Delivering a Healthy WA

REVIEW OF LANGUAGE SERVICES IN THE WA HEALTH SYSTEM

FINAL REPORT
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EXECUTIVE SUMMARY

Western Australia (WA) has the highest proportion of people born overseas (27%), almost half a million people, with currently over 200 different countries and 170 different languages represented in the local population (Appendix 1). In 2006, 11% of Western Australians stated that they spoke a language other than English at home.¹ Culturally and linguistically diverse groups (CaLD) enrich all aspects of the WA community. The provision of language services supports basic human rights and values associated with the delivery of fair and equitable services and substantive equality.

This report provides information and recommendations on language services in WA Health as a result of work undertaken on projects in four key areas, namely:

1. Consumer experiences;
2. Service delivery;
3. Communication and awareness; and
4. Services for Indigenous people.

Outside the scope of this review are industrial issues which are critical to the future of interpreter services and currently under negotiation with the Industrial Relations Service at the Director General’s Office.

There are different modes of providing interpreter services, including on-site (face-to-face) and the national telephone Translating and Interpreting Service (TIS). Translated information is also provided to facilitate interpreting processes. WA Health’s tertiary hospitals provide over 21,000 language services every year for inpatients, outpatients and community based services at an annual cost of approximately $2 million. Additionally, services are provided by secondary hospitals and WA Country Health Services.

The valuable role of language services and their increasingly high activity levels are acknowledged. Whilst strategies are being developed to maximise efficiencies in hospitals and health services, there are some areas requiring attention. Increasing numbers of immigrants and demands for specialised services for certain patient groups have increased overall demand. In order for patients to obtain the most appropriate services available (and hospitals and health services to maintain maximum value from existing resources) one approach is to strengthen relationships between services. Establishing a comprehensive and consistent approach to the implementation of language services policy would support this strategy. To that end, issues involving the interpreter workforce as well as training and accreditation are paramount.

Whilst language services are relatively inexpensive and there is minimal scope for efficiency gains, recommendations for both system wide and hospital level improvements in language services have been identified. Implementation of these will require ongoing commitment to this important service and, in some instances, will require a modest investment.

¹ Australian Bureau of Statistics (accessed on 5 March 2008)
RECOMMENDATIONS

Recommendation 1
Establish a Language Services Network to improve the integration and coordination of language services through interaction between service providers and other stakeholders.

Recommendation 2
Require the Cultural Diversity team to:
- Coordinate the Language Services Network;
- Evaluate the TAFE Interpreter Training Course;
- Develop a centralised, web-based, clearinghouse for translated information;
- Regularly liaise with the Department of Immigration and Citizenship in order to monitor refugee influxes and the Commonwealth Department of Health and Ageing to increase awareness of interpreter services with general practitioners; and
- Develop a marketing strategy to promote interpreter services to consumers.

Recommendation 3
Investigate the possibility of SMS telephone text messages being used for deaf patients across the health system.

Recommendation 4
Hospitals to recognise that both Auslan and deaf interpreters may be required for interpreting sessions.

Recommendation 5
Maintain and strengthen the current hospital and health service configurations for delivering language services.

Recommendation 6
Hospitals to recognise insufficient capacity and the increasing (and changing) demand for language services by:
- Reviewing the organisational structure of delivery of language services at Royal Perth Hospital, Fremantle Hospital, Sir Charles Gairdner Hospital, Princess Margaret Hospital, King Edward Memorial Hospital and Graylands Hospital, with the intention of increasing capacity;
- Ensuring each Language Services Coordinator has sufficient funds to provide adequate interpreter training and professional development, translation costs and cover debriefing sessions for interpreters;
- Providing access to facilities to support telephone interpreting, including conference style speaker phones and appropriate settings.

Recommendation 7
Fremantle Hospital and Mental Health Services (Alma Street) to review the efficacy and effectiveness of consolidating language services within one unit.

Recommendation 8
Hospitals to develop consistent data collection methods and systems for language services planning, monitoring and reporting.
Recommendation 9
Hospitals to ensure health service professionals are provided with the opportunity to receive orientation and ongoing professional development in cultural competency, cultural awareness and the correct use of language services.

Recommendation 10
1.0 INTRODUCTION

Western Australia (WA) has the highest proportion of people born overseas (27%), almost half a million people, with currently over 200 different countries and 170 different languages represented in the local population (Appendix 1). In 2006, 11% of Western Australians stated that they spoke a language other than English at home. The most frequently reported of these languages were Italian, Mandarin, Cantonese, Vietnamese and Arabic. Culturally and linguistically diverse groups (CaLD) enrich all aspects of the WA community. The provision of language services supports basic human rights and values associated with the delivery of fair and equitable services and substantive equality. Demand for interpreting services is increasing and changing across all health services.

The WA Government’s Language Services Policy seeks to ensure that language is not a barrier to services for people who require assistance in English. The Language Services Policy is a commitment to the development of efficient communication strategies to enable agencies to deliver services that are responsive and equitable for all CaLD clients, including Indigenous populations where English may be a second language for many people.

WA Health’s Language Services in Health Care Policy and Guidelines strives for equal health care and service outcomes for people who have no (or minimal) English proficiency or who are deaf. The policy acknowledges that neither language nor cultural differences should be a barrier to health care. Minimum standards are set to uphold fundamental values and ensure that health and legal liabilities are addressed.

Both the WA Government’s and WA Health’s Language Services policies are currently being reviewed.

2.0 BACKGROUND

In March 2007, in a meeting with the Director General, the Executive Director of the Health Consumers’ Council raised concerns regarding the lack of accessibility of interpreter services to patients in the hospital system, including mental health services.

Project Development Division undertook a brief overview of interpreter services in selected metropolitan hospitals and health services to identify possible areas requiring further work. Four recommendations were endorsed by the Director General, specifically:

1. Commission the Health Consumers’ Council to undertake a targeted debate with groups of relevant consumer representatives to provide further insights into consumers’ experiences with local health-based interpreter services. The process should also be used to identify and/or confirm ‘gaps’ in the existing provision of services.
2. Review the current service configurations and examine the potential for greater integration of the existing services to ensure consistency across

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2 ibid
3 Government of Western Australia, Language Services Policy 2000
4 Government of Western Australia, WA Health, Language Services in Health Care, Policy and Guidelines
services i.e. an area-based or metropolitan-wide based service, with particular focus on improved cost effectiveness and robust performance monitoring. This project would also examine the current Department of Health (DOH) models for employing interpreters and the development of an appropriate model, in line with current industry standards.

3. Develop marketing and communication strategies for both patients and health professionals to increase awareness of key aspects of interpreter services (e.g. the availability of hospital language services, their importance, the processes to access said services, practical and legal limitations, cultural sensitivities).

4. Undertake a review of interpreter service provisions for Aboriginal populations. (Although service provision for Aboriginal people was not raised as a concern in this brief, it is important that the current Kimberley, Kalgoorlie and Pilbara based telephone services are reviewed to ensure they are meeting the needs of this population).

A summary of the project work undertaken and the findings on each of these recommendations is provided in sections 2.1 to 2.4.

Outside the scope of this review are industrial issues which are critical to the future of interpreter services and currently under negotiation with the Industrial Relations Service at the Director General’s Office.

In reviewing current service configurations and examining the potential for greater integration of services, a number of broader contextual issues arose. These issues included policy, access and availability of interpreters, quality standards and training as well as concerns relating to specific groups such as those with mental health conditions and the deaf community. Given the potential impact of these issues on service delivery and the implications for developing models to employ interpreters, these issues are explored in more detail in the discussion section of this report.

Selected anecdotes from the work undertaken by the Ethnic Communities Council of WA (ECCWA) are also included in the report.

“There was a pregnant Afghan lady who was admitted to hospital and did not eat for three days because she thought the food came as an additional cost for her.”

“A case worker mentioned the case of a woman who took her baby who had malaria to hospital and had to wait for 20 hours before being provided with an interpreter. She was not given access to a phone line and the husband was worried that his wife and daughter were missing for 20 hours.”
2.1 Consumer Experiences

Project Objective
To undertake a targeted debate with relevant consumer representatives to obtain further insights into consumers’ experiences with local health based interpreter services and to identify and/or confirm gaps in the existing provision of services.

Strategy
Information for this project was obtained between June and September 2007. An earlier scoping project was used as the basis for the further investigation and collection of information. Key stakeholders were identified in consultation with the Health Consumers’ Council, Cultural Diversity team and the Office of Aboriginal Health. Using qualitative methods, a series of small forums were held in the metropolitan area and participants were interviewed individually and in small groups. Participants also completed a simple questionnaire. One forum was held in Geraldton to obtain a regional viewpoint. An on-line questionnaire was distributed to a range of health care providers and this information was included in the final summary. The Health Consumers’ Council provided feedback from the Community Advisory Councils.

A report based on consumer perceptions of interpreting services was commissioned from the Ethnic Communities Council of WA (ECCWA). The type of information collected included trend analysis data, survey responses, anecdotal information of consumer health service experiences from consultation forums and feedback from interpreter service providers.

Findings
- There is better access to language services in large metropolitan hospitals than in regional centres.
- There is a lack of awareness of language services amongst health service staff. The most apparent gap (and weakness) in accessing language services appears to be the lack of knowledge of the Language Services Policy. Health providers require training to obtain and maintain the relevant skills to work effectively with interpreters. Many consumers reported that health service providers had little or no training in the necessity of using accredited interpreters and often expected relatives to interpret. Using relatives has become ‘accepted practice’ in some health services. Staff often made assumptions on the consumer’s level of English and determined whether or not an interpreter should be called. Doctors often had to be encouraged to indicate the need for interpreters on referral letters.
- Bilingual speakers are often accepted by service providers without knowing their skill level or the dialect of the consumer.
- Interpreters are often not included in the overall care of the consumer, including debriefing sessions.
- Most CaLD consumers are unaware that they are entitled to a professional interpreter, especially in medical and legal situations, and do not know how to request one. Language services are not promoted to consumers.
- The distribution and use of the Department of Immigration and Citizenship’s Interpreter Card (Appendix 13) varies between services.
- Better communication between ethnic communities and the health sector is required.
General Practitioners are often not aware of language services, eg. they may overcharge clients as they do not realise they can bulk bill the additional interpreter time.

“Mr A had confidence in his GP who he saw with his sick wife. The doctor organised a face-to-face interpreter to explain the operation Mrs A was about to undergo in hospital. Mrs A could not speak English and Mr A had minimal English skills.

Following the operation Mrs A was in considerable pain. The hospital staff made no attempt to provide an interpreter even though Mrs A’s pain did not ease. On the fourth day (without seeing the doctor), Mrs A was sent home. She returned to the hospital Emergency Department after experiencing severe pain. An interpreter was requested but not provided. Mrs A was x-rayed and it was discovered that a clip had come undone, requiring another operation. The doctor organised a telephone interpreter to explain the need for a second operation. Mr A was very angry at the hospital for not having organised an interpreter earlier.”

“Mrs S had to have an operation on her thyroid. An interpreter was not called as Mrs S understands some English. The doctor spoke very quickly and Mrs S was only able to understand some of the description of the operation and its after-effects.”
2.2 Delivery of Language Services

Project Objective
Review the current service configurations and examine the potential for greater integration of the existing services to ensure consistency across services i.e. an area-based or metropolitan-wide based service, with particular focus on improved cost effectiveness and robust performance monitoring. Also examine the current WA Health models for employing interpreters and the development of an appropriate model, in line with current industry standards.

Strategy
Information for this project was obtained from meeting with Language Services Coordinators and other key stakeholders in the tertiary and major secondary hospitals and health services between June and September 2007 (Appendix 2). Hospital based language service providers expressed a desire to be involved in the process, wherever possible. Information collected from specific hospitals was sent to Language Services Coordinators and Unit Managers for comment. All hospitals responded and amendments were included, as appropriate. Qualitative and quantitative strategies were used to collect the information, including:

- Face-to-face meetings with identified key stakeholders;
- Telephone contact with eastern states health services staff involved with language service delivery;
- Trend analysis of expenditure and occasions of service data; and
- A brief literature review was undertaken of relevant documents including information from language service reviews and projects from other jurisdictions.

Current Service Provision
WA Health’s tertiary hospitals provide over 21,000 language services every year for inpatients, outpatients and community based services at an annual cost of more than two million dollars. (See Appendix 3 for charts on the annual expenditure by major hospitals in 2006/07 and Appendix 4 for annual occasions of service at the major hospitals for the past four years). Care needs to be taken in reviewing the data and/or making comparisons since the services at these sites have different operational systems and availability of information i.e. some potential underreporting.

Additionally, services are provided by secondary hospitals and WA Country Health Services. These services include face-to-face interpreting and telephone services.

Demand for interpreter services is increasing and changing across all health services. The majority of services are provided for out-patients on-site.

There are different modes of providing interpreter services, including on-site (face-to-face) often via contractors and the national telephone Translating and Interpreting Service (TIS). Translated information is also provided to facilitate interpreting processes. Due to the ongoing demand for interpreter services, the best practice model of face-to-face contact (when important medical information and procedures are being explained) may not always be readily available, especially in the case of uncommon languages. Bookings for interpreter services are often required in advance and difficulties may arise in instances where the patient has cancelled.
The Australian Government, through the Department of Immigration and Citizenship, provides the TIS for people who have no (or limited) proficiency in English. TIS is available to any person or organisation requiring interpreter assistance and is available 24 hours a day, 7 days a week. This service is provided free to consumers as the referring health service incurs the cost. The cost is $22.40 per 15 minute block (telephone link during working hours) and $147.00 for a 90 minute, face-to-face service. A GP and Hospital Priority Line is provided to ensure medical issues are dealt with as a matter of priority, however waiting times may be lengthy for some languages. If an on-site interpreter is not available, using TIS may be difficult as speaker phones are required. (Telephone interpreting without a speakerphone is non facilitative to the clinical consultation process).

Royal Perth Hospital (RPH), Sir Charles Gairdner Hospital (SCGH), Fremantle Hospital (FH), King Edward Memorial Hospital (KEMH) and Princess Margaret Hospital (PMH) all provide interpreter services across the entire patient care spectrum (inpatient, outpatient, ambulatory care, community based and Hospital in the Home). A detailed description of interpreter services and processes at the major hospitals and health services is provided in Appendices 5-11.

Services to regional WA health systems are more restricted and usually rely on the TIS telephone system. Aboriginal language services are predominantly based in the Kimberley, Kalgoorlie or Pilbara regions. Interpreter assistance is provided by telephone or teleconference through the Kimberley Interpreting Service (KIS).

More sophisticated information on the outcomes of language services provision, including the quality of services provided and the accountability of both government and language service providers in delivering these outcomes is not available.

Findings
- The provision of language services across the State is hospital-centric with each service operating independently.
- WA Health’s *Language Services in Health Care Policy Guidelines* outlines requirements for correct use of interpreter services but confusion exists among some health professionals regarding its correct use.
- The access to and availability of interpreter services is contingent upon whether the consumer has a major, minor or rare language.
- There is a projected future inadequacy of interpreters due to demographic changes. An ageing population (with many elderly people reverting to their first language) and an influx of new languages will increase demand. Specialist health service trained interpreters are in limited supply.
- The departure of interpreters from the health sector may lead to future supply problems. Interpreter pay rates are low and many interpreters can earn a higher income by working in business and industry, especially Japanese and Indonesian languages. There is also a lack of career pathways for interpreters.
- There is no system to monitor the employment of trained, qualified and accredited interpreters as only minimal monitoring and quality assurance mechanisms are available. It is difficult for health services to ensure interpreter standards.
• Interpreters and those involved with Language Services Coordination are performing a valuable role and dealing with increasingly high activity levels.
• Language Services Coordinators often perform a range of functions, including administration, and may be employed part-time which limits their ability to meet as a group and to undertake professional development.
• Increasing costs associated with providing interpreters and translators was identified as a key issue across health services.
• There are inconsistencies across hospitals in the way data is collected, coded and interpreted, especially in relation to expenditure budgets.

In reviewing current service configurations and examining the potential for greater integration of services, a number of broader contextual issues arose which are explored in more detail in the discussion section of this report.

“Mrs T took her neighbour to the hospital as she was in a serious state with asthma. The neighbour could not speak any English at all and Mrs T could only speak a little. No interpreter was offered to them.”

“Mrs S thought that after the operation she would be fine, her metabolism would be normal and she would no longer have to take medication. However, this was not the case and she found that her metabolism slowed and she rapidly put on weight and now takes tablets every day. Mrs S cannot remember signing a consent form for the operation. If she did, she received no help from an interpreter, as there was no interpreter during her time with the doctor or in hospital.”

“One nurse prevented an interpreter from going to theatre with a patient and waiting until after the operation so they could be with the patient in the recovery room. The reason given was that the interpreter should not be in the recovery room with the patient and it would cost too much money.”

**Health Services’ Staff Comments**

• “Patient was really quite good at English as long as simple terminology was used.
• Often relatives can interpret for them.”
• “Difficulties in an emergency situation – staff don’t know what language the patients speak and the service is not always available when required.”
• “Too time consuming to have to wait for an interpreter.”
• “We use relatives because of habit and because untold policy goes like that.
• “Patients may revert to their first language when unwell.”
• “Interpreting for many people by phone can be difficult – we know of one instance where 11 people were involved in the meeting with the interpreter.”
2.3 Awareness Raising

Project Objective
To develop marketing and communication strategies for both patients and health professionals to increase awareness of key aspects of interpreter services (eg. the availability of hospital language services, their importance, the processes to access said services, practical and legal limitations and cultural sensitivities).

Strategy
Information for this project was obtained from the Ethnic Communities Council Consumer Survey, health service staff and from discussions with eastern states health service representatives.

Findings
• Many consumers were not aware of their rights to obtain professional interpreters and the importance of doing so, eg. providing consent has legal implications. 56% of health service providers interviewed indicated that patients might experience difficulties in accessing interpreter services because they are not aware of the service.
• There is a lack of promotion of language service policies and practices with service providers. 25% of service providers surveyed indicated health professionals' lack of awareness was a barrier to service provision. Professional development and orientation about the provision of language services is required for all health providers, eg. consent forms.
• Promotional items such as telephone stickers and posters outlining interpreter service numbers are not readily available at health service sites.
• Refugees are required to undergo extensive health assessments on arrival and language services to support this service may be unanticipated by health service providers.
• There is a general lack of resources and translated materials available in CaLD languages.
• The WA Interpreter Card (Appendix 13) is not widely used by patients.
• The Migrant Health Nurses’ Network was identified as a suitable distribution point for promoting the Interpreter card.

“There was an elderly 79 year old Afghan man who was booked for an X ray and had to cancel the appointment because there were no interpreters.”
2.4 Services for Aboriginal People

Project Objective:
To review interpreter service provisions for Aboriginal people.

Strategy
Information for this project was obtained from the Office of Aboriginal Health (OAH), the Equal Employment Commission (EEO), health and language services staff and the KIS.

During meetings with the OAH, it was identified that the EEO had recently undertaken cross government research on Indigenous Interpreter Services in the Kimberley, Pilbarra and Goldfields regions. The purpose of the project was to identify any gaps in the delivery of interpreter services to Aboriginal populations and develop proposed service delivery models. The final report titled *Scoping Paper: Indigenous Interpreting Service* was reviewed as part of this project.

Findings:

- A significant number of Aboriginal patients do not understand interactions between themselves and health professionals. This area is particularly difficult as some Aboriginal people tend to answer “yes” to all questions. There is an increasing volume of anecdotal evidence which indicates a lack of communication between Aboriginal clients and service providers.
- There are very few trained interpreters in Indigenous languages and community members, relatives, health workers and hospital staff are often used as interpreters. (KIS is a telephone service and not always a suitable option as non verbal communication is an important part of Aboriginal culture.)
- It is often difficult to arrange face-to-face Aboriginal interpreter services in the metropolitan area due to a shortage of qualified interpreters in this area.
- Concerns have been raised that Aboriginal patients may be receiving medical treatment, including surgery and medication, without fully understanding the informed consent process or required medicine regime.
- There is a considerable need for Indigenous interpreters in the area of mental health.
- KIS is frequently used by metropolitan health service staff. Access difficulties have been reported. There are many different Aboriginal dialects so there is often a delay between requesting an interpreter and an appropriate interpreter being located.
- Indigenous interpreting has not been accredited beyond the paraprofessional level in Australia. There are no accredited Indigenous interpreting training courses in WA. The Aboriginal languages interpreting course ceased at Central TAFE in 2003.

“Mr T, an Aboriginal man from the Kimberley region, was hospitalised in Perth for a surgical procedure. Although the Kimberly Interpreting Service was utilised, the process took considerable time and involved a number of calls and return calls. A competent interpreter was not available in the metropolitan region to assist with filling in the necessary consent forms.”
3.0 DISCUSSION

3.1 Delivery of Language Services

The valuable role of language services and the increasingly high service levels are acknowledged. Whilst strategies are being developed to maximise efficiencies in hospitals and health services, there are some areas requiring attention. In reviewing current service configurations and examining the potential for greater integration of services, a number of broader contextual issues arose. These issues included policy, access and availability of interpreters, quality standards and training as well as concerns relating to specific groups such as mental health and deaf populations. Given the potential impact that these issues have on service delivery and the implications for developing models to employ interpreters, it is important to investigate each issue individually.

3.1.1 Language Services Network

The development of a Language Services Network (LSN) has been identified as a priority strategy to assist with policy development and implementation. Advantages of a LSN include sharing of resources across sites, developing partnerships, monitoring of industry standards and professional development.

A LSN is a means to provide a new focus to improve language services within WA Health through better integration and coordination. The six major functions of the Network would include:

- Developing policy that supports the changing language needs of the population;
- Defining meaningful performance measures;
- Setting targets and monitoring outcomes for CaLD consumers;
- Developing protocols to ensure efficiency, effectiveness and safety in service delivery;
- Investing in people by providing opportunities to develop skills and knowledge of language services; and
- Fostering leadership and advising on future workforce planning which will subsequently influence priorities on how language services are allocated across the health system.

The LSN would be supported by the Cultural Diversity team and consist of representatives from key hospitals and area health services, WA Country Health Services, Language Services Coordinators, Workforce Development Division, the Office of Aboriginal Health, ethnic and Indigenous community consumers, the Office of Multicultural Interests, the Department of Immigration and Citizenship, and health networks.

The guiding principles of the Network would be:

- Improving patient care in terms of quality, access appropriateness and integration;
- Promoting continuous improvement in all services and clinical practice;
- Integrating language services within and across regions;
- Engaging CaLD and Indigenous consumers in planning and service delivery processes; and
• Addressing emerging language service issues.

The Language Services Network, in undertaking its key functions, would address the following items:

i. Ensure hospitals improve staff awareness of the appropriate use of interpreters. This is likely to occur firstly in orientation programs;

ii. Develop recommendations for training and professional development across sites. This could include ensuring interpreters have individual professional development plans and receive orientation and ongoing training in working within specialized health areas and providing health service practicums for Technical and Further Education (TAFE) students.

iii. Provide advice to Perth Central TAFE on specialised health service courses for interpreters including mental health and health interpreting;

iv. Oversee the distribution of the WA Interpreter Card by Language Services Coordinators;

v. Ensuring the Migrant Health Nurses Network is made aware of the fact the WA Interpreter Cards are not widely used and encourage them to distribute it;

vi. Develop guidelines for monitoring and evaluating interpreter services and developing a 'Report Card' for interpreter services;

vii. Develop a simple, standard test for clinicians to use with patients to determine if an interpreter is required;

viii. Provide regular, on-site training for interpreters; and

ix. Develop an orientation program for interpreters to ensure they are familiar with service requirements and self care, e.g. punctuality, dress code, hospital culture, need for regular breaks.

The trend to live in regional centres due to housing shortages and migration settlement practices may lead to higher numbers of migrants living in regional areas. Regional hospitals are often inexperienced with dealing with interpreting issues. It is therefore important that a regional health service representative is on the Language Services Network.

**Recommendation 1**

Establish a Language Services Network to improve the integration and coordination of language services through interaction between service providers and other stakeholders.

### 3.1.2 Policy Issues

WA Health’s Cultural Diversity team is responsible for the Department’s *Language Services in Health Care Policy and Guidelines*. This policy is available on the intranet for health services staff.\(^5\) This policy is generally understood and supported by Language Services Coordinators at major hospitals and most health service staff are aware of the document. The policy is available on the Department’s website and is currently being updated. Whilst the new policy is keenly anticipated by the health services, there are some policy implementation areas which require attention.

Policy implementation by health professionals is inconsistent and many are confused about the correct use of interpreter services, eg. situations when to use the service or occasions when family members of a patient can be used. Clinicians often rely on their observations of simple language interactions with patients but proficiency in simple conversation does not necessarily equate with an understanding of more specialised clinical concepts. Some patients overestimate their language skills or insist on using family members. Some interpreters have complained that they have been handed material to interpret and the health professional has left the room. Obtaining consent for treatment is also a very important issue and interpreters are often placed in difficult situations as they can only sign the forms that they have interpreted “to the best of their ability”. Language Services staff strongly request policy direction on how to manage obtaining consent.

In the past, policy coordination was a function of the Department of Health’s Multicultural Access Unit but this role has not existed for many years since the unit was abolished in 2002. A Cultural Diversity Project Officer was appointed to the Department in 2006 and more recently a second officer has been appointed. The Cultural Diversity team is well placed to address high level, system-wide cross cultural policy issues. A brief outline of the Cultural Diversity team's functions is provided at Appendix 14. There is considerable support across health services for strengthening the role of the Cultural Diversity team to reinstate certain centralised functions and networking opportunities previously provided by the Multicultural Access Unit.

Resources need to be made available at the hospital level to fully implement new policy, practices and procedures. Cross cultural training is also required to increase the knowledge base of health service staff. This training could be built around migration patterns. Managers need to actualise policy by reinforcing occasions when interpreters should be used.

Recommendation 2:
Require the Cultural Diversity team to:
• Coordinate the Language Services Network.

3.1.3 Accessibility and Availability of Interpreters

A number of factors impact on the nature and demand for interpreting services, such as the speed in which a message needs to be interpreted, location, overall size of the language group, and age profile and distribution of a particular language group. With increased numbers of new and emerging migrant languages, e.g. African dialects, the imperative to use accredited interpreters will become more difficult to fulfil. Community members are unlikely to have the necessary accreditation, skill or experience required to act as interpreters. The use of untrained and unaccredited interpreters is problematic and not enough scrutiny is being given to the experience, qualifications and accreditation of those employed in the interpreting sector.

Increasing demand for interpreter services for African populations, especially sub Saharan groups, such as from Somalia, Sudan, Uganda, and Ethiopia, has been identified across a number of hospitals. Migrant and refugee populations (especially in the north metropolitan area) are also requiring interpreter support in a range of health services. The pressures of an ageing population are
currently leading to an increased demand for interpreter services as a result of some elderly patients reverting to their first language.

Clients from emerging language groups may be suffering trauma and interpreters may not be available if they are required immediately. Some consumers prefer to use a familiar interpreter for continuity, especially if a relationship has developed. Concerns have been raised that this may result in impartiality or a conflict of interest. Consumer insistence on using an interpreter of choice may be a costly option. This may result in clinicians using a family member or the consumer refusing to continue treatment.

The interpreter industry in WA is small and fragmented and does not have unifying representation. The Western Australian Institute of Translators and Interpreters (WAITI) and the Independent Practising Interpreters Association (IPIA), however, provide member support services. WAITI is a professional organisation which furthers the interests of its members (interpreters, translators and language specialists) and supports the development of quality language services. WAITI was one of the driving forces behind the creation of the National Accreditation Authority for Translators and Interpreters (NAATI). The organisation has an active membership and organises workshops, seminars and other events to assist members in professional development. WAATI also assists with safeguarding and defending the interests of its members. IPIA was established in 2004 with the purpose of supporting the interests of interpreters. IPIA aims to address industrial issues and meets regularly with RPH and SCGH departmental heads. In the absence of a union, IPIA performs an important role in negotiating pay rises and other important industrial matters. IPIA also provide input into language services policies and provide a professional development course in AMA medical terminology.

Interpreter pay rates are considered low and many interpreters can earn a higher income working in business and industry. The longer term recruitment and retention of interpreters is an important consideration. There are currently national and state issues regarding interpreter standards and training.

Industrial matters relating to pay rates and employment conditions which are critical to the future of interpreter services are currently being negotiated by the Industrial Relations section at the Director General’s Office and fall outside the scope of this review.

3.1.4 Quality Standards and Training

There is no capacity for health services to assess interpreter competency as there are no formally accepted criteria available for monitoring standards. Health services rely on NAATI accreditation. Concerns have been raised about the adequacy of current accreditation as some unskilled interpreters already practicing may have received prior accreditation due to working in the area. Reliance on NAATI accreditation removes the incentive for some interpreters to undertake additional training.

A person with excellent language skills may not necessarily be a good interpreter. Sound communication, empathy, confidentiality, memory and paraphrasing skills are also required. Some interpreters may take on an ‘advocacy’ role, rather than remaining neutral. There are limited ongoing training opportunities for interpreters to develop their skills. As the TIS is now consolidated into a centralised based model there is a training gap in WA in
some areas. TIS previously provided ongoing support and training opportunities for WA interpreters, including professional development courses for qualified interpreters and translators.

In the last few years, NAATI has been organising professional development courses for professional interpreters and translators. See Appendix 15 for further information. Courses conducted in 2007 included:

- Is Culture Important as a Context for Translating?
- Editing and Proofreading for Translators;
- Interpreting for Trauma Victims; and
- Software Options for Translators.

NAATI, in partnership with Centrecare Migrant Services, also provides courses for interpreters for new and emerging communities depending on demand and available resources. NAATI also runs preparatory workshops to assist interpreters and translators going for their accreditation.

Formal interpreter training in WA is conducted at TAFE. There is some criticism about the effectiveness and relevance of the TAFE interpreting courses. There is also some concern that the TAFE course does not recognise an interpreters’ prior training, experiences and skill levels. Local, health service based, practical training sessions are considered a more essential element of interpreter training. One metropolitan hospital provides practical training placements for TAFE interpreting students. This practice supports TAFE and also provides an opportunity for students to obtain health specific skills and knowledge. Hospitals need to provide ongoing professional development training and orientation in cultural awareness and interpreter service use, including when it is appropriate to engage language services. Some hospitals currently provide cultural diversity training and orientation programs for staff and interpreters. Specialised programs are also provided for interpreters, eg. hospital jargon, gynaecological terms.

There are only two TAFE professional development courses currently available (Health Interpreting and Mental Health). The Cultural Diversity team will be evaluating these courses in the near future to identify scope for future improvement. Many interpreters have indicated that they cannot afford the cost of ongoing training and TAFE courses. Some health services support their interpreters to attend TAFE courses in newly emerging migrant languages and this investment results in skill development, goodwill and reciprocal loyalty.

Approved study leave may be available (on request) for WA Health employees who wish to undertake courses recognised by NAATI in a language relevant to the needs of the Public Sector.

**Recommendation 2 cont.:**

Require the Cultural Diversity team to:

- Evaluate the TAFE Interpreter Training Course.

### 3.1.5 Mental Health

Mental health patients tend to remain in hospital for longer durations resulting in difficulties in the continuity of service delivery, including interpreter services. Communication is an essential component for treating mental health patients
who often present with a range of psycho-social issues. This is particularly the case with Aboriginal patients (some from remote areas) who constitute 25-30% of all mental health patients at Graylands Hospital. The Council of Official Visitors supports the principle that every public mental health services client has the right to access a qualified interpreter.

Specialist interpreting skills are required when dealing with mental health conditions especially complex cases, such as delusions and confusion, and it is often difficult to find mental health trained interpreters who have an awareness of cultural issues, e.g. an interpreter recently berated a client for expressing suicidal intentions. A mental health interpreting course is available at TAFE but not all interpreters complete this course. Interpreters are often not trained in mental health culture and do not know how to interpret the concepts and jargon.

Telephone interpreting is not suitable for mental health patients, especially Aboriginal patients where cultural significance is attached to non-verbal communication. Interpreting for a person with an acute mental illness by telephone is also difficult because they are often confused and the conversation does not flow.

In 2001, Graylands Hospital based multicultural support staff amalgamated with the East Metropolitan Health Service which subsequently devolved to the South Metropolitan region and can no longer be accessed by Graylands Hospital. This move has left a significant gap in language services at Graylands Hospital and no comparable service currently exists. Graylands Hospital staff would benefit from information being provided during orientation programs that captures cultural sensitivity issues and appropriate use of language services.

The WA Health Transcultural Mental Health Centre (WATMHC) provides a range of programs for health service providers and people from CaLD backgrounds, including clinical services, mental health promotion, research, resources, consultancy and education and training. There is a need for patients to be provided with translated written information on mental health issues as many disorders may be unknown within their culture. If the patient is literate, the opportunity to read about the condition in their own language facilitates treatment and ongoing management. WATMHC collates and disseminates materials but considerable resources must be dedicated to this process, especially in checking the accuracy of the information if it is accessed from the internet.

WATMHC has developed training material specific to mental health staff working with CaLD patients. The Cultural Competency in Clinical Practice workshop provides an entire module on language barriers and appropriate and effective use of interpreter services. The course is available to clinicians and mental health services free of charge. Although this course is available, attendance is not mandatory.

It was identified that information technology systems may impede service delivery and access to WA health website information, e.g. Language Services Policy. System difficulties associated with the Psychiatric Services On-Line Information System have been raised and not all health service computers are compatible. Additionally, some clinicians are not operating on line.
3.1.6 Auslan

The deaf community is a small, isolated group with a distinct ‘collectivist sub-culture’. Auslan is a complex language, is not comparable to other languages and does not have a written form. English is a second language for deaf people. As deafness is a lifetime condition, interpreters are required throughout the life span whereas non English speaking people will usually develop some English language skills. Deaf people may have disability issues as well as language issues and there is debate over whether their requirements are comparable to people requiring spoken language services.

Some deaf people have indicated that they are frustrated that hearing people do not understand the needs of the deaf community. There are approximately 1,200 Auslan users in WA but some will only use interpreting services in certain situations. There are significant numbers of Aboriginal people who suffer from deafness due to otitis media (middle ear infection). Older people with deafness, who develop blindness, have a dual disability. Deaf refugees and migrants from developing countries may not be familiar with Auslan.

There are currently supply and demand issues for Auslan interpreters as very few Auslan students graduate each year. Interpreters traditionally provided ‘community interpreting’ to assist deaf people with their everyday functioning. Auslan interpreters are now requested across a range of other areas, e.g. health services, tertiary institutions, and critical shortages are predicted. Auslan interpreting is a physically demanding job and recruitment and retention is an ongoing concern. Industry standards allow interpreters to work up to two hours per session. Relay and tandem teams are often used for lengthy sessions, e.g. conferences, where regular breaks may not be possible.

Two groups of interpreters exist within the deaf community: Auslan interpreters (hearing people) and deaf interpreters (deaf people). Deaf interpreters display a ‘cultural connection’ with clients, are familiar with the nuances of the language, and may be required to act as mediators between Auslan interpreters, health professionals and patients. Deaf interpreters are often booked for people from overseas countries which do not have Auslan, for mental health cases, or if there is a disability such as autism or cerebral palsy. Auslan and deaf interpreters are often both required for interpreting sessions.

Some hospitals provide Auslan interpreters from their own pool. Consumers are encouraged to use the allocated interpreter for neutrality. Some deaf people have complained that hospitals do not advise them in advance who their interpreter will be. This situation may cause anxiety, especially as the deaf person often has to search for the interpreter in crowded areas. Deaf people may also be put in a difficult situation if they have to use the allocated interpreter to inform hospital staff that they prefer another person. Some hospitals allow consumers to use an interpreter of choice, depending on availability. Interpreters are matched on gender, skill level, experience and trust. Consumers may insist on using a specific Auslan interpreter due to ‘compatibility of interpreting’ as a relationship or sub language shorthand has been formed.

Some health service staff do not understand the importance of using professional interpreters when working with deaf people and may view the service as an ‘expensive add on’. It is not appropriate for family members (especially children) to be used as interpreters when important medical
procedures are being discussed. Staff require training in how to work effectively with an interpreter and deaf person, e.g. talk to the person directly, ensure the room has adequate lighting, and avoid excessive background noise.

The WA Deaf Society provides programs and support to service providers and consumers. Ongoing professional development opportunities and NAATI revalidation is provided for interpreters employed by the WA Deaf Society. All interpreters have an individualised professional development plan and monitoring and performance appraisal occurs regularly to ensure high standards of accreditation. Some service providers use the WA Deaf Society as a preferred provider for service delivery. This model has proven to be cost effective for some service providers as pool interpreters are able to provide a more coordinated and flexible service (especially if relay teams are required). This arrangement allows cancellation penalties to be waived and reduced fees may be offered. This model may not be suitable for other hospitals who have found it more cost effective to provide interpreters from their own pool and only engage the WA Deaf Society if their regular services are not available.

Some concerns were raised about the TAFE training courses for deaf interpreters. The course consists of only six contact hours per week (part time) and students may graduate with very little practical work experience. The course is situated within the Tourism and Hospitality program. The current TAFE graduates are not taught finger spelling in the Diploma of Interpreting (Auslan). They may have received training in earlier courses but not been able to access forums to maintain their skill level. The development of a university level course in Auslan interpreting would raise standards in the area and provide a career path for interpreters. The WA Deaf Society recommends developing a Registration Board for Auslan accreditation to oversee industry standards.

There are several suggestions for improved marketing and communication strategies for deaf people. Deaf people, especially the elderly, prefer receiving information via faxes. The use of SMS telephone text messaging has also been suggested as a possible communication tool. Hospital pamphlets and letters written in large, bold text on white paper support effective communication. DVDs are important communication tools for deaf people and policies and procedures should specify the use of sub-titles and captions. The Department of Health’s Cultural Diversity website should be accessible to deaf people, e.g. Auslan video footage.

**Recommendation 3**
Investigate the possibility of SMS telephone text messages being used for deaf patients across the health system.

**Recommendation 4**
Hospitals to recognise that both Auslan and deaf interpreters may be required for interpreting sessions.

3.1.7 Service Delivery

The level of service delivery and access to interpreters varies across geographic regions and cultural groups. Many of the same issues exist in metropolitan and regional areas in relation to access and availability. The major metropolitan hospitals operate hospital-centric language services
independently of each other due to historical precedents and structural changes.

Some hospitals have experienced a significant increase in interpreter costs due to increased demand. Many newly arrived immigrants and refugees have children or are of child bearing age which places disproportionate demand on health services catering for this group.

The costs involved in providing interpreting services have been cited as a barrier to service provision. Increased costs associated with providing interpreters and translators were identified as a key issue across health services. Research indicates that patients from non English speaking backgrounds (NESB), on average, remain in hospital at least a day longer than English speaking patients due to safety and communication concerns. NESB patients also present with conditions much worse, or further advanced, than English speaking patients and require more aggressive or intensive treatments, which can be costly.

Current evidence highlights that the cost of poor communication has significant implications. These include:

- Increased length of stay;
- Increased unnecessary diagnostic testing in emergency departments;
- Increased planned readmission rates;
- Poorer health outcomes due to access issues and patient comprehension;
- Decreased compliance with treatment;
- Increased medico-legal risks and complaints;
- Increased failure to arrive and cancellation rates; and
- Reduced hospital in the home substitution rates.

The provision of interpreter services, while appearing to be a high cost, can save significantly on resources by:

- Reducing diagnostic testing due to the ability to accurately take a medical history;
- Reducing re-admission and complications due to increased compliance with treatment;
- Reducing adverse advents due to improved communication;
- Increasing efficiency by reducing failure to attend rate (when the patient actually knows about appointment);
- Reduced length of stay due to improved discharge planning; and
- Improving patient’s ability to manage their chronic illness successfully.

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7 ibid
13 Information received from Northern Health Service, NSW Health.
14 ibid
The placement of language services within the health system was raised during the review. Service providers commented that language services should not operate in isolation as many refugees may have social and financial problems as well as language issues. The Social Work department was identified by services as the best option. The positioning of language services within Social Work departments ensures ongoing professional support for both interpreters and coordinators. Hospitals are very complex systems and local knowledge is often required, e.g. ‘juggling’ multiple appointments, geographical layout for consecutive appointments. Relationship building is very important for the effective delivery of language services and Language Coordinators have positive existing relationships with interpreters, staff and clients and provide mentoring, leadership and professional development programs.

Other specific service delivery issues identified include:
- Interpreter services are generally not available for people in the recovery room. (The first 30-60 minutes following surgery are the most important in patient safety);
- Medical and health professionals may be barriers to effective communication if they come from different CaLD backgrounds and have minimal English language skills;
- It cannot be assumed that all health workers, including doctors, have computer access or program compatibility to access all departmental patient information systems; and
- Hospital in the Home services require interpreters when visiting CaLD families. Interpreters are often not booked for ‘short’ home visits (even if required).

A ‘gold standard’ model would ensure interpreters are available for on site consultations with CaLD patients, especially those with very limited English skills. Interpreters should also be engaged for brief sessions (e.g. 10-15 minute slots) if critical questions about treatment and medicine regimes are likely to be asked during such sessions.

It was observed that the Fremantle Hospital Mental Health Unit (Alma Street Clinic) currently organises its own interpreter services. The Fremantle Hospital Language Services Unit proposed consideration of merging their language services with this section. While additional FTE would be required to operate a consolidated model, it would be cost effective due to economies of scale. An integrated model would deliver considerable savings as the Alma Street Clinic could utilise the permanent staff interpreters. As agency contract interpreters are paid for one hour minimum slots (even if the service only takes half an hour) an integrated model would allow surplus time to be shared across both services.

There are some inconsistencies across hospitals in the way data is collected, coded and interpreted, especially in relation to budgets. This discrepancy has made it difficult to interpret expenditure findings. The inability of services to readily extract information regarding the number of interpreters used is problematic for review of services.

**Recommendation 5**
Maintain and strengthen the current hospital and health service configurations for delivering language services.
Recommendation 6
Hospitals to recognise insufficient capacity and the increasing (and changing) demand for language services by:

• Reviewing the organisational structure of language services at Royal Perth Hospital, Fremantle Hospital, Sir Charles Gairdner Hospital, Princess Margaret Hospital, King Edward Memorial Hospital and Graylands Hospital, with the intention of increasing capacity;
• Ensuring each Language Services Coordinator has sufficient funds to provide adequate interpreter training and professional development, translation costs and cover debriefing sessions for interpreters; and
• Proving access to facilities to support telephone interpreting, including conference style speaker phones and appropriate settings.

Recommendation 7
Fremantle Hospital and Mental Health Services (Alma Street) to review the efficacy and effectiveness of consolidating language services within one unit.

Recommendation 8
Hospitals to develop consistent data collection methods and systems for language service planning, monitoring and reporting.

3.2 Marketing and Communication

Marketing and communication is an important component of language services delivery. A key issue identified in this area was inadequate promotion of language services with consumers as well as with staff.

Promotional strategies such as stickers on patient files are rarely used. One metropolitan hospital has developed a small, laminated card to attach to a security card worn by staff. The card provides information on how to book interpreter services during and after hours. The card also provides a checklist of steps to follow to effectively work with an interpreter. The details on the card are revised at regular intervals. This creative communication strategy has considerable merit in that it is cost effective (laminated on site), easily implemented and easily revised.

Another metropolitan hospital has developed a very effective orientation program. Language Services staff are allocated slots in the general orientation program for new staff. ‘Top up’ information is provided to staff at regular intervals to ensure all staff are aware of language policies and practices. One hospital indicated that they had previously operated a similar program but as they now were competing with a range of orientation programs they no longer were allocated a slot.

Adequate communication is required between the Department of Health and the Department of Immigration and Citizenship to address influxes of refugees to counter against unanticipated demand for interpreter services for health assessments.

Similarly, improved communication strategies are required for dealing with provision of information to general practitioners on access to interpreters.
There is a lack of resources and translated materials available in CaLD languages. Expert input should be provided when translating marketing materials and original pamphlets should be written in simple English to allow for easier translation. These pamphlets could be made available to major language groups and placed on the internet for clinicians to download. A budget could be provided to health services to have materials translated. There are many consumers who are illiterate in their own language therefore consideration needs to be given to the production of videotapes and DVDs. The translation of patient care information unique to a specific patient can be problematic. Although general pamphlets may be available, health professionals are often required to write the information by hand. Health professionals may also have to interpret medical reports and information provided by the patient that is written in a foreign language. The development of a centralised, web-based, clearinghouse model for translated information has been requested.

**Recommendation 2 cont. :**

Require the Cultural Diversity team to:

- Develop a centralised, web-based clearinghouse for translated information; and
- Regularly liaise with the Department of Immigration and Citizenship in order to monitor refugee influxes and the Commonwealth Department of Health and Ageing to increase awareness of interpreter services with general practitioners; and
- Develop a marketing strategy to promote interpreter services to consumers.

**Recommendation 9**

Hospitals to ensure health service professionals are provided with the opportunity to receive cultural orientation and ongoing professional development in cultural competency, cultural awareness and the correct use of language services.

The WA Interpreter Card is not widely used, even though it is readily available. This card was developed by the WA Department of Citizenship and Multicultural Interests to assist people from non English speaking backgrounds. The required language is written on the front of the card and the person shows this information when interacting with staff. Qualified TIS and WA Deaf Society interpreters are available to assist with communication. The card can be used at WA government agencies, including public hospitals, community health centres, courts, police stations, state schools, Centrelink and immigration and employment services. The Interpreter Card was identified as a positive mechanism to improve communication processes. The card assists service providers in determining consumer needs by ensuring the correct language and dialect is provided. The suggestion of ensuring this card is promoted across key distribution points was provided. Possible distribution sites include the Health Consumers’ Council, Language Services Network, hospitals and health services and via Settlement Workers. Multicultural Radio stations were also identified as a possible medium to promote the card.
3.3 Services for Aboriginal People

Aboriginal people are the most disadvantaged in our society. English is not a first language for many Aboriginal people and it is often assumed they are capable of comprehending complex concepts and jargon associated with the health system. It is estimated one in five Aboriginal people living in remote areas in WA have language difficulties. Aboriginal language interpreting services are predominantly based in the Kimberley, Kalgoorlie or Pilbara regions. Interpreter assistance is available by telephone or teleconference from the Kimberley Interpreting Service (KIS).

The scoping paper noted that every service area is a priority for Indigenous people who are not fluent in English. Many can be traumatised by simple visits to hospitals, banks or shops. There are an insufficient number of Indigenous interpreters to cater to the needs of Indigenous people, none of whom are trained at a professional level of competence which is required for complex communication exchanges within justice and health.

A significant number of Aboriginal patients do not understand interactions between themselves and health professionals. Legal concerns are raised over consent, especially in the area of mental health where legislative terms are involved.

Transport and distance issues impact on availability of services.

NAATI does not have a test for Indigenous interpreters beyond the paraprofessional level.

The EEO has proposed:
- Establishment of a centralised Indigenous Interpreting Service in Perth located within a government department. Regionally based coordinating bodies to be responsible for each of the three regions, Kimberley, Pilbara and Goldfields.
- A centralised allocation for Indigenous interpreter services managed by the Language Services Unit to cover fees for all public sector agencies.

In assessing the viability of a centralised service, the EEO has identified a range of issues and models. The OAH, Department of Health provided brief comment on the proposal. As this is an area of new development, the EEO recommendation of investigating the feasibility of a centralised Indigenous Interpreting Services Unit based in Perth is supported as well as a strategy to raise awareness of interpreter services amongst health service providers and Indigenous people.

Recommendation 10
3.4 Summary & Conclusion

Increasing numbers of immigrants and demands for specialised services for certain patient groups are increasing overall demand for language services. In order for patients to obtain the most appropriate services available (and hospitals and health services to maintain maximum value from existing resources) strengthening relationships between key stakeholders is important.

Whilst language services are relatively inexpensive and there is minimal scope for efficiency gains, recommendations for both system wide and hospital level improvements in language services have been identified. Implementation of these will require ongoing commitment to this important service and, in some instances, will require a modest investment.
APPENDICES

APPENDIX 1 – FASTEST GROWING LANGUAGE GROUPS

<table>
<thead>
<tr>
<th>Rank</th>
<th>Language</th>
<th>2001 Census</th>
<th>1996 Census</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Somali</td>
<td>590</td>
<td>132</td>
<td>447.0</td>
</tr>
<tr>
<td>2</td>
<td>Afrikaans</td>
<td>1,645</td>
<td>658</td>
<td>150.0</td>
</tr>
<tr>
<td>3</td>
<td>Maori (Cook Island)</td>
<td>65</td>
<td>26</td>
<td>150.0</td>
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<tr>
<td>4</td>
<td>Mintwoong</td>
<td>136</td>
<td>55</td>
<td>147.3</td>
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<tr>
<td>5</td>
<td>Norwegian</td>
<td>415</td>
<td>177</td>
<td>134.5</td>
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<tr>
<td>6</td>
<td>Gujarati</td>
<td>897</td>
<td>389</td>
<td>130.6</td>
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<tr>
<td>7</td>
<td>Amharic</td>
<td>193</td>
<td>67</td>
<td>121.8</td>
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<td>8</td>
<td>Kurdish</td>
<td>215</td>
<td>98</td>
<td>119.4</td>
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<tr>
<td>9</td>
<td>Shona</td>
<td>70</td>
<td>32</td>
<td>118.8</td>
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<td>10</td>
<td>Swahili</td>
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<td>11</td>
<td>Bengali</td>
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<td>Wu</td>
<td>19</td>
<td>10</td>
<td>90.0</td>
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<td>13</td>
<td>Burman, n.f.d.</td>
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<td>68</td>
<td>195.5</td>
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<td>14</td>
<td>Pashto</td>
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<td>Kannada</td>
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<td>17</td>
<td>Auslan</td>
<td>323</td>
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<td>18</td>
<td>Samoan</td>
<td>186</td>
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<td>77.1</td>
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<td>19</td>
<td>Serbian</td>
<td>3,841</td>
<td>2,231</td>
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<td>Jaru (Djaru)</td>
<td>550</td>
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<td>Yoruba</td>
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<td>Bulgarian</td>
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<td>27</td>
<td>Indonesian</td>
<td>6,716</td>
<td>4,549</td>
<td>47.0</td>
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<tr>
<td>28</td>
<td>Arabic (incl. Lebanese)</td>
<td>5,048</td>
<td>3,786</td>
<td>36.5</td>
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APPENDIX 2 – CONSULTATION LIST

Consultation List

- Health Consumer’s Council WA.
- Fremantle Hospital, Sir Charles Gairdner Hospital, King Edward Memorial Hospital, Princess Margaret Hospital and Royal Perth Hospital Languages Services and Social Work Departments.
- Ethnic Communities Council of WA.
- Office of Aboriginal Health.
- Mental Health Services.
- Office of Quality and Safety.
- Country Health Services.
- Kimberley Interpreting Service.
- Department of Immigration and Citizenship.
- Health Reform Implementation Taskforce.
- WA Institute of Translators and Interpreters.
- Independent Practising Interpreters’ Association.
- Interpreters employed by Royal Perth Hospital.
- Ethnic Disability Advocacy Centre.
- Community Law Centre - Mental Health.
- Metropolitan Migrant Resource Centre.
- Centrecare Migrant Services.
- Fremantle Multicultural Services Centre.
- Multicultural Services Centre.
- ISHAR Multicultural Women's Health Centre.
- Edmund Rice Centre – Mirrabooka.
- Dar Al Shifah.
- Women's Health Centre, Northbridge.
- WA Deaf Society.
- Muslim Women’s Support Centre.
- Australian Asian Association.
- New and Emerging Refugee Support Groups.
- Home and Community Care (HACC).
- Hospital in the Home (HITH).
- Ambulatory Care services.
- Department of Health Services – Cultural Diversity Unit, Victoria.
- National Association of Accredited Translators and Interpreters.
- NSW Multicultural Health Communication Service.
- NSW Department of Health.
- Hunter Area Health Service.
- Council of Official Visitors.
- Office of Health Review.
- Central TAFE WA – Interpreter Training Program.
APPENDIX 3 - CURRENT INVESTMENT
(* Includes Language Services Coordinator costs, interpreters, agency interpreters, telephone services, etc.).

$2,121,069 was spent on interpreting services at the major hospitals in 2006-2007.

Chart 1: Annual Expenditure for Interpreter/Language Services by Site

<table>
<thead>
<tr>
<th>Site</th>
<th>2003-04 ($)</th>
<th>2004-05 ($)</th>
<th>2005-06 ($)</th>
<th>2006-2007 ($)</th>
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<tbody>
<tr>
<td>RPH/SHENTON</td>
<td>840,335</td>
<td>873,849 (+4.0%)</td>
<td>993,849 (+13.7%)</td>
<td>1,004,379 (+1.1%)</td>
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<tr>
<td>FH</td>
<td>206,912</td>
<td>242,927 (+17.4%)</td>
<td>243,709 (+0.3%)</td>
<td>235,047 (-3.6%)</td>
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<tr>
<td>SCGH</td>
<td>261,386</td>
<td>315,420 (+20.7%)</td>
<td>371,862 (+17.9%)</td>
<td>418,727 (+12.6%)</td>
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<tr>
<td>PMH</td>
<td>104,628</td>
<td>123,279 (17.8%)</td>
<td>149,768 (+21.5%)</td>
<td>187,908 (25.5%)</td>
</tr>
<tr>
<td>KEMH</td>
<td>155,586</td>
<td>179,498 (+15.4%)</td>
<td>225,283 (25.5%)</td>
<td>275,008 (+22.1%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,568,847</td>
<td>1,734,973 (+10.6%)</td>
<td>1,984,471 (+14.4%)</td>
<td>2,121,069 (+6.9%)</td>
</tr>
</tbody>
</table>

APPENDIX 4 – ANNUAL OCCASIONS OF SERVICE

Chart 2: Annual Occasions of Service by Site

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>RPH/SHENTON</td>
<td>8,927 (-1.2%)</td>
<td>8,819 (+11.6%)</td>
<td>8,714 (-1.2%)</td>
<td>8,922 (+2.4%)</td>
</tr>
<tr>
<td>FH</td>
<td>2,583 (+20.0%)</td>
<td>2,883 (+11.6%)</td>
<td>3,177 (+10.2%)</td>
<td>2,970 (-6.5%)</td>
</tr>
<tr>
<td>SCGH</td>
<td>2,272 (+20.0%)</td>
<td>2,727 (+19.0%)</td>
<td>3,244 (+19.0%)</td>
<td>3,595 (+10.8%)</td>
</tr>
<tr>
<td>PMH</td>
<td>1,789* (-7.7%)</td>
<td>1,651 (+14.3%)</td>
<td>1,887 (+14.3%)</td>
<td>2,088 (+10.7%)</td>
</tr>
<tr>
<td>KEMH</td>
<td>1,789* (+54.3%)</td>
<td>2,761 (+6.6%)</td>
<td>2,944 (+16.6%)</td>
<td>3,433 (+16.6%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>17,360 (+8.5%)</td>
<td>18,841 (+6.0%)</td>
<td>19,966 (+6.0%)</td>
<td>21,008 (+5.2%)</td>
</tr>
</tbody>
</table>

* 50% split estimation.
APPENDIX 6 – PRINCESS MARGARET & KING EDWARD MEMORIAL HOSPITALS

<table>
<thead>
<tr>
<th>Hospital / Health Service</th>
<th>Contact Person</th>
<th>Interpreting Services</th>
</tr>
</thead>
</table>
| PMH / KEMH               | Charlie Anderson 9340 8256 | • One full-time Language Coordinator covers both PMH and KEMH and approximately 100 contract interpreters are available.  
• Flexible contractor model with interpreters available during office hours. Agency interpreters are used.  
• The model predominantly uses on-site interpreters with telephone interpreters provided as a backup.  
• Patients are referred by hospital staff.  
• PMH and KEMH do not provide an on-site 24 hour, 7 day a week service.  
• Out of hours services are available if the booking is known in advance.  
• Bookings need to be made a week in advance if possible and emergencies are catered for immediately. Scheduling is done one month in advance.  
• The hospitals revert to the TIS number on weekends and if out of hours.  
• Twenty-four major, sixteen minor and sixteen rare languages are offered.  
• Telephone support is provided if an interpreter is not available for a particular language.  
• Face-to-face Aboriginal language services are not provided. The Kimberley Interpreter Service is utilised if an interpreter is not available in the metropolitan area.  
• Inpatient and outpatient, Hospital in the Home, community care, ambulatory care service, Allied Health and Sexual Assault Referral Counselling services are available.  
• Accredited interpreters are used except for a few non accredited interpreters in the ‘emerging languages’ and for simple things such as physiotherapy.  
• All bookings are manually recorded as there is no computerised Language Services System in place.  
• The Language Services Coordinator belongs to the Language Services Committee which meets regularly with nurses and social workers.  
• A mentoring program for interpreters is available.  
• An annual professional development day is provided for interpreters.  
• Staff education programs are provided on a regular basis, as well as mentoring programs |
## APPENDIX 7 – ROYAL PERTH HOSPITAL

<table>
<thead>
<tr>
<th>Hospital / Health Service</th>
<th>Contact Person</th>
<th>Interpreting Services</th>
</tr>
</thead>
</table>
| RPH                       | Bill Edward    | • A full time Language Services Coordinator is based on site (Monday to Friday) during business hours.  
|                           | 9224 2050      | • The current model utilises a combination of permanent, contract and agency interpreters (WA Interpreters and On Call).  
|                           |                | • TIS is only used if no other alternative is available. The service has been used decreasingly since April 2007.  
|                           |                | • WA Interpreters and On Call now provide most on site services not provided by permanent or by contract interpreters.  
|                           |                | • TIS is used for after hours on-site and telephone interpreting where contract interpreters are not able to be contacted between 9 am and 4.30 pm weekends and public holidays.  
|                           |                | • Auslan interpreters are accessed from the WA Deaf Society. Two Auslan interpreters are available as contractors.  
|                           |                | • The total number of languages catered for in one year is between 60-70.  
|                           |                | • Four staff are available on site (fulltime interpreters for Cantonese, Mandarin, Vietnamese).  
|                           |                | • Face-to-face and telephone services are available.  
|                           |                | • Clinics book patients a month in advance and interpreter services are informed by referrals.  
|                           |                | • RPH has provision for on site or telephone services to be accessed 24 hour a day, 7 days a week.  
|                           |                | • Contracts exist for 10 main languages.  
|                           |                | • No Aboriginal face-to-face interpreters are available so the Kimberley telephone service is used.  
|                           |                | • The service prefers Outpatient Department bookings to be received a month in advance. Emergencies are attended to immediately  
|                           |                | • Interpreter services are available for inpatients and outpatients.  
|                           |                | • Interpreters require a minimum of Level 2 qualifications (NAATI) (except for emerging languages). RPH staff prefer to use professional interpreters. In emergency situations, doctors will ascertain whether or not a relative can be used.  
|                           |                | • No cross jurisdiction arrangements.  
|                           |                | • 52 contractors (as needed).  
|                           |                | • A Computerised Language Services System.
### APPENDIX 8 – SIR CHARLES GAIRDNER HOSPITAL

<table>
<thead>
<tr>
<th>Hospital / Health Service</th>
<th>Contact Person</th>
<th>Interpreting Services</th>
</tr>
</thead>
</table>
| SCGH                      | Mary Joyce     | • Part-time (0.5 FTE) Interpreter Co-ordinator on site who coordinates all interpreting and translation requests during office hours. The Language Services Coordinator makes most bookings for onsite interpreters with two private agencies. To complement this, a freelance interpreter speaking Persian and Dari is booked on an ad hoc basis. Ad hoc bookings are directed to freelance interpreters and most AUSLAN interpreters.  
   • A face-to-face, on site service is provided. TIS services can also be used for emergencies and for bookings outside office hours.  
   • Clients are identified by clinical or clerical staff, as well as referrals being accepted from family, client or community. The emergency department has phone numbers for agencies and handles requests outside working hours.  
   • A 24 hour, 7 days per week service is provided by one of the existing agencies, as well as by TIS. TIS is not utilised as frequently due to higher costs associated with this service.  
   • SCGH provides access to over 50 languages. No Aboriginal or Torres Strait face-to-face interpreters are available and the Kimberley/Pilbara/Kalgoorlie telephone service is utilised.  
   • Advance bookings (up to 6 weeks) are preferred unless the case is an emergency.  
   • Inpatient and outpatient services are provided, as well as Hospital in the Home and ambulatory/community based care.  
   • Most agency interpreters have NAATI qualifications and accreditation. In some instances involving ‘emerging languages’, qualified interpreters may not be available and in these situations ‘experienced’ but unqualified interpreters are used.  
   • A data base is used to record usage and associated costs of the interpreter service.  
   • Irregular contact occurs with other hospital interpreter services. |
|                           | 9346 4666      |                       |
### APPENDIX 9 – FREMANTLE HOSPITAL

<table>
<thead>
<tr>
<th>Hospital / Health Service</th>
<th>Contact Person</th>
<th>Interpreting Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>FH</td>
<td>Diane Bianchini</td>
<td>• Part-time Language Services Coordinator manages a team of in-house part-time interpreters, providing Serbian, Croatian, Bosnian, Spanish and Portuguese languages and accesses interpreters of other languages via agency bookings for face–to–face and telephone situations.</td>
</tr>
<tr>
<td></td>
<td>9431 2477</td>
<td>• Agencies/Service Providers: On-Call Interpreters, WA Deaf Society.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Language Services receives requests for bookings from areas including outpatients clinics, wards, RITH, HITH, Occupational Therapy, Physiotherapy, Waitlist, Pre-Admissions, DOSA, which are received via TOPAS, email, telephone, internal mail and sometimes from patients’ relatives.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Bookings for on site face-to-face interpreters can be placed through Language Services/Social Work Dept during office hours. Out of hours face to face and telephone interpreter services bookings are made by the user directly with the Agency concerned.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A 24 hour, 7 days a week service is not available on site but out of hours services are provided by an agency. TIS is also used but can be expensive thus a last option. The AUSLAN number is also utilised. Six languages are provided ‘in house’ and access to most other languages is provided by agency contractors.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• No face-to-face Aboriginal services available (KIS is utilised).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Booking requested with good advance notification. Emergency cases are addressed immediately.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• All agency registered interpreters are required to be NAATI accredited. Generally, only accredited interpreters are used, except in the case of &quot;emerging languages&quot; where accredited interpreters may be unavailable.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• No direct arrangements are entered into with interpreters who are not on the payroll of the hospital.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Own data collection system “Fremantle Hospital Interpreter Data Base”.</td>
</tr>
<tr>
<td>Hospital/Health Service</td>
<td>Contact Person</td>
<td>Interpreting Services</td>
</tr>
<tr>
<td>-------------------------</td>
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</tr>
</tbody>
</table>
| Joondalup Hospital      | Sam Luong, Social Work Manager | - On Call Interpreters, Interpreters International and TIS are used for after hours work.  
- Generally on site interpreting and phone interpreting is offered to inpatients.  
- No interpreting services provided to outpatients  
- The most commonly requested languages are Italian, Vietnamese, Greek, Sudanese and African.  
- The ward clerk identifies the need for an interpreter and is responsible for making the booking, especially in medical diagnoses.  
- Bilingual staff are usually used for housekeeping or routine purposes such as checking temperatures and toileting.  
- An existing policy outlines when to use an interpreter.  
- A Multicultural File is kept in each ward and this provides a range of information for dealing with CaLD patients. |
| Migrant Health Unit, Bentley Hospital | Robyn Sterett | - The need for an interpreter is noted in the files of clients who are newly arrived refugees.  
- The hospital uses On-Call Interpreters for on site and telephone interpreting.  
- Also organises and pays for interpreters when accompanying clients to GP appointments.  
- Corporate in-service is provided for new nurses, dietitians, gardeners and other staff every month and covers the topic of communicating in a multicultural society. |
| Mirrabooka Mental Health Clinic |          | - TIS is the only service used.  
- The largest client group is Vietnamese. In the last three years, African, Sudanese, Yugoslavian, Croatian, Chinese, Kenyan and Ethiopian groups (with limited English skills) have attended.  
- Interpreters are booked in advance, except in emergency situations.  
- Interpreter request forms are faxed to TIS.  
- The site does not have a specific budget item for interpreting services but expenses are closely monitored. |
| Katanning Hospital      | Chris Ryan, Director of Nursing | - Phone interpreting is used (TIS).  
- Clients are mostly from Malay, Vietnamese and Afghani backgrounds.  
- Family members usually assist in interpreting.  
- The need for interpreters is identified by ward nurses.  
- There is no prior training for staff on using interpreters. (This is on-the-job training.) |
<table>
<thead>
<tr>
<th>Location</th>
<th>Contact Person</th>
<th>Notes</th>
</tr>
</thead>
</table>
| Osborne Park Hospital         | Donna Pewsey, Health Information Manager | - No language services policy is in place.  
- They do not collect data on ethnicity or use of interpreters.  
- The hospital uses WA interpreters, On Call, TIS and Deaf Interpreters.  
- Clerical staff identify the need for interpreters at the appointment booking stage. This may be undertaken either at ambulatory, theatre, outpatient department or ward stages.  
- The clients are mostly Vietnamese. Some brochures have been translated into Vietnamese.  
- Other languages requested include Arabic, Dinka, Somali, Italian and Mandarin.  
- Both on-site and telephone interpreting is utilised.  
- There have been concerns about the competencies of some of the interpreters. Staff who book interpreters have been instructed to enquire about the interpreter’s accreditation and/or qualifications.  
- No allocated item for language costs in budget. |
| Armadale Health Service       |                                       | - TIS services are used. No private contractors.  
- The WA Deaf Society is used for deaf interpreting services.  
- The need for an interpreter is identified at the time of booking a medical appointment. This information is recorded on a request form and booked. The hospital tries to allocate the same interpreter for pre-admission and post surgery.  
- No requests have been made for Aboriginal language interpreting.  
- On-site and telephone interpreting is used. Three way conference phones are available.  
- The most common languages requested are Mandarin, Serbian, Cantonese, Persian, Indonesian and Polish. |
| Swan District Hospital        |                                       | - Use TIS only. No contractors  
- Each unit rings and books interpreters.  
- Request for an interpreter usually done at pre-admission clinic.  
- Use interpreters in the home, hospital and mental health clinic.  
- No allocated item for language costs in budget.  
- Not included in annual report. |
APPENDIX 11 – GRAYLANDS HOSPITAL

<table>
<thead>
<tr>
<th>Hospital/ Health Service</th>
<th>Contact Person</th>
<th>Interpreting Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Graylands Hospital</td>
<td>N/A</td>
<td>The TIS and KIS services are used.</td>
</tr>
</tbody>
</table>
BreastScreen WA provides clients with face-to-face or telephone interpreters on request. The interpreters are booked through the TIS National Centre, although other registered interpreter services may be used. BreastScreen WA screening and assessment services involve procedures and processes which require consent, therefore it is important that customers fully understand what is required. Family members may provide interpreting assistance but professional interpreters are usually preferred. Interpreters are booked in advance and meet with customers prior to service delivery. A range of language specific pamphlets are available for CaLD groups which are sent out to the client at time of booking and are available on the BreastScreen WA website.

The Cervical Cancer Prevention Program WA includes the TIS number on all introductory letters to customers. When health campaigns occur in regional areas the specific health site or GP practice caters for interpreting needs by providing interpreters on request. The TIS service is also available as a back-up. Language specific pamphlets are available for CaLD groups.

The Health Call Centre (McKesson Asia-Pacific) uses TIS to provide an interpreter service for all programs operating from their centre, including HealthDirect. This service is part of the Department of Immigration and Citizenship and is available 24 hours a day, 7 days a week. An average of one to four calls a month across all programs requires interpreter assistance.
The WA Interpreter Card was developed by the Department of Citizenship and Multicultural Interests to assist people from non-English speaking backgrounds. The language required for interpreter services is written on the front of the card and the person shows this information when interacting with agencies or services. Qualified TIS and WA Deaf Society (WADS) interpreters are available to assist. The card can be used at any WA state government agency including public hospitals, community health centres, courts, police stations, state schools, Centrelink and immigration and employment services.
APPENDIX 14 – CULTURAL DIVERSITY TEAM

Vision

A socially just and sustainable Western Australian society where people enjoy equitable, accessible, safe and high quality health care necessary for their wellbeing.

Mission

The Cultural Diversity team leads policy development and evaluation and provides expert advice to WA Health management, Health Networks, Area Health Services and other parts of the Government health system to reduce inequities in health and enable access to health services for people from culturally and linguistically diverse backgrounds.

Principal Tasks

- Development, planning and evaluation of statewide health sector cultural diversity policy including the Language Services in Health Care Policy and Guidelines.
- Support to Health Networks and WA Health Services to develop and implement culturally competent and linguistically appropriate services and initiatives.

Our Stakeholders

Our team relies on appropriate and timely engagement with key internal and external stakeholders to achieve the best outcomes for the Western Australian community.

South Metropolitan Area Health Service
North Metropolitan Area Health Service
WA Country Health Service
Child and Adolescent Health Service
Health Networks
Office of Aboriginal Health
Health System Support
Transcultural Mental Health Centre
Workforce Development
Safety and Quality Coordinators
Health Consumers’ Council
Ethnic Communities Council
Office of Multicultural Interests
Migrant Resource Centres
Department of Immigration and Citizenship
Department of Child Protection
Aboriginal Health Services
Migrant Community Organisations
National Association Accredited Translators and Interpreters (WA):

- 2005-Monash University designed training program ‘Basic Interpreting Skills Training” for potential interpreters in small and emerging community languages, funded by Department of Immigration. NAATI WA agreed to provide a ‘mini course’ based on basic interpreting skills and preparation for NAATI examinations.

- 2007-NAATI WA Professional Development Courses for both professional interpreters and those considered ‘candidates.’ These courses are presented by practitioners in the field who share their experiences and expertise.

  Courses offered in September/December 2007 are:
  - Is culture important as a context for translating?
  - Editing and proofreading for Translators
  - Interpreting for Trauma Victims
  - Software Options for Translators

- NAATI short term courses for interpreters of new and emerging communities in partnership with Centrecare Migrant Services. These courses are run on demand and when resources are available.

- Preparatory workshops for Translating tests in March and October and preparatory workshops for Interpreting tests annually in March/April. These workshops are also offered ‘on line’ on the NAATI website.

Technical and Further Education (TAFE) WA:

See the Catalogue of training opportunities in 2007.
REFERENCES

Australian Government National Health and Medical Research Council (2005) Cultural Competency in Health: A Guide for policy, partnerships and participation


Department for Community Development, Cultural Diversity Policy and Strategic Framework 2006 –2009

Department of Premier and Cabinet, Government of Western Australia, Better Planning: Better Futures, 2006

Department of Health, Government of Western Australia, A Healthy Future for Western Australians, Report of the Health Reform Committee, 2004


Government of Western Australia, Language Services Policy

Government of Western Australia, Office of Multicultural Interests Analysis of the Need for Interpreting and Translating Services with the Western Australian Government Sector


NSW Health Health Services for a Culturally Diverse Society: An Implementation Plan


WA Health Language Services in Health Care Policy and Guidelines