (2005). *Language Services Policy*. Melbourne: Victoria, p. 17.
- ⁶⁴³ NSW Health Care Interpreter Service comments to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁶⁴⁴ Victorian Multicultural Commission. (2010). *Using interpreting services: Victorian Government policy and procedures*. Melbourne, Victoria, p. 15.

Chapter 6: Facilitators of the engagement of credentialed interpreters

6.1 Health practitioners and support staff

- ⁶⁴⁵ Gerrish, K. et al. (2004). Bridging the language barrier: the use of interpreters in primary care nursing. *Health and Social Care in the Community*, 12(5), p. 407.
- ⁶⁴⁶ Jacobs, E. et al. (2006). The need for more research on language barriers in health care: a proposed research agenda. *The Milbank Quarterly*, 84(1), p. 120.
- ⁶⁴⁷ Friedman-Rhodes, E. & Hale, S. (2010). Teaching Medical Students to work with interpreters. *The Journal of Specialised Translation*, 14, p. 125.
- ⁶⁴⁸ deJongh, K. (2005). *The 2005 Sir William Kilpatrick Churchill Fellowship: To research hospital language service systems and analyse policy frameworks and strategies to deliver quality health interpreting/translation services to multicultural communities*, p. 24. Accessed 6 June, 2013, from <http://churchilltrust.com.au/fellows/detail/2933/karella+de-jongh>.
- ⁶⁴⁹ VOMA, (2004), Language Services Strategy Report Card.
- ⁶⁵⁰ Heaney, C. & Moreham, S. (2002). Use of interpreter services in a metropolitan healthcare system. *Australian Health Review*, 25(3), p. 43.
- ⁶⁵¹ Commonwealth Ombudsman. (2009) *Factsheet 4 – Use of Interpreters*. Retrieved 6 June, 2013, from <http://www.ombudsman.gov.au/docs/fact-sheets/onlineFactSheet4-interpreters.pdf>.
- ⁶⁵² Centre for Culture Ethnicity and Health. *Language Services: Good Practice in the Victorian health and community sector*. North Richmond, Victoria: p. 10.
- ⁶⁵³ Department of Health. (2010). *Language services in health care policy consultations: discussion paper*. Government of Western Australia: p. 15.
- ⁶⁵⁴ Friedman-Rhodes, E. & Hale, S. (2010).Op. cit.
- ⁶⁵⁵ Refugee Council of Australia. (2009). *Australia's refugee and humanitarian program 2009–10*. Surrey Hills, New South Wales, p. 72.
- ⁶⁵⁶ deJongh, K. (2005). op. cit., p. 60.
- ⁶⁵⁷ Lee, T., Lansbury, G. & Sullivan, G. (2005). Health care interpreters: A physiotherapy perspective. *Australian Journal of Physiotherapy*, 51, p. 163.

-
- ⁶⁵⁸ Garrett, P. (2009). Healthcare interpreter policy: policy determinants and current issues in the Australian context. *Interpreting and Translations*, 1(2), p. 51.
- ⁶⁵⁹ Multicultural Mental Health Australia. (2009). *Inquiry into suicide in Australia: A response from the Multicultural Mental Health Australia's National CALD consumer and carer reference groups*, p. 5.
- ⁶⁶⁰ Lee, T., Lansbury, G. & Sullivan, G. (2005). op. cit., p. 165.
- ⁶⁶¹ Ethnic Communities' Council of Victoria. (2012). *An investment not an expense: enhancing health literacy in culturally and linguistically diverse communities*. Carlton, Victoria: p. 18.
- ⁶⁶² St Vincent's submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁶⁶⁴ Friedman-Rhodes, E. & Hale, S. (2010).Op. cit.
- ⁶⁶⁵ Commonwealth of Australia. (2011). *HLTHIR403C Work effectively with culturally diverse clients and co-workers*. Community Services and Health Industry Skills Council.
- ⁶⁶⁶ Australian Government. *HLT07 Health Training Package*. Accessed 6 June, 2013, from <http://training.gov.au/Training/Details/HLT07>.
- ⁶⁶⁷ Commonwealth of Australia. (2011). *HLTHIR403C Work effectively with culturally diverse clients and co-workers*. Community Services and Health Industry Skills Council.
- ⁶⁶⁸ Ethnic Communities Council of Western Australia. (2007). *A report on interpreters and the West Australian public health service*. Perth, Western Australia: Chan-Furness, N. & Atkinson, A., p. 28.
- ⁶⁶⁹ Mental Health Council of Australia. (2005). *Not for service: experiences of injustice and despair in mental health care in Australia*. Deakin West: Australian Capital Territory, p. 622.
- ⁶⁷⁰ Heaney, C. & Moreham, S. (2002). op. cit., p. 41.
- ⁶⁷¹ Victorian Transcultural Psychiatry Unit submission to the Senate Select Committee on Mental Health's *Inquiry into the provision of mental health services in Australia*, 2005, p. 9.
- ⁶⁷² Transcultural Mental Health Centre submission to the *Australian Senate Inquiry into Suicide*, 2009.
- ⁶⁷³ Multicultural Mental Health Australia submission to the *Inquiry into Multiculturalism in Australia*, 2011, p. 29.
- ⁶⁷⁴ Refugee Council of Australia submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁶⁷⁵ Oncall Interpreters and Translators. *Oncall training*. Accessed 6 June, 2013, from <http://oncallinterpreters.com/Community-interpreting-training.html>.
- ⁶⁷⁶ Centre for Culture, Ethnicity and Health. *Training topics*. Accessed 6 June, 2013, from <http://www.ceh.org.au/training/topics.aspx>.
- ⁶⁷⁷ NSW Health Care Interpreter Service comments to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁶⁷⁸ Centre for Culture, Ethnicity and Health. (2007). *Report to the Victorian Multicultural Commission: working effectively with professional interpreters in private general practice*. North Richmond, Victoria.
- ⁶⁸⁰ St Vincent's submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁶⁸¹ Dr I-Hao Cheng Refugee Health Program Manager, South East Melbourne Medical Local and Refugee Health Research Fellow, Southern Academic Primary Care Research Unit, personal communication, 28 May, 2012.

-
- ⁶⁸² South Eastern Melbourne Medicare Local submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁶⁸³ The Royal Australian College of Physicians. Intercultural learning modules. Accessed 2 August, 2012, from <http://www.racp.edu.au/index.cfm?objectid=5D762916-CAD9-2C40-5884D866E7F65207>.
- ⁶⁸⁴ LDC Group. Evaluation of "Cultural Competence in Professional Practice" Training Program for Early Childhood Professionals. Accessed 2 July, 2012, from <http://www ldc.net.au/Default.aspx?PageID=4115643&A=SearchResult&SearchID=5039299&ObjectID=4115643&ObjectType=1>.
- ⁶⁸⁵ Municipal Association of Victoria comments to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁶⁸⁶ Department of Health. (2009). *Cultural responsiveness framework: guidelines for Victorian health services*. Melbourne, Victoria: p. 26.
- ⁶⁸⁷ Huang, Y-T., Phillips, C., (2009), p 444.
- ⁶⁸⁸ Victorian Transcultural Psychiatry Unit. (2001). *Working with interpreters*. Fitzroy, Victoria: Minas, H., Stankovska, M. & Ziguas, S., p. 13.
- ⁶⁸⁹ Adult Multicultural Education Services comments to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁶⁹⁰ St Vincent's submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁶⁹¹ Health West Partnership submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012
- ⁶⁹² St Vincent's submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁶⁹³ Department of Health. (2009). *Cultural responsiveness framework: guidelines for Victorian health services*. Melbourne, Victoria: p. 26.
- ⁶⁹⁴ Renzaho, A. (2008). Re-visioning cultural competence in community health services in Victoria. *Australian Health Review*, 32(2), p. 233.
- ⁶⁹⁵ Centre for Culture, Ethnicity and Health. (2007). *Report to the Victorian Multicultural Commission: working effectively with professional interpreters in private general practice*. North Richmond, Victoria.
- ⁶⁹⁶ Friedman-Rhodes, E. & Hale, S. (2010). op. cit.
- ⁶⁹⁷ deJongh, K. (2005). op. cit., p. 27.
- ⁶⁹⁸ The Royal Eye and Ear Hospital. (2011). *Quality of Care Report 2010-2011*. East Melbourne, Victoria: p, 19.
- ⁶⁹⁹ Victorian Multicultural Commission. (2010). *Using interpreting services: Victorian Government policy and procedures*. Melbourne, Victoria, p. 10.
- ⁷⁰⁰ NSW Community Relations Commission. (2002). *Use of interpreters in domestic violence and sexual assault cases: a guide for service providers*, p. 12. Retrieved 24 May, 2012, from http://www.crc.nsw.gov.au/publications/documents/interpreters_domestic_violence.
- ⁷⁰¹ Victorian Multicultural Commission. (2010). *Using interpreting services: Victorian Government policy and procedures*. Melbourne, Victoria, p. 15.
- ⁷⁰² Victorian Interpreting and Translating Services. *We speak your language: a guide to cross cultural communication*. Melbourne, Victoria: p. 15.
- ⁷⁰³ Centre for Culture, Ethnicity and Health. *Assessing the need for an interpreter*. Retrieved 28 May, 2012, from http://www.ceh.org.au/downloads/CEH_TipSheet2_Assessing_need_for_interpreter.pdf.
- ⁷⁰⁴ Victorian Multicultural Commission. (2010). op. cit.

-
- ⁷⁰⁵ Centre for Multicultural Youth. (2011). *Good practice guide: working with interpreters*. Accessed 28 May, 2012, from <http://www.cmy.net.au/ResourcesfortheSector>.
- ⁷⁰⁶ Queensland Government, Queensland Health. (2007). *Working with interpreters guidelines*, p. 11.
- ⁷⁰⁷ Department of Victorian Communities. (2003). *Improving the use of translating and interpreting services: A guide to Victorian Government policy and procedures*. Melbourne, Victoria. Victorian Office of Multicultural Affairs: p. 32.
- ⁷⁰⁸ NSW Community Relations Commission. (2002). *Use of interpreters in domestic violence and sexual assault cases: a guide for service providers*, p. 23. Accessed 24 May, 2012, from http://www.crc.nsw.gov.au/publications/documents/interpreters_domestic_violence.
- ⁷⁰⁹ Victorian Multicultural Commission. (2010). op. cit., p. 18.
- ⁷¹⁰ NSW Community Relations Commission. (2002). *Use of interpreters in domestic violence and sexual assault cases: a guide for service providers*, p. 23. Accessed 24 May, 2012, from http://www.crc.nsw.gov.au/publications/documents/interpreters_domestic_violence.
- ⁷¹¹ Department of Human Services. (2005). *Language Services Policy*. Melbourne: Victoria, pp. 8–11.
- ⁷¹² Victorian Multicultural Commission. (2010). op. cit., p. 21.
- ⁷¹³ Australian Institute of Interpreters and Translators. *AUSIT guidelines for health professionals working with interpreters*. Retrieved 28 May, 2012, from http://www.ausit.org/page/health_guidelines.html.
- ⁷¹⁴ Multicultural Mental Health Australia. (2009). *Inquiry into suicide in Australia: A response from the Multicultural Mental Health Australia's National CALD consumer and carer reference groups*, p. 5.
- ⁷¹⁵ Victorian Interpreting and Translating Services. *We speak your language: a guide to cross cultural communication*. Melbourne, Victoria: p. 19.
- ⁷¹⁶ Atkin, N. (2008). Getting the message across: professional interpreters in general practice. *Australian Family Physician*, 37(3), p. 175.
- ⁷¹⁷ Christine Phillips, Medical Director, Companion House, personal communication, 22 April, 2012.
- ⁷¹⁸ Victorian Foundation for Survivors of Torture. (1998). *Rebuilding shattered lives*. Parkville, Victoria: Kaplan, I., p. 163.
- ⁷¹⁹ Victorian Transcultural Psychiatry Unit. (2006). *Guidelines for working effectively with interpreters in mental health settings*. Fitzroy, Victoria: Miletic, T. et al., p. 27.
- ⁷²⁰ NSW Health Care Interpreter Service, NSW Service for the Treatment and Rehabilitation of Torture and Trauma Services & NSW Refugee Health Service. (2005). *Guidelines for working with interpreters for counselling and health care staff working with refugees*. Accessed 6 June, 2013, from http://www.swslhd.nsw.gov.au/refugee/pdf/Resource/FactSheet/FactSheet_14.pdf.
- ⁷²¹ Refugee Council of Australia response to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁷²² Australian Institute of Interpreters and Translators. *AUSIT guidelines for health professionals working with interpreters*. Retrieved 28 May, 2012, from http://www.ausit.org/page/health_guidelines.html.
- ⁷²³ NSW Community Relations Commission. (2002). *Use of interpreters in domestic violence and sexual assault cases: a guide for service providers*, p. 23. Accessed 24 May, 2012, from http://www.crc.nsw.gov.au/publications/documents/interpreters_domestic_violence.
- ⁷²⁴ Victorian Interpreting and Translating Services. *We speak your language: a guide to cross cultural communication*. Melbourne, Victoria: p. 18.

⁷²⁵ Royal Australian and New Zealand College of Psychiatrists submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

⁷²⁶ Department of Human Services. (2005). *Language Services Policy*. Melbourne: Victoria, p. 16.

⁷²⁷ Mercy Health submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

⁷²⁸ Victorian Multicultural Commission. (2010). *op. cit.*, p. 22.

⁷²⁹ NSW Community Relations Commission. (2002). *Use of interpreters in domestic violence and sexual assault cases: a guide for service providers*, p. 23. Accessed 24 May, 2012, from

http://www.crc.nsw.gov.au/publications/documents/interpreters_domestic_violence.

⁷³⁰ Translating and Interpreting Service National. TIS National Promotional DVD. Accessed 28 May, 2012, from http://www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/promotional-dvd.htm.

⁷³¹ Victorian Department of Human Services. Making the connection – language services in the human service sector. Accessed on 7 June, 2012 from <http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/reports-publications/making-the-connection-manual>.

⁷³² Department of Human Services. (2005). *Language Services Policy*. Melbourne: Victoria, pp. 26-27.

⁷³³ Victorian Interpreting and Translating Service. Training CD on working with interpreters. Accessed 28 May, 2012, from <http://www.vits.com.au/publications.htm>.

6.2 Health services

⁷³⁴ Centre for Culture Ethnicity and Health. *Language Services: Good Practice in the Victorian health and community sector*. North Richmond, Victoria: p. 8.

⁷³⁵ Department of Health. (2009). *Cultural responsiveness framework: guidelines for Victorian health services*. Melbourne, Victoria: p. 26.

⁷³⁶ Primary Care Connect Community Health Services, personal communication, 20 December, 2012.

⁷³⁷ European Commission, (2005), *Project Summary Migrant Friendly Hospitals Project*, p. 7. Accessed 6 June, 2013, from <http://www.mfh-eu.net/public/files/mfh-summary.pdf>.

⁷³⁸ Migrant Friendly Hospitals. *Migrant friendly hospitals project – in a nutshell*. Accessed 14 June, 2012, from <http://www.mfh-eu.net/public/home.htm>.

⁷³⁹ European Commission, (2005), *Project Summary Migrant Friendly Hospitals Project*, p. 7. Accessed 6 June, 2013, from <http://www.mfh-eu.net/public/files/mfh-summary.pdf>.

⁷⁴⁰ Mercy Health submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

⁷⁴¹ Bendigo Health submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

⁷⁴² Health West Partnership submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

⁷⁴³ NSW Health Care Interpreter Service comments to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

⁷⁴⁴ Gray, B., Hilder, J. & Donalson, H. (2011). Why do we not use trained interpreter for all patients with limited English proficiency? Is there a place for using family members. *Australian Journal of Primary Health*, 17, pp. 243-244.

⁷⁴⁵ Hsieh, E. (2006). Understanding medical interpreters: reconceptualising bilingual health communication. *Health Communication*, 20(2), p. 180.

⁷⁴⁶ Western Health. (2011). *Quality of Care Report 2010–2011*, p. 12. Accessed 6 June, 2013, from

http://www.wh.org.au/Media/Media_Releases/201011_Western_Health_Quality_of_Care_Report/indexdl_13578.aspx.

⁷⁴⁷ G21 Geelong Region Alliance comments to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

6.3 Interpreter equipment technologies

⁷⁴⁸ Bonacruz Kazzi, G. & Cooper, C. (2003). Barriers to the use of interpreters in emergency room paediatric consultations. *Journal of Paediatric Child Health*, 39, p. 262.

⁷⁴⁹ Community Health Action Group. (2004). Lost in translation: a discussion paper on interpreting issues in health care settings in Queensland: p. 12.

⁷⁵⁰ Adult Multicultural Education Services comments to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

⁷⁵¹ Bonacruz Kazzi, G. & Cooper, C. (2003). op. cit., p. 262.

⁷⁵² Riggs, E. et al. (2012). Accessing maternal and child health services in Melbourne, Australia: reflections from refugee families and service providers. *BMC Health Services Research*, 12, p. 117.

⁷⁵³ Municipal Association of Victoria comments to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

⁷⁵⁴ Municipal Association of Victoria comments to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

⁷⁵⁵ Bendigo Health submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

⁷⁵⁶ Health West Partnership submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012

⁷⁵⁷ G21 Geelong Region Alliance comments to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

⁷⁵⁸ Riggs, E. et al. (2012). Accessing maternal and child health services in Melbourne, Australia: reflections from refugee families and service providers. *BMC Health Services Research*, 12, p. 117.

⁷⁵⁹ Health West Partnership submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012

⁷⁶⁰ RACGP, (2010), *Standards for General Practices 4th Edition*, p 108.

⁷⁶¹ Language Line website, accessed 6 June, 2013, from http://www.languageline.com/page/global_sites.

⁷⁶² <http://www.languageline.co.uk/llp>

⁷⁶³ Language Line. Frequently asked questions. Accessed 6 June, 2013, from http://www.languageline.com/llp_faq

⁷⁶⁴ deJongh, K. (2005). *The 2005 Sir William Kilpatrick Churchill Fellowship: To research hospital language service systems and analyse policy frameworks and strategies to deliver quality health interpreting/translation services to multicultural communities*, p. 51. Accessed 6 June, 2013, from

<http://churchilltrust.com.au/fellows/detail/2933/karella+de-jongh>.

-
- ⁷⁶⁵ NSW Health Care Interpreter Service comments to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁷⁶⁶ Kostadinovska, G. (2011). Providing services of CALD patients in emergency departments. *Diversit-e*, 2, p. 7.
- ⁷⁶⁷ Polycom. *Soundstation 2W Wireless Conference Phone*. Accessed 6 June, 2013, from <http://www.polycom.com/global/documents/products/voice/datasheets/soundstation2w-datasheet.pdf>.
- ⁷⁶⁸ Discussion with Primary Care Connect Community Health Services, personal communication, 20 December, 2012.
- ⁷⁶⁹ Health West Partnership submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁷⁷⁰ Peter MacCallum Cancer Centre submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁷⁷¹ Discussion with Primary Care Connect Community Health Services, personal communication, 20 December, 2012.
- ⁷⁷² Medibabble. Medibabble translator. Accessed 3 May, 2012, from <http://medibabble.com/index.html>.
- ⁷⁷³ University of California San Francisco. (2011, June 22). *UCSF Medical Students Create Free Medical Translation App, Conquering Language Barriers to Patient Care*. Accessed 3 May, 2012, from <http://www.ucsf.edu/news/2011/06/10099/ucsf-students-create-medical-translation-app-conquer-language-barriers>.
- ⁷⁷⁴ Ibid.
- ⁷⁷⁵ Ibid.
- ⁷⁷⁶ Reiss-Koncar, S., Milos, E., (2011), There is no "Babble" in Medicine, p 2.
- ⁷⁷⁷ Reiss-Koncar, S., Milos, E., (2011), There is no "Babble" in Medicine, p 2.
- ⁷⁷⁸ iTunes. *Google translate app description*. Accessed 6 June, 2013, from <http://itunes.apple.com/au/app/google-translate/id414706506?mt=8>.
- ⁷⁷⁹ Jibbiggo. *Jibbiggo translator app*. Accessed 6 June, 2013, from <http://www.jibbiggo.com/website/index.php>.
- ⁷⁸⁰ Gany, F. et al. (2007). The impact of medical interpretation method on time and errors. *Journal General Internal Medicine*, 22(2), p. 319.
- ⁷⁸¹ Gany, F. et al. (2007). The impact of medical interpretation method on time and errors. *Journal General Internal Medicine*, 22(2), p. 319.
- ⁷⁸² deJongh, K. (2005). Op. cit p. 28.
- ⁷⁸³ deJongh, K. (2005). op. cit. p. 52.
- ⁷⁸⁴ Health Link Interpreters. Today's picture of interpretation. Accessed 6 June, 2013, from <http://www.healthlinkinterpreters.com/VideoMedicalInterpreting/TechnicalRequirements.aspx>.
- ⁷⁸⁵ Android Apps.Com. *Purple VRI app description*. Accessed 2 July, 2012, from <http://android-apps.com/applications/communication/purple-vri>.
- ⁷⁸⁶ Hirsh, J. & Marano, F. (2007). Better patient care through video interpretation. *Health Management Technology*, March, p. 30.
- ⁷⁸⁷ Rancho Los Amigos. Language and culture resource centre. Accessed 6 June, 2013, from http://www.rancho.org/ServiceReint_LangCult.aspx.
- ⁷⁸⁸ Rancho Los Amigos. Increasing access to visual trained interpreters for limited English proficient patients. Accessed 6 June, 2013, from <http://www.rancho.org/Forms/LangCultPoster.pdf>.

-
- ⁷⁸⁹ Paras and Associates Interpreter Systems. Clients. Accessed 6 June, 2013, from <http://www.parasandassociates.net/clients.html>.
- ⁷⁹⁰ Northern Health. (2011). *Quality of care report 2010–11*, p. 6. Accessed 6 June, 2013, from <http://www.nh.org.au/documents/publications/10-11-QoC-web-version.pdf>.
- ⁷⁹¹ Sunraysia Community Health Services. (2011). *Quality of Care Report 2010–2011*, p. 32. Accessed 6 June, 2013, from <http://www.schs.com.au/Quality%20of%20Care%20Report%202010-11.pdf>.
- ⁷⁹² Northern Health, personal communication, 23 July, 2012.
- ⁷⁹³ Southern Health. (2011). *Quality of Care Report 2010-2011*, p. 34.
- ⁷⁹⁴ Sunraysia Community Health Service, personal communication, 12 June, 2012.
- ⁷⁹⁵ NSW Health Care Interpreter Service comments to Foundation House's Exploring barriers and facilitators to the use of qualified interpreters in health, discussion paper, May 2012.
- ⁷⁹⁶ Fuller, J. & Ballantyne, A. (2000). Immigrants and equitable health care delivery in rural areas. *Australian Journal of Rural Health*, 8, p. 192.
- ⁷⁹⁷ St Vincent's submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁷⁹⁸ Department of Human Services – Medicare. *Telehealth information page*. Accessed 23 July, 2012, from <http://www.medicareaustralia.gov.au/provider/incentives/telehealth.jsp> and Department of Health and Ageing. *Changes to telehealth*. Accessed 23 July, 2012, from <http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/connectinghealthservices-2012-13BudgetFactsheet.htm>.
- ⁷⁹⁹ Australian College of Rural and Remote Medicine comments to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

6.4 Service planning and data collection

- ⁸⁰⁰ Zimbudzi, E., Thompson, S. & Terrill, B. (2010). How accessible are interpreter services to dialysis patients of Non-English Speaking Background? *Australasian Medical Journal*, 1(3), p. 210.
- ⁸⁰¹ Department of Victorian Communities. (2003). *Improving the use of translating and interpreting services: A guide to Victorian Government policy and procedures*. Melbourne, Victoria. Victorian Office of Multicultural Affairs: p. 21.
- ⁸⁰² NSW Health Care Interpreter Service comments to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁸⁰³ Romios, P., McBride, T. & Mansourian, J. (2008). Participation with culturally and linguistically diverse communities in health services – what helps and what hinders. *Health Issues*, 95, p. 29.
- ⁸⁰⁴ Centre for Culture Ethnicity and Health. *Language Services: Good Practice in the Victorian health and community sector*. North Richmond, Victoria: p. 13.
- ⁸⁰⁵ Bendigo Health submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.
- ⁸⁰⁶ Department of Health and Ageing. (2011). *Medicare Locals: Guidelines for the establishment and initial operation of Medicare Locals and information for applicants wishing to apply for funding to establish a Medicare Local*, p. 20. Accessed 6 June, 2013, from [http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/featurednews-20110222b/\\$File/Medicare%20Locals%20Guidelines%20and%20Information%20for%20applicants.pdf](http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/featurednews-20110222b/$File/Medicare%20Locals%20Guidelines%20and%20Information%20for%20applicants.pdf).

⁸⁰⁷ Ibid.

⁸⁰⁸ Ibid, p. 15.

⁸⁰⁹ Department of Health and Ageing. *Guide and template for Medicare Locals Needs Assessment Report*, p. 1. Accessed 19 September, 2012, from http://www.gpnnt.org.au/client_images/339321.pdf.

⁸¹⁰ Garrett, P., Forero, R., Dickson, H. & Whelan, A. (2008a). Communication and healthcare complexity in people with little or no English: the communication complexity score. *Ethnicity and Health*, 13(3), p. 215.

⁸¹¹ Department of Health. (2010). *Language services in health care policy consultations: discussion paper*. Government of Western Australia: p. 15.

⁸¹² Department of Victorian Communities. (2010). *Victorian Government standards for data collection on interpreting and translating services*. Melbourne, Victoria. Victorian Office of Multicultural Affairs.

⁸¹³ Department of Health. (2010). *Quality of care reports: guidelines and minimum reporting requirements 2010-2011*. Melbourne, Victoria.

⁸¹⁴ NSW Health Care Interpreter Service comments to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

⁸¹⁵ The Goerge Washington University Medical Center. (2008). *In any language: improving the quality and availability of language services in hospitals*. Robert Wood Johnson Foundation: Regenstein, M., Trott, J., West, C. & Huang, J.

⁸¹⁶ Bendigo Health submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

6.5 Interpreter booking systems

⁸¹⁷ Zimbudzi, E., Thompson, S. & Terrill, B. (2010). How accessible are interpreter services to dialysis patients of Non-English Speaking Background? *Australasian Medical Journal*, 1(3), p. 208.

⁸¹⁸ Renzaho, A., (2008), p 228.

⁸¹⁹ Health West Partnership submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

⁸²⁰ Centre for Culture Ethnicity and Health. *Language Services: Good Practice in the Victorian health and community sector*. North Richmond, Victoria: p. 10.

⁸²¹ Victorian Transcultural Psychiatry Unit. (2001). *Working with interpreters*. Fitzroy, Victoria: Minas, H., Stankovska, M. & Ziguras, S., p. 13.

⁸²² Discussions with Northern Health, the Royal Women's Hospital and Western Health, date unknown.

⁸²³ Dental Health Services Victoria. (2011). *Quality of care report 2010-11*, p. 13. Accessed 6 June, 2013, from <http://www.dhsv.org.au/about-us/reports-and-publications/#quality/!ts=1370502875232>.

⁸²⁴ Western Health and Dr Notes Solutions Pty Ltd, personal communication, date unknown.

⁸²⁵ Mercy Health submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

⁸²⁶ St Vincent's submission to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

⁸²⁷ ISIS Primary Care, personal communication, 19 December, 2011.

⁸²⁸ Southern Health, personal communication, 12 April, 2012.

⁸²⁹ Primary Care Connect Community Health Services, personal communication, 20 December, 2011.

⁸³⁰ Dental Health Services Victoria. (2011, January 27). *Interpreters – removing language barriers at the Royal Dental Hospital of Melbourne*. Accessed 24 September,

2009, from <http://www.dhsv.org.au/news-stories/2011/01/27/interpreters-removing-language-barriers-at-the-royal-dental-hospital-of-melbourne/>.

⁸³¹ NSW Health Care Interpreter Service comments to Foundation House's *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, May 2012.

⁸³² Auditor General Victoria. (2011). *Maternity services: capacity*. Victorian Government Printer, p. 71.

⁸³³ Eastern Access Community Health. (2011). *The pregnancy and birth experience of women from refugee backgrounds living in the Outer East of Melbourne*. Melbourne, Victoria: Nicolaou, M., p 16.

⁸³⁴ The Allen Consulting Group. (2002). Report to the Department of Premier and Cabinet, Victorian Office of Multicultural Affairs: a needs analysis of language services. Melbourne, Victoria: p. 10.

⁸³⁵ Victorian Transcultural Psychiatry Unit. (2001). *Working with interpreters*. Fitzroy, Victoria: Minas, H., Stankovska, M. & Ziguras, S., p. 11.

⁸³⁶ Department of Immigration and Citizenship comments to the Foundation House Discussion Paper *Exploring barriers and facilitators to the use of qualified interpreters in health*, discussion paper, 30 April, 2012.

⁸³⁷ Victorian Transcultural Psychiatry Unit. (2006). *Guidelines for working effectively with interpreters in mental health settings*. Fitzroy, Victoria: Miletic, T. et al., p. 11.

6.6 Policies and procedures

⁸³⁸ Commonwealth Ombudsman. (2009) *Factsheet 4 – Use of Interpreters*. Retrieved 6 June, 2013, from <http://www.ombudsman.gov.au/docs/fact-sheets/onlineFactSheet4-interpreters.pdf>.

⁸³⁹ Victorian Multicultural Commission. (2010). *Using interpreting services: Victorian Government policy and procedures*. Melbourne, Victoria, p. 22.

⁸⁴⁰ Centre for Culture Ethnicity and Health. *Language Services: Good Practice in the Victorian health and community sector*. North Richmond, Victoria: p. 18.

⁸⁴¹ Giacomelli, J. (1997). A review of health interpreter services in a rural community: a total quality management approach. *Australian Journal of Rural Health*, 5, p. 161.

⁸⁴² Kostadinovska, G. (2011). Providing services of CALD patients in emergency departments. *Diversit-e*, 2, p. 7.

6.7 Internal reviews

⁸⁴³ Goulburn Valley Primary Care Partnership. (2005). *Language Services Toolkit*. Accessed 6 June, 2013, from [http://nps718.dhs.vic.gov.au/rrhacs/hacc/ch.nsf/images/Language_services_toolkit/\\$file/language%20services%20toolkit.pdf](http://nps718.dhs.vic.gov.au/rrhacs/hacc/ch.nsf/images/Language_services_toolkit/$file/language%20services%20toolkit.pdf).

⁸⁴⁴ Primary Care Connect Community Health Services, personal communication, 20 December, 2011.

⁸⁴⁵ ISIS Primary Care, personal communication, 19 December, 2011.

⁸⁴⁶ Western Region Health Centre and Victorian Multicultural Commission. (2010). *Language Services Report, Executive Summary*. Melbourne, Victoria.

⁸⁴⁷ Royal Woman's Hospital, personal communication, 1 March, 2012.

Appendices

⁸⁴⁸ Heaney, C. & Moreham, S. (2002). Use of interpreter services in a metropolitan healthcare system. *Australian Health Review*, 25(3), p. 42.

-
- ⁸⁴⁹ Health Care Interpreter Network. *About us*. Accessed 6 June, 2013, from <http://www.hcin.org/index.php/aboutus-whoweare>.
- ⁸⁵⁰ Health Care Interpreter Network. *How it works*. Accessed 6 June, 2013, from <http://www.hcin.org/index.php/solution-howitworks>.
- ⁸⁵¹ Jacobs, E. et al. (2011). Shared networks of interpreter services, at a relatively low cost, can help providers serve patients with limited English skills. *Health Affairs*, 30(10); pp. 1930-1938.
- ⁸⁵² Health Care Interpreter Network. *Solutions*. Accessed 6 June, 2013, from <http://hcin.org/index.php/solution-membershipplans/>.
- ⁸⁵³ Cisco. *Video interpreters connect patients and doctors*. Accessed 6 June, 2013, from <http://www.cisco.com/web/strategy/docs/healthcare/HCIN.pdf>.
- ⁸⁵⁴ Paras and Associates Interpreter Systems. *Clients*. Accessed 6 June, 2013, from <http://www.parasandassociates.net/clients.html>.
- ⁸⁵⁵ Cisco, op. cit.
- ⁸⁵⁶ Health Care Interpreter Network. Accessed 31 July, 2012, from <http://hcin.org>.
- ⁸⁵⁷ Jacobs, E. et al. (2011). Shared networks of interpreter services, at a relatively low cost, can help providers serve patients with limited English skills. *Health Affairs*, 30(10); pp. 1930-1938.
- ⁸⁵⁸ Cisco, op. cit.
- ⁸⁵⁹ Jacobs, E. et al. (2011). op. cit.
- ⁸⁶⁰ Victorian Department of Health. (2012, March 12). *Health innovation reform council established*. Accessed 17 July, 2012, from <http://www.health.vic.gov.au/news/health-innovation-reform-council-established.htm>.
- ⁸⁶¹ Victorian Department of Health. *Health Information Reform Council*. Accessed 17 July, 2012, from <http://www.health.vic.gov.au/hirc>.
- ⁸⁶² Department of Health. (2011). *Victorian Health Priorities Framework 2012-2022: Metropolitan Health Plan*. Melbourne, Victoria, p. 54. Accessed 6 June, 2013, from <http://docs.health.vic.gov.au/docs/doc/Victorian-Health-Priorities-Framework-2012-2022:-Metropolitan-Health-Plan>.
- ⁸⁶³ Victorian Department of Health. *Health Information Reform Council*. Accessed 17 July, 2012, from <http://www.health.vic.gov.au/hirc>.
- ⁸⁶⁴ Ibid.
- ⁸⁶⁵ Diabetes Australia, Victoria, personal communication, 6 June, 2012.

