Bilingual staff in mainstream healthcare: Policy development for NSW Health Services
Report No. 3

This report is part of a series of documents:

Report 1 Health communication between non-English speaking patients and bilingual staff within our health services. ISBN 1 875 909 89 3
Report 2 Matching non-English speaking patients and bilingual staff within wards or units. ISBN 1 875 909 90 7
Report 3 Bilingual staff in mainstream healthcare: Policy development for NSW Health Services. ISBN 1 875 909 91 5
Report 4 Language proficiency testing in health settings. ISBN 1 875 909 92 3

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Introduction

The development of policy for Area Health Services and NSW Health was the overall aim of Phase 3 of the Bilingual Staff in Mainstream Health Services Research program. This policy related to the appropriate use of language skills in the healthcare setting. The discussion paper, *Development of a Bilingual Health Staff Communication Strategy for NSW Health Services*, is the major outcome to date of this phase. The paper was prepared by the Policy Development Reference Group (Bilingual Health Staff Research Project), for consideration by NSW Health. It is designed as a preliminary document seeking feedback from Area Health Services and other relevant stakeholders in regard to the development of policy on these issues.

The Discussion paper aims to promote:

- Increased understanding of the various roles played by bilingual staff, interpreters and multicultural health staff;
- A recognition of the settings and situations to which these roles are suited, or are feasible;
- Workforce planning to optimise the employment and use of bilingual staff.

It locates the issue of effective use of bilingual staff, within the broader policy contexts of ethnic affairs, workforce diversity and providing culturally competent health care.

The paper suggests delineation between Minimum Practice, Improved Practice, and Good Practice in employment and use of bilingual staff, based on the number of people with a language other than English residing in the Area Health Service and the number of bilingual staff within a health service. The nature of the service, its consumers (actual or potential), and the skills required of health professionals to deliver appropriate care are recognised as critical to the effort warranted and the management strategies that can be utilised by health services.

The paper also foreshadows a range of issues and processes for health services that would need to be addressed by policy:

- Identifying the language needs of clients;
- Identifying the current language skills of staff;
- Role definitions: how language skills can be used;
- Confirming proficiency: language assessment/further skills training;
- Matching language needs of clients with available bilingual health staff;
- Recruitment and selection issues; and
- The value of bilingual staff.

This report describes the relationship between the research carried out in Phases 1 and 2 of the Bilingual Staff in Mainstream Health Services Project, and the Policy Development phase (Phase 3). It outlines the process used to engage appropriate stakeholders and transform a set of problems and issues raised through the initial research, into actionable policy for NSW health services.

Genesis of the policy 'problem' addressed

Multicultural health policy in NSW

It has been argued that multicultural health policy has remained a matter of 'tinkering at the edges', rather than producing systemic change in health services (Fuller, 1997; Jayasuriya, 1993; Garrett & Lin, 1990). Questions about the extent to which universalist versus mainstream particularist approaches should be used have been at the core of debates about effective ethnospecific change. Fuller states:

> *The type of human service organization best suited to meet the needs of a culturally diverse society is the subject of an extensive body of literature… One of the issues of concern is the degree to which one universal (or mainstream) service can meet the needs of all groups and the extent to which specialist (or ethno-specific) services are required to meet the needs of particular groups, especially those that are disadvantaged.* (Fuller, 1997, p.153)

This tension is reflected, to a degree, in the now rather long history (some 20 years) of various attempts to grapple with questions about the role of bilingual health professionals in mainstream health services.

NSW health services have invested considerable effort and resources in meeting the needs of a culturally and linguistically diverse population. To date, significant attention has been paid to two key programs - Health Care Interpreter Services and multicultural health staff. However, less attention has been paid to the role of mainstream health staff. Strategies in this regard have tended to focus on cross-cultural training, stipulating procedural requirements (such as interpreter use) and encouraging collaborative working relationships with multicultural health staff. There has been only a limited focus on the actual or potential value of care provided by bilingual health professionals.

Use of community language skills extant within the workforce and positive attempts to recruit staff with such skills are not new notions in NSW government agencies. Positive action to recruit into positions 'identified' for cross-cultural skills was evident in the 1980s: the Public Service Board of NSW produced guidelines on the matter and the Department of Housing and the Home Care Service, for example, had active strategies to recruit bilingual staff into the workforce (Public Service Board of NSW 1987). The Community Language Allowance Scheme (CLAS), paid to staff in government agencies who use a language other than English to communicate with clients as part of their normal duties, has operated in NSW for over ten years. It has been under review in 1999, and the outcome is unclear at this stage.

Currently, NSW government EEO requirements include 'a diverse and skilled workforce' as a program outcome, with the expectation that agencies progress towards particular employment targets for women, Aboriginal people and people whose first language was not English (ODEOPE, 1998). 'Productive diversity'

is receiving increasing support as a NSW government policy direction. Cope and Kalantzis summarise the concept thus:

> The necessary and surprisingly synergistic paradox of Productive Diversity is cohesion through diversity; sameness and difference; shared achievements based on differential inputs (Cope & Kalantzis, 1997, p.17).

This implies that government agencies, including health services, need to recognise that increasing diversity is a positive development per se (as the workforce moves closer to reflecting the population served), but also that effective use of this diversity requires an active commitment by management to fostering the use of the additional skills available (linguistic and cultural).

The Premier's Department conducted a Productive Diversity Review using selected agencies, in late 1998. SWSAHS was selected as the agency to survey for the component of the review relating to staff speaking a language other than English (LOTE). To date, this report has not been released.

These concepts have not yet been actively supported within the health system, despite evidence of a number of attempts to promote them. Departmental policy documents on migrant access to health services, from as early as 1987, have encouraged bilingual health professionals to use their language skills in direct patient care (NSW Health 1987). Strategies relating to 'identified positions' appeared in the 1991 SWSAHS Area Ethnic Health Plan. Policy discussion papers on this matter were prepared in SWSAHS in 1992 and the Health Department in 1993, but neither received a great deal of support outside of the Multicultural Health Units that prepared them. Both attempts were subsequently discontinued. Nevertheless, both at state level and in some Area Health Services alternative ways of placing this idea on the agenda have been put forward through Ethnic Affairs planning documents.

The Bilingual Staff in Mainstream Health Services Research Program

In 1996, SWSAHS attempted to redress this situation by commencing a study of bilingual staff employed within the Area Health Service. The project was a collaborative effort between Multicultural Health Services and the South West Sydney Centre for Applied Nursing Research (a joint unit of SWSAHS and UWS Macarthur). Phase 1 of the project consisted of quantitative and qualitative studies of:

- the number and languages of the bilingual staff employed and how this profile compared with the population profile;
- the frequency of use of their community language skills and the situations in which they used them; and
- perceptions of both bilingual and monolingual staff of the benefits of this in the workplace.

This research found that substantial numbers of bilingual staff were employed and were using their language skills, although some mismatch was evident in terms of the major language groups in the area (Johnson, Noble, Matthews & Aguilar, 1998). With social or 'everyday' language use more common than

technical or complex use, bilingual staff were using their skills and knowledge both for verbal communication and to establish rapport with patients. The researchers concluded that bilingual staff were seen within the system as valuable 'assets', but often unrecognised as such and underused or inappropriately used. Participants in the qualitative study frequently referred to the need for 'policy'. Policy was required to resolve issues relating to recognition of skills, protection against inappropriate use and to clarify issues around roles (boundaries) and language proficiency.

From this initial research, three further research projects were designed. **Phase 2** aimed to develop innovative roles and service models utilising bilingual staff. The objective of **Phase 3** was to develop policy for NSW health services on the use of bilingual staff in various communication roles with clients and patients and is the subject of this report. **Phase 4** related to development of language assessment tools for bilingual staff.

Phase 2 (innovative roles and service models for bilingual staff) consisted of a series of qualitative studies conducted primarily in three sites - a long-stay/rehabilitation unit, a sub-acute medical ward and an emergency department. These studies have both added to and refined our knowledge about the roles and functions of bilingual health staff. The important role of family to NES patients, during their hospital stay, has also emerged. However, significant issues have emerged about the opportunities presented, effort involved and/or willingness of managers and staff to ensure bilingual staff could be 'matched' to patients of the same language background. This served to strengthen the Research Team's conviction that policy on this matter is a priority for NSW Health, with such policy indicating the need for better performance by health services in regard to employment and use of bilingual staff and providing practical guidance to managers about implementation.

Phase 3 (policy development) responds to various findings from Phase 1 and 2, and is the subject of this report.

For **Phase 4** (language assessment tools), the Language Testing Research Centre (LTRC) at the University of Melbourne and SESAHS, joined the SWSAHS team as research partners. The LTRC has expertise in developing health-related tests (for example, the Occupational English Test for doctors) and specific-purpose tests of LOTE proficiency. A Feasibility Study was conducted by the LTRC in 1999 and work on test development is now complete. Initially, pilot testing has been conducted for the Vietnamese and Cantonese languages, with participants drawn from SWSAHS and SESAHS. Two tests have been designed: a self-assessment questionnaire, to establish proficiency at a 'simple' or social level; and a phone-based test of oral skills at a 'complex' or technical level. These tests, and the availability of language assessment tools, are fundamental to certain aspects of policy in this area. Funding has been provided to develop tests in a further four languages.

Support for the research program from stakeholders and experts

Traditional accounts of decision-making in organisations describe a rational, goal-oriented approach by a single 'decision-maker', or a single-minded set of actors (Simon, 1957; Audley, 1967). There is now a large body of literature which refutes this view as either empirically accurate or normatively desirable (for example, Cohen, March & Olsen, 1972; March, 1982; Colebatch, 1998). The world of decision-making is, rather, more likely to be characterised by many actors operating in an environment of coalitions, contests, ambiguity and complexity (March, 1982).

Over the life of the *Bilingual Staff in Mainstream Health Services Research Program*, the Research Team has recognised the importance of widening the base of interest in the role of bilingual health staff and has therefore actively sought the support and involvement of stakeholders from a broad range of health-related fields and expertise.

NSW Health (the Health Services Policy Branch) has supported this project since its commencement, with the provision of the initial grant to commence the project (Phase 1) being made from the Multicultural Service Enhancement Program (MSEP), in 1996/97. Further funding was provided in 1997/98. Details are provided in Table 1.

Table 1: Funding from NSW Health for the research and subsequent policy development.

Source	Amount	Purpose
MSEP 1996/97	$10,000	Contribution towards undertaking language audit and focus groups
MSEP 1997/98	$4,000	Top-up to help meet additional costs associated with language audit and focus groups
MSEP 1997/98	$20,000	Contribution towards initial costs of language assessment study (Phase 3) and policy development (Phase 4)

During negotiations between SWSAHS and the Department regarding the 1997/98 submission for funds, the Senior Policy Officer Multicultural Health placed an additional condition on the grant that the policy development work be expanded to include policy on 'Identified Positions'. In doing so, Phase 3 of the project was to re-vitalise work undertaken by the Health Services Policy Branch in 1993 and 1996, on the identification of positions requiring intercultural skills within the NSW health system.

The support and involvement of SESAHS, the LTRC, University of Melbourne and the Faculty of Education and Languages (Division of Languages and Linguistics) at UWS Macarthur was also subsequently secured. Details of the financial support provided by these organisations are provided in Table 2:

Table 2: Funding contributions

Unit	Contribution
SESAHS	$12,000 contribution towards costs for Phase 3 (language assessment).
LTRC (Uni of Melb)	$7,500 contribution towards Phase 3 (language assessment).
Faculty of Education and Languages UWSM	• Provision of language assessors for Phase 2 (innovative roles & service models study). • $7,400 Internal collaborative grant for discourse analysis of interactions between NESB clients and providers (bilingual, monolingual through interpreter, English-speaking provider and client).

The policy development process

Reference Group

As previously noted, NSW Health negotiated with the Research Team that Phase 3 include work on policy relating to 'identified positions', that is the identification of positions requiring cross-cultural skills (such as community language skills, experience in working with a range of language/cultural groups, cross-cultural counselling experience, a bi-cultural background).

The SWSAHS research team formed a Reference Group in 1998 to guide the policy development process (Phase 3). This group represented a range of interest groups, as relevant as possible to the whole state.

This group was comprised of Departmental representatives (Senior Policy Officer Multicultural Health; a representative of the Corporate Services Branch), representatives of 6 Area Health Services (Multicultural Health/Interpreters/ Human Resources - SWSAHS, SESAHS, NSAHS, CSAHS, Hunter AHS, Wentworth AHS) and the Office of the Director of Equal Opportunity in Public Employment. The Terms of Reference and Membership are provided in Appendix 2.

The group met regularly (bi-monthly) over the period June 1998 to December 1999.

Reference Group process and tasks

The initial briefing for this Reference Group, by the Research Team, included a background to the research conducted by SWSAHS, the findings from this research and the policy issues which emerged. Early discussions by the Reference Group were focused on identifying concerns and central principles for policy. The concerns initially documented were:

- Impact of the use of languages on workload and time from participants' perspectives;
- Use of targeted recruitment to increase numbers of bilingual staff with the recognition of limited supply for certain languages/disciplines;
- Policy needs to ensure that staff and standards are not compromised;
- Choice needs to be recognised, for both staff members and clients;
- Defining the scope of policy – who and what disciplines are included?;
- What support/training is to be offered?

Suggested principles identified by the group were:
- **Sustainability** (within mainstream health services);
- **Flexibility** (different population groups, responsiveness to different staff and client profiles);
- **Applicability** across the health system;
- To provide **better client services** (effectiveness – as distinct from social justice);
- It is acceptable to think differently, service models may need to **change over time**;
- The need to produce guidelines that reflect **current industrial** arrangements.

Early discussions also occurred on the appropriate 'home' for this policy work and the nature of the policy itself. It was agreed that it was 'more appropriately a human resources policy, providing both minimum standards for health services and examples of good practice' (Reference Group minutes 7 July 1998, 19 August 1998).

Initially, work commenced on developing a policy document. However, given the potentially contentious nature of aspects of the proposed policy and different levels of familiarity amongst health service managers with these policy issues, the Reference Group resolved that three documents be prepared:
- A discussion paper, as the initial consultative document;
- A policy, of no more than 4 pages; and
- A set of guidelines, to provide practical and more detailed assistance to health service managers and/or those who would be promoting policy implementation (e.g., Area Multicultural Health Coordinators, Human Resources Managers).

The policy reference group submitted a draft discussion paper to Area Multicultural Health Coordinators for comment, in November 1999. The appropriate and relevant feedback received was incorporated, as far as possible, in the final version of the document. A balance has been sought between promoting obligations and benefits in regard to using bilingual health staff, and acknowledging the complex reality of workforce planning, recruiting from often a limited supply base and changing accepted work practices. In brief, the major areas of debate (amongst Reference Group members and Area Multicultural Health Coordinators) have been:
- That the use of interpreters is not undermined;

- That staff roles are adequately distinguished, particularly in regard to consent;
- That differences in capacity to respond to the document between Areas are acknowledged, especially in regard to NES population and availability of bilingual staff;
- Implications for Area Health Services are noted and expectations are not so great that Areas will respond with 'why bother?', 'it doesn't apply to us' and other similar issues;
- That the need to adjust workloads for bilingual staff and for managers to provide them with adequate support, is clearly indicated;
- That the benefits for Areas are clearly pointed out, particularly in improving patient care;
- That the use of language by bilingual staff is a voluntary issue and coercion must not be used by managers; and
- Whether bilingual staff should receive an allowance similar to CLAS – the industrial, financial and equity issues involved in deciding who should receive allowances as well as the criteria.

Appendix 1 is the Discussion document that was delivered to the NSW Health Department in January 2000.

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APPENDIX 1:

Discussion Paper:

Development of a *Bilingual Health Staff Communication Strategy* for NSW Health Services

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Prepared by SWSAHS/CANR for the
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January 2000

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GLOSSARY OF TERMS

ADB Anti-Discrimination Board of NSW

EAPS Ethnic Affairs Policy Statement

EEO Equal Employment Opportunity

LOTE Language other than English

Mainstream In the context of this paper, *mainstream* refers to health services, or the health workforce, generally.

NAATI National Accreditation Authority for Translators and Interpreters

NES Non-English speaking

NESB Non-English speaking background. In statistical terms, a person is of non-English speaking background if they or one of their parents was born in a country where English is not the first language.

ODEOPE Office of the Director of Equal Opportunity in Public Employment

TIS Translating and Interpreting Service, an Australia-wide service provided by the Commonwealth Department of Immigration and Multicultural Affairs

1. Introduction

NSW health services have made significant progress in their efforts to deliver culturally competent health care. Recent experience here and overseas, however, is demonstrating that health services still experience difficulties in meeting a fundamental obligation – to ensure that effective communication occurs between provider and client. The imperative for health services to address language and communication issues in a far more comprehensive way while focusing upon direct care outcomes cannot, therefore, be overstated.

While broad-based strategies that address language barriers (such as Health Care Interpreters) are important, more attention needs to be paid to the clinical context of language use. This means recognition of the value of bilingual doctors, nurses, allied health staff and others delivering care within a shared cultural understanding of health and illness and conveying information in a shared language.

This paper aims to stimulate discussion within NSW health services about ways to efficiently and effectively utilise the skills of bilingual staff in the course of their day to day duties in the workplace.

The development of a *Bilingual Health Staff Communication Strategy* for NSW Health Services would serve to guide Area Health Services in this way. Such a strategy would define the roles and functions of bilingual staff and be inclusive of existing services such as interpreters and Multicultural Health workers, but go beyond these services.

It would focus on use of the bilingual skills of staff within existing duties and ways to increase the future employment of bilingual staff, in order to improve client-provider communication.

In doing so, however, it is recognised that health services need to continue to work towards achieving a number of complementary strategies:

- Optimum use of Health Care Interpreter Services;
- Effective use of available bilingual staff;
- Increased employment of bilingual health staff; and
- Optimum use of multicultural health staff, including extensive consultation and collaboration with these staff and, where relevant, workers from non-government organisations.

It is, further, recognised that such a strategy would have varying implications for Area Health Services across NSW. Greater attention to the language and cultural needs of the population may be expected from those Areas with a high population of residents with limited English language ability and/or speaking a language other than English at home, and with greater opportunities to employ bilingual staff. Policy relating to the use and employment of bilingual staff will, therefore, need to take account of these differences while recognising that effective communication with patients and clients is a universal obligation for health care providers.

The intent of this discussion paper is that use of the skills of bilingual staff is complementary to use of health care interpreters, rather than a substitute for them.

2. The Need for a Bilingual Health Staff Communication Strategy

2.1. Approaches to Communication with a Diverse Population – The Experience in NSW Health Services

Much of the attention on immigrant health in Australia, especially since the 1970s, has been about overcoming language barriers and improving access to services. The two major responses to this were the establishment of specialist health care interpreter services (in 1975) and the employment of ethnic health workers (as they were then known)[i]. NSW Health, in particular, has continued to develop these services and today has a comprehensive, professional Health Care Interpreter Service and a sound infrastructure of multicultural health positions.

The desirability of employment of bilingual health professionals was noted as early as 1978, in the *Review of Post-Arrival Programs and Services to Migrants* (known as the Galbally Report)[ii]. At the time, however, the number and range of bilingual health professionals was extremely limited.

With the increased emphasis in NSW government ethnic affairs policy, from the early 1980s, on changing 'government service provision for immigrants from a marginal to a central concern of government institutions'[iii], it might be expected that attention would return to the issue of bilingual health professionals. However, work undertaken with the 'mainstream' health workforce has tended to be about cross-cultural training, procedural requirements (eg interpreter use) and encouraging co-work with Ethnic Health staff – rather than direct use of or employment of bilingual staff.

The idea of utilising the community language skills available within a workforce or of positively recruiting bilingual staff is not new to NSW government agencies. Positive action to recruit into positions 'identified' for cross-cultural skills was evident in the 1980s and the Public Service Board of NSW produced guidelines on the matter. These ideas have not to date been actively promoted within the health system, even though some planning documents have identified the benefits of a workforce that reflects the community it serves[iv].

Recently, research in SWSAHS and SESAHS has indicated that, whether officially recognised or not, a substantial number of bilingual staff are employed in health services and are utilising their language skills on a regular basis, with clients and patients.

2.2. Cultural Diversity in Health Care – The Policy Context & Quality Care

Attention to cultural diversity and health care is motivated and/or obligated by government policy, legislation and concern to deliver quality care. In this sense, several purposes are served by effective utilisation of bilingual staff. The main considerations are:

- Social justice & NSW Ethnic Affairs Policy
- Employment equity & managing for diversity
- Providing culturally competent health care

(Further detail on these policy areas is provided in Appendix 1.)

An additional concept which is relevant to this discussion paper is ***productive diversity,*** a term first used in 1992 by the then Prime Minister (Keating) and then Deputy Opposition Leader (Fischer). It initially focussed on 'working effectively with an immigrant workforce', but has since been envisioned as a much broader management approach[v]. A major report

commissioned by the commonwealth government, *Enterprising nation: report of the Industry Taskforce on Leadership and Management Skills* (known as the Karpin Report), also referred to management of diversity[vi]. This report concluded that 'effective management of a diverse workforce is a source of competitive advantage' for Australian organisations; with the potential to improve efficiency, promote creativity and increase marketing opportunities.

While NSW health services are not currently structured in the same sort of competitive environment as private enterprise, they certainly strive for efficiency and are concerned to deliver the best possible care to consumers. At state government level, these sentiments are reflected in requirements for EEO program outcomes:

> *'A Public Sector that reflects the diversity of the community it serves is better able to formulate policy and provide services that meet community needs. Workforce diversity provides the Public Sector with a range of skills, knowledge and perspectives that contribute to excellence.'*[vii]

The employment of bilingual staff meets both Ethnic Affairs Policy and EEO expectations that health services work towards increasing the ability of the mainstream workforce to deliver services to a diverse population. It is a demonstrable way of utilising the cultural and linguistic assets of the state's population in line with the concept of productive diversity. In some instances, purposeful employment of bilingual staff can also be used (and has been used) to increase access to health services.

Besides policy and legislative requirements, health services and individual health professionals are motivated by a desire to deliver high quality care. The term 'culturally competent health care' is increasingly being used in Australia and overseas, as a shorthand way of expressing the skills, knowledge and approaches required to accommodate language and cultural differences in a sensitive and meaningful way. Since communication is the cornerstone to most health care encounters, the presence of a language barrier seriously jeopardises diagnosis and treatment. The consequences of failure to overcome the language barrier have been investigated and documented in a number of studies, and include:

- **Poor exchange of information**, which can lead to misdiagnosis and/or poor understanding for the patient of their diagnosis and treatment[viii];
- **Increased costs**: Limited communication in the diagnostic interview may lead to increased reliance upon tests, or conversely a failure to recognise the need for a particular test[ix]. There is evidence of a higher rate of resource utilisation - increased use of diagnostic tests and length of stay - in Emergency Departments, associated with a language barrier between provider and patient[x]. Language barriers have also been associated with longer workdays for RMOs[xi].
- **Compromised Care**: Poor understanding of diagnosis and treatment may effect compliance with treatment. Language barriers have also been associated with patient dissatisfaction, poor clinical outcomes and ineffective patient education[xii].
- **Ethical and medico-legal problems**: It is highly questionable that consent obtained without adequate bridging of the communication gap, through professional interpreters, is informed[xiii].
- **Increased work and stress for staff** was found in an American study of the impact of language barriers on residents. Increased length of workdays, increased daily stress and reduced teaching effectiveness were all evidenced[xiv].

- **Isolation** created by the inability to communicate with health workers or others has been noted within the hospital environment and in the community[xv].
- **Limited use of health services** has been documented in Australia and overseas, stemming from both language barriers and cultural differences[xvi].

While the likelihood for health professionals of encountering a client with limited English language ability varies across NSW, it is nevertheless a population feature of relevance to all Area Health Services. At the 1996 census, over 226,000 residents of NSW reported speaking English not well or not at all. The table below indicates this population, by Area Health Service. It should be noted, however, that it is likely that the number of people who would report difficulty in communicating on health-related matters with a health care provider would be somewhat greater than what is reported in the Census[xvii].

Table 1: Population speaking English not well or not at all, by Area Health Service, 1996

AREA HEALTH SERVICE	Speaks English Not Well or Not at All	%	LOTE Population*	%	Total Population
Central Coast	995	0.4%	8247	3.2%	260152
Central Sydney	50721	11.2%	197630	43.6%	453056
Hunter	3218	0.6%	20110	4.0%	505881
Illawarra	7921	2.5%	42123	13.1%	322300
Northern Sydney	19914	2.8%	119331	16.9%	707813
South Eastern Sydney	31352	4.4%	174735	24.7%	706096
South Western Sydney	65892	9.4%	251909	35.8%	703457
Wentworth	3452	1.2%	27491	9.4%	291974
Western Sydney	36700	5.9%	185730	30.0%	619277
Far West	199	0.4%	1653	3.3%	50024
Greater Murray	1800	0.7%	10517	4.2%	250625
Macquarie	251	0.2%	1662	1.6%	101476
Mid North Coast	706	0.3%	5421	2.2%	248009
Mid Western	604	0.4%	3965	2.5%	161423
New England	524	0.3%	3733	2.1%	174740
Northern Rivers	712	0.3%	5846	2.3%	248879
Southern	1306	0.7%	9666	5.2%	187405
New South Wales	**226237**	**3.8%**	**1069851**	**17.9%**	**5992707**

Source: ABS Census of Population & Housing 1996, Ethcon96 V. 2.1
***** Population speaking a language other than English (LOTE) at home

A study of recent immigrants to Australia found that those proficient in English tended to report better health and less use of medical services, than those with limited or no English language proficiency[xviii]. 1996 Census data for NSW reveals that women and the aged report significantly lower levels of English language proficiency than men or younger people, respectively. For example, 22.8% of women in NSW reported speaking English not well or not at all, compared with 17.8% of men. 39.6% of those aged 65-74 years and 49.8% of those aged 75 years or more reported speaking English not well or not at all, compared with 4.5% of 13-18 year olds and 8.2% of 19-24 year olds.[xix]. With the ageing of many of the immediate post-war wave of immigrants, health services will be further utilised by people with limited English language skills. These population factors mean that Health Services in NSW will be increasingly looking for innovative ways to deal effectively with patient communication in languages other than English.

2.3. Research on Communication & the Role Played by Bilingual Staff

Recent research has identified the importance of communication by bilingual staff in both social and technical aspects of health care and suggests that varying levels of language proficiency are available and are being utilised by health professionals.

In a study undertaken in South Western Sydney Area Health Service, most bilingual staff were found to use their language skill to assist in establishing rapport with clients, particularly in inpatient settings[xx]. In contrast, relatively few staff felt competent to undertake medical consents with patients, instead relying upon the Interpreter Service. Those staff who felt capable of performing this function tended to have gained their professional qualifications overseas and in the language concerned.

While a number of roles for bilingual staff were identified in this study, predominant was 'simply the use of language skills within my normal work'[xxi].

There was evidence in this study that bilingual staff restricted use of their language skill, where they did not feel comfortable or that it was appropriate to do so, particularly according to their level of language competence. At the same time, study participants believed that 'support and protection' should be provided 'through a system of accreditation'[xxii]. A USA study of interpreter use similarly identified the benefits of physician and patient communicating through a shared language, but also highlighted the need for health services to test for clinicians' competence in that language[xxiii].

Communication between bilingual health professionals and non-English speaking background (NESB) clients in a common language and common cultural contexts, is the optimal means of service delivery.

Limited attention to maximising use of the skills of bilingual staff, particularly through pro-active 'matching' of clients and staff, was however evidenced in both the SWSAHS study and in a study of mental health services in Victoria[xxiv]. The *Bilingual Health Staff Communication Strategy* aims to redress this.

3. Improving Practice in Utilising Bilingual Health Staff

It is intended that a policy, for use by chief executive officers and human resource practitioners, will be developed from the discussion generated by this paper. In broad terms, it would be promoting:

- Increased understanding of the various roles played by bilingual staff, interpreters and multicultural health staff;
- A recognition of the settings and situations to which these roles are suited, or are feasible;
- Workforce planning to optimise the employment and use of bilingual staff.

The policy may cover the following areas:

- Identifying the language needs of clients;
- Identifying the current language skills of staff;
- Role definitions: how language skills can be used;
- Confirming proficiency: language assessment/further skills training;
- Matching language needs of clients with available bilingual health staff;
- Recruitment and selection issues; and
- The value of bilingual staff.

The configuration of staff and/or systems required will vary considerably between Area Health Services. As previously indicated, the population of residents with limited English language ability and/or speaking a language other than English at home (LOTE) varies considerably between Area Health Services. Greater attention to the language and cultural needs of the population may therefore be expected from those Areas with a high LOTE population and with greater opportunities to employ bilingual staff. This will also vary between services within an Area.

In many rural areas attention has been focussed in recent years on securing a workforce of professional interpreters – this strategy, and the opportunistic use of existing bilingual staff, are likely to continue to be key concerns for rural health services. In areas with either a significant LOTE population or a concentration of residents from particular language groups, the need for workforce planning in relation to bilingual staff is more pressing – and is likely to be needed at a local level, for individual hospitals (or services within hospitals) and community health services.

The Strategy therefore aims to ensure that health services attend to the needs of defined populations and the needs of specific health services. The nature of the service, its consumers (actual or potential), and the skills required of health professionals to deliver appropriate care are all critical to the management strategy that can be utilised by health services.

For this reason, it is suggested that there be a delineation between Minimum Practice, Improved Practice, and Good Practice, based on size of the Area Health Service and the NESB population covered.

3.1. Suggested Role Delineation

Compliance with the Standard Procedures for Use of Health Care Interpreters (Departmental Circular 94/10) is a minimum requirement for all NSW health services.

Beyond this, the first step towards improving communication with NES clients and utilising bilingual staff, is undertaking a basic analysis of the population and client profile and the language skills of existing staff. From this, bilingual staff can be identified, their willingness to use their language skills ascertained and language proficiency assessed.

The suggested **minimum practice** level, therefore, also includes:

- Using demographic and service utilisation data for non-English speaking (NES) patients to identify the need for bilingual staff;
- Collecting data on existing staff to identify current language use and any gaps between the staff profile and analysis of client needs;
- Identifying and listing bilingual staff in the workplace;
- Clearly defining the roles and functions of bilingual staff, and nominating suitable and willing bilingual staff for language assessment.

At a **minimum practice** level, the use of bilingual staff may simply be *opportunistic*. That is, with relatively dispersed service use by NES clients and low numbers of bilingual staff, using staff to communicate may need to be for expediency or as circumstances arise.

For **improved practice**, a level of intentional action about matching language needs of clients with available bilingual health staff might be expected. This would vary according to the nature of service utilisation and availability of bilingual staff, but there may be particular service areas with distinct patterns of NESB client usage. Greater effort at ensuring effective communication through bilingual staff may therefore be warranted. This practice level therefore additionally includes:

- Matching language needs of clients with available bilingual health staff, where possible.

Five Area Health Services have very large populations of NESB people and significant levels of NES clients utilising hospital and community health services: Central Sydney; Northern Sydney; South Eastern Sydney; South Western Sydney; and Western Sydney.

Pro-active matching of the language needs of clients with available bilingual health staff is warranted. Further, the population, client and bilingual staff analysis will identify where there are gaps between the staff profile and client needs, enabling workforce planning exercises to actively recruit bilingual staff to address these gaps. Therefore, the good **practice** level additionally includes:

- Identifying positions and active recruitment of bilingual staff;

The table below summarises this suggested delineation. The case examples that follow (in section 4.3) further illustrate how these differences might apply.

Table 2: A Possible Delineation of Levels of Practice

DELINEATION	DESCRIPTION	SUGGESTED APPLICATION TO AREA HEALTH SERVICES
MINIMUM PRACTICE	• Use of interpreters in accordance with the Standard Procedures for Use of Health Care Interpreters (Circular 94/10) • Analysis of language needs of clients & language skills of staff • Identification of bilingual staff & language assessment processes • Opportunistic use of available bilingual staff	Central Coast Far West Greater Murray Macquarie Mid North Coast Mid Western New England Northern Rivers Southern
IMPROVED PRACTICE	• Use of interpreters in accordance with the Standard Procedures for Use of Health Care Interpreters (Circular 94/10) • Analysis of language needs of clients & language skills of staff • Identification of bilingual staff & language assessment processes • Matching language needs of clients with available bilingual staff, where possible	Illawarra Hunter Wentworth
GOOD PRACTICE	• Use of interpreters in accordance with the Standard Procedures for Use of Health Care Interpreters (Circular 94/10) • Analysis of language needs of clients & language skills of staff • Identification of bilingual staff & language assessment processes • Pro-active matching of language needs of clients with available bilingual staff • Identifying positions and active recruitment of bilingual staff	Central Sydney Northern Sydney South Eastern Sydney South Western Sydney Western Sydney

4. Role Definitions and Case Examples

4.1. Role definitions – Health Care Interpreters, Multicultural Health Staff & Bilingual Staff

It is important that health managers and staff understand the difference in roles of Health Care Interpreters, Multicultural Health Staff and Bilingual Staff. These roles are briefly defined below (see Appendix 2 for more detailed definitions).

- **Health Care Interpreters** are staff employed within the health system for their proficiency in a particular community language (or languages) and English, and their professional interpreting skills.

- **Multicultural Health Staff** are staff employed in designated positions within Multicultural Health Services. They undertake a range of tasks to ensure that local non English speaking communities have access to health services and information, and that health services are responsive to local needs.

- **Bilingual and Multilingual Health Staff** are staff employed within the health system for their expertise and skills in a particular area of health service provision, including nurses, doctors, allied health staff, clerical and administrative staff. In addition to expertise in health service provision, bilingual staff speak one or more languages other than English (LOTE).

- **An Identified Position (also termed 'targeted' or 'designated' positions)** is a position for which the ability to use one or more cross-cultural skills is recognised as being an essential job component (cross-cultural skills are further discussed in Appendix 2).

4.2 Communication Roles

The above role definitions, as well as the proximity of staff to client care and a number of other aspects of service delivery, impact on the type of communication roles staff can fulfil (the table in Appendix 2 describes features of the communication skills and roles by staff type).

Bilingual health staff need to be in close proximity to the patient and available for their language skills to be useful. The bilingual health professional could communicate with a patient in the patient's preferred language if they are already allocated this patient as part of their direct care role. They may also negotiate to 'exchange' patients to work directly in the patient's language.

In circumstances, where there are no bilingual health staff allocated to the ward/unit/department, or the bilingual health staff do not have the level of skill required to perform the required task in the patient's preferred language, then the interpreter service is the better option. If an interpreter is not available, the Translating and Interpreting Service (TIS) would become the best option.

The following case examples are used to illustrate some of these considerations.

4.3 Case examples

The following case examples are provided to illustrate minimum, improved and good practice in a range of situations:

4.3.1	Use of existing staff	1. Maternity Unit (Improved Practice, Good Practice) 2. Planned - long-term hospital stay (Good Practice) 3. Emergency setting (Improved Practice) 4. Short-stay hospital setting (Improved Practice) 5. Rural setting (Minimum Practice)
4.3.2	Identified positions	1. Community Health (Good Practice) 2. Diabetes Centre (Good Practice) 3. Mental Health (Good Practice)

1. Maternity Unit (Improved Practice, Good Practice)

Hopscotch Hospital *has a busy Maternity Unit. 40% of its patients are of a non-English speaking background, from a number of language groups. 20% of the Unit's staff are bilingual. The NUM, Marie, checks data on both the language background of patients and the language skills of staff. She also raises the matter for discussion in a staff meeting.*

Marie finds that Hopscotch Maternity Unit is making extensive use of the language skills of its Mandarin and Cantonese speaking midwife. Sue, in fact, admits she feels burnt-out with the demands made of her by staff, patients and family. She is happy to utilise her skills and knowledge but wants the team to recognise that she can't be all things to all people. Marie also finds that there is no call for the language skills of her German-speaking nurse. Further, she finds that her staff are consulting frequently with a Spanish-speaking nurse at the Early Childhood Health Centre. While Marie knows there is an Arabic-speaking Multicultural Health worker at the Community Health Centre, it appears that Maternity Unit staff have not had contact with her.

What does Marie do? She is, first and foremost, concerned to ensure maternity patients receive the best possible care. That means ensuring that the most effective communication occurs in any given circumstance. So…

- *The team works out a protocol whereby staff don't assume all Chinese-speaking women become part of Sue's case load, OR that all Chinese patients want to see a Chinese-speaking midwife. Is it urgent? Is she available? Is an Interpreter the preferred option?*
- *It becomes acknowledged that Anna's skills in German are not immediately useful for the Unit. Anna does, however, have experience in teaching cross-cultural communication and so it is arranged that she provide some programs for staff.*
- *A meeting with the ECHC staff discusses streamlined options for referral between the Unit and the Spanish-speaking nurse, including the nurse visiting the Unit before discharge. They also discuss arrangements for the nurse to conduct some ante-natal classes in Spanish.*
- *A meeting is arranged with the Arabic-speaking multicultural health worker, to discuss client needs, staff education, referral options etc.*

2. Planned – long-term hospital stay (Good Practice)

Clareview Rehabilitation Unit

The Rehabilitation Unit at Clareview received a commendation for its excellence in providing culturally and linguistically appropriate care to their NES patients. The unit had participated in a number of research studies that investigated the cultural context of stroke and rehabilitation and the ways in which care for those patients could be improved. There were already a number of bilingual nurses on the ward and the NUM had all languages listed on the Proact system. Because of the planned nature of rehabilitation and the long term stay, staff routinely booked interpreters for assessment, case and family conferences. Where bilingual staff were available, they were allocated as case manager and were responsible for facilitating cultural understanding within the multidisciplinary team, and participation of carers and families in treatment. All staff used translated aids to enhance communication, and specific ones were developed for the major language groups, however, most were pictorial due to the nature of the patients' conditions.

The unit found that involving the family in care was crucial to the healing process and for future discharge home. Often patients would only communicate with the familiar voices of family members and staff had to organise a telephone link in case of distress. Bilingual staff found that the workload and relationship established with some NES families was intense and the NUM had to consult on the best way to deal with this on a case by case basis.

3. Emergency setting (Improved Practice)

Spencer Hospital Emergency Room

The ER is a busy unit with about 30% of patients requiring primary health care services. There are three predominant LOTEs reflected in the patient load, and the unit is fortunate to have recruited bilingual doctors in two of those languages, with the third often covered by the rotating RMOs. Several of the nurses, allied health and technical staff speak a LOTE. The unit has recently adopted a system where all staff have their other languages recorded, as well as those of nearby units (such as X-ray department). This was done as …

One evening an Arabic-speaking woman came in by ambulance, bleeding from a head wound and multiple abrasions on all limbs; she was moaning and her vital signs indicated that she was going into shock. Staff wanted to find out her story – if she had pain or any obvious head or neck injury. While she was being stabilised, it became apparent that she did not understand English and spoke what sounded like Arabic. It was clear that unless an interpreter was already in the unit, it was not possible to call them in to help in the immediate situation. The Arabic-speaking doctor was not on duty, but the technician in the neighbouring X-Ray unit spoke Arabic and, given the seriousness of her condition, was called in. The doctor on duty said "Find out anything you can – what happened to her; where her pain is; has she eaten…"

Once the new system was in place, the Unit Manager found that time was saved when a NES patient was admitted. Nurses who spoke other languages were listed on the Proact system and it was easy to check their rosters. Given the high level of usage by the three major groups, a rostering system was designed so that nearly all shifts had someone who spoke those languages rostered on. As the Unit Manager explained "In emergency situations, you will try and communicate in any way you can – but the key factor is to treat the medical condition. That is our priority". The unit decided to develop a multilingual discharge information sheet for patients to explain basic but vital information on their diagnosis, duration of stay and treatment.

4. Short-stay hospital setting (Improved Practice)

Noble Medical Ward

Noble Medical Ward is a 30-bed short-stay unit treating patients with a range of conditions such as liver failure, respiratory and cardiac conditions. Patients are admitted through emergency services or from GP referrals. Admissions are generally planned and in some cases, patients may become "regulars" and known to staff. About 15% of patients are from varying language groups, most with extensive family contact while in hospital. The unit has six bilingual nursing staff and the occasional bilingual rotating RMO. There was no explicit matching of NES patients with bilingual staff, and bilingual staff were often being called on by family to assist in information or support even while they were not directly responsible for that patient.

Juliana, the Nurse Unit Manager, who was keen to develop a reputation for excellence in her unit discussed the issue of communication with NES patients with staff, using a Quality Improvement framework. The staff came up with a number of strategies that they agreed to trial for 3 months:

- *Admission staff asked all patients what languages they spoke; how well they understood and spoke English and were told that while they were in hospital, staff would request an interpreter to help them in particular situations – such as explanation about treatments, consents for procedures and discharge. Staff used a translated brochure to assist in providing this information, or used the telephone interpreting assistance of TIS.*
- *Their LOTE was noted on the board beside their name with a code for whether an interpreter was needed. The interpreter service was notified and informed about a time to visit.*
- *Bilingual staff who spoke their language were asked how they felt about being allocated that patient (taking into account patient dependency level as well as family context).*
- *Staff were either allocated the patient during their stay, or were asked to formally check in with the patient at the start of each shift. Should other staff need assistance in communicating with the patient, they would be called on, but given some "trade-off" which they negotiated (one nurse agreed to do the medication round). Nursing staff notified doctors that they could not be used to interpret for consents.*
- *'Trade-offs' were also negotiated between staff in relation to individual patients, such as aspects of their care. For example, 'swapping' clients for giving medication or teaching a patient how to take their blood sugar. Direct communication between staff member and patient (ie involving two people) was, in this way, maintained as far as possible.*
- *The NUM developed a list of staff's language proficiency. This information was available to all staff as an attachment to the policy on language use. Training was provided on policy implementation and staff were made aware that language use was limited to the direct care role and to facilitating communication on matters within their area of expertise.*
- *The NUM would speak with the patient and their family about the ward policy on bilingual staff and ask that they respect the needs of staff as well. If the patient or their family felt that they needed anything, they were not to wait until the bilingual staff member was on, but were to ask other staff. A sheet with translated phrases and pictures was given to the patient to keep by their bed so they could communicate basic needs at times when an interpreter or the bilingual staff member were not available.*
- *Interpreters were booked once a discharge date was known, although this was always hard to predict, given the variable need for beds. However, staff believed that good discharge information was crucial to prevent unnecessary re-admission.*

5. Rural setting (Minimum Practice)

Wattle Creek Hospital
Wattle Creek Hospital had very small numbers of NES people in their catchment area, but when they were admitted, communication posed a major problem. The Health Service did not have a local health care interpreter service and had to rely on a neighbouring Health Service, four hours away. The major town had a few bilingual community and welfare workers, and the Health Service had identified two bilingual staff. In collaboration with the Ethnic Affairs Commission, they identified key people in the community who had some proficiency in a LOTE and asked them to participate in developing their skills. Those who agreed undertook a specific intensive language skills course and were tested for their proficiency. Medical terminology was included. Once they were assessed as competent, bilingual workers were encouraged to gain interpreting skills and to take the NAATI test. Training was done in work time and additional time was granted for them to study and sit tests. The Health Service recognised their efforts with a Certificate of Appreciation.

However, not all languages spoken within the community were covered by NAATI accredited interpreters. The Health Service continued to use language skills available within the community in emergency situations. For example, a Lao speaking worker from the local council was called in to help out when a young man speaking Lao was involved in a car accident. This enabled the staff to ascertain essential, basic information immediately and then follow-up with the interpreter service in the neighbouring health area.

4.3.2 Identified positions

1. Community Health (Good Practice)

Long Town Community Health Primary Health Nursing Team
Long Town Community Health Service has a significant population of elderly Chinese-speaking people. The Primary Health Nursing Service has a number of Chinese-speaking clients, however team members have reported a number of concerns. Referrals come through, but there is a high service cancellation rate following assessment. Nurses have noticed a low rate of compliance with various treatments. A high rate of acute admissions to hospital, followed by re-referral of these clients, is apparent. This is compounded by the fact that an Interpreter can be arranged for assessment, but this cannot be guaranteed for ongoing visits.

The Primary Health Nursing team decides to 'identify' a position for a Chinese speaking nurse. That is, in addition to the usual selection criteria covering qualifications, experience and skills, fluency in Cantonese becomes an essential criterion, as does a requirement that applicants demonstrate an understanding of the impact of cultural factors on primary health care. The nurse in this position will have the usual duties of a PHN but will also have some Chinese-speaking referrals allocated. The nurse will also provide case advice to other team members and will coordinate community education and health promotion work with this community, for the team. The workload for the position will be adjusted accordingly.

6 months after recruiting to the position, the Team Manager sees evidence of increased service utilisation by Chinese-speaking clients, due to both an increase in referrals and a decrease in service cancellations. Some evidence of improved client outcomes is also emerging.

2. Diabetes Centre (Good Practice)

St Zacchary Hospital Diabetes Centre

It has been noted over the last few years that the number of Russian patients referred to the St Zacchary's Diabetes Centre has increased significantly, so when one of the educators takes leave to finalise a research project her position is advertised with "Fluency in Russian" as an additional essential criterion. Natasha is employed for a year and she sees all the Russian patients on an individual basis.

St Zacchary's Diabetes Centre has had a reputation of providing very well received group education sessions in English or to NES groups using interpreters. Natasha is asked to organise such a series of sessions for a Russian group. Rather than ask a variety of other professionals eg. A dietitian, a podiatrist, an eye specialist etc to present a number of talks, Natasha spends some time with them and with their help she prepares lecture material, such as overhead transparencies and questionnaires in Russian. As Natasha is not confident with her Russian writing skills she pilots the information with some Russian clients and then organises for the payment of a Russian translator to check the material, to ensure there are no spelling mistakes and the language is appropriate for her group. Natasha actually delivers the talks herself, directly to her clients. Relevant other professionals are invited to attend particular sessions to answer any questions, perhaps through an interpreter; and if appropriate, to provide some physical care eg examine patients' feet. As Natasha speaks to the group members directly in their language it is easier to command their attention and to adjust her language register. She is also able to discuss diabetes management issues with the group, within an appropriate cultural context.

3. Mental Health (Good Practice)

Shortfield Mental Health Service

Shortfield has experienced a steady growth in recent years in the population of Vietnam-born residents, however the number of Vietnam born clients using mental health services is very low. Joe, Team Leader of the Mental Health Team, has had a number of discussions with the local Vietnamese community worker at the Migrant Resource Centre and gains a picture of the community. It is a mix of those who arrived in the 1980s, settled initially in Long Town but now moving into Shortfield, and more recently arrived people under the family reunion program – the latter tending to be parents of the former.

Joe further investigates with STARTTS, with local GPs and with a Vietnamese Counsellor in another area. In general terms, this community can be characterised as having an adult population of people who were likely to have experienced torture and trauma; this same group appears to be experiencing high levels of unemployment. The more newly arrived, but older residents, might be expected to be experiencing isolation due to poor English language ability and problems in adjusting to their new country and environment.

Couldn't it be expected that the Vietnamese community has the same, if not greater, needs for mental health services? Yet the service has received no referrals. The Vietnamese Counsellor, however, reported she was inundated with calls from all over the region and frequently is anxious about how and where to refer. Joe decides to identify a team position for someone who speaks Vietnamese. He checks with Multicultural Health staff in his area, and while he recognises that the availability of qualified mental health nurses, social workers, psychologists and other allied health staff who speak Vietnamese is not great, it's nevertheless worth a try. He advertises for a Vietnamese speaking person experienced in mental health service provision and with one of a range of relevant qualifications.

Joe will use this position to assist in addressing the mental health needs of the local Vietnamese community, as well as fulfil other mental health team functions.

5. Implications of a Bilingual Health Staff Communication Strategy

5.1. Issues highlighted by case examples

The case examples illustrate a number of factors that effect how use of bilingual staff can be implemented or improved:

- Population and service utilisation patterns
- Considerations of proximity and matching
- The relative utility of roles
- Understanding the difference between 'interpreting' and 'facilitating communication'
- Valuing staff and the importance of choice and negotiation

5.1.1 Population and service utilisation patterns

The obligation to ensure that communication with NES clients or patients is effective is not, in itself, a 'numbers game'. That is, duty of care considerations oblige health care providers to address language and/or cultural barriers, regardless of whether a provider encounters a client or patient with limited or no English once a year or twenty times a day.

However, the population profile of an Area Health Service clearly influences the extent to which effort needs to be applied to addressing the needs of NESB consumers. The higher the NESB population, the more likely it is that clients or patients will have limited or no English, and the potential for matching their language needs with bilingual staff also increases. This in turn effects the extent to which attention to data collection on the language skills of staff, and to workforce planning to meet identified gaps, is necessary to ensure quality service provision.

Hence, the suggested delineation in practice levels (as described in section 3.1) is an attempt to recognise these differences and guide Areas about appropriate strategies to implement.

5.1.2 Considerations of proximity and matching

Bilingual staff need to be in close proximity to the patient and available, for their language skills to be useful. However, there is no simple formula for how bilingual staff can be best used or the extent to which changes in the work of a unit or department are necessary. While data on service utilisation and the language skills of staff are proposed as important starting points for determining use, judgments still need to be made about how and when use of bilingual staff will be effective.

The nature of the communication required is an important factor and can range from giving directions to obtaining written consent for a surgical procedure. These communications have related linguistic complexity and may appear simple in their meaning but may require complex language skills. It is important to take into consideration the role of the health professional who would normally deliver this care or communication.

The planned or unplanned nature of the encounter will influence the selection and indeed the possible resources available to a health staff member or manager. The care needs of the patient and the need to do no harm are important considerations, but wherever time permits, effort should be invested in the best possible communicator within these limitations.

The length of stay of the patient may vary from a brief encounter or more long term care over weeks or months. The average length of stay of a particular service would influence the

communication support roles that managers would be considering for their health staff. This length of stay also influences the selection of the most appropriate staff member for the communication task.

In brief, the key considerations for a service are:

- Planned or unplanned admissions
- Length of stay of client – short term or long term
- Availability and language competence of staff
- Opportunity – to match staff language skills with client need.

5.1.3 The relative utility of roles

As indicated by the role definitions provided (section 4.1 and Appendix 2), Interpreters, Multicultural Health staff and Bilingual staff have different roles to play in the health system and, hence, different skills and experience. The relative strengths and weaknesses of these roles is summarised below.

Interpreters are accredited at a particular level of language proficiency ('para-professional' or higher), by the National Accreditation Authority for Translators and Interpreters (NAATI), and have professional interpreting skills. A far greater range of languages is available than that covered by multicultural health staff, or has been evidenced by data on the language skills of health professionals.

Health care interpreters receive training in medical terminology and continuing in-service education, however they do not usually have a clinical background. As Health Care Interpreter Services are currently structured (to work across one or more Area Health Services), interpreters' encounters with clients and patients tend to be brief and discontinuous.

Multicultural Health Staff provide an important 'consultancy' role to mainstream staff. They undertake a range of tasks to ensure that local non-English speaking communities have access to health services and information, and that health services are responsive to local needs. The focus of this paper is on direct care, however multicultural health staff are not alternative care providers; their positions are designed to address issues of access, community development and health promotion.

This is, therefore, a small workforce with specialised roles – which rarely include direct care. Some multicultural health staff are employed within a clinical setting and provide a direct care role to clients who speak the same language. Positions include Ethnic Obstetric Liaison Officers, ethnic health workers employed for example in a renal unit.

Bilingual Health Staff are able to directly communicate with clients and patients in a common language, and potentially with a shared cultural understanding. Care can be provided in the usual manner. *Communication between bilingual health professionals and non-English speaking background (NESB) clients in a common language, is therefore considered to be the optimal means of service delivery.*

However, the proficiency of bilingual health staff in their LOTE may range from a simple social, or 'conversational', level to a complex and technical level. This, clearly, affects the range of communication tasks possible and the extent to which the staff member can perform their normal duties in both English and the LOTE. Hence, suitable tools for assessing

language competence need to be developed (see section 5.2 The need for language assessment tools).

If the staff member is not in an identified position, it is unlikely that if they leave, their replacement will also have the same language skills. Although the number of bilingual health professionals has increased in recent years, there are significant supply problems. There are, for example, few registered nurses that speak Arabic or Vietnamese and health professionals are less likely to exist amongst small or recently arrived communities.

The strategy of **identifying positions** for a particular language, is useful when assuring the availability of a particular language/cultural group will mean the service can be used by that group and that acceptable, high quality care can be provided. Bilingual workers are the most effective strategy available for improving access to services.

Identifying positions will not be useful when a significantly different approach or a specific service is needed, or when the mainstream position skills are not available in the identified community. STARTTS, for example, was a specific service established to meet unique needs of overseas-born people who had suffered torture and trauma. A further example would be employing a health promotion officer to work on a range of mental health issues with the Lao community. This strategy would be more feasible, and more appropriate, than attempting to employ a social worker or psychologist.

Hence, these various roles are not 'substitutes' for each other. In a complex system, it is assumed that there are ample opportunities for maximising the chances of communication in the client's preferred language through interpreters, multicultural health staff *and* mainstream bilingual staff. Attention is needed, in today's health care system, to clarifying and promoting the role that bilingual health professionals can play.

5.1.4 Understanding the difference between 'interpreting' and 'facilitating communication'

The difference between interpreting and direct communication is often not well understood. It appears that this is particularly so where one person requests another to communicate to a third person, in a different language. In the case of interpreting, the interpreter must receive and understand a message from one of the parties, expressed in a particular language. The interpreter must then rapidly convert the message into another language and finally transmit this to the other party.

The process is rarely one of substituting words in one language for words in another. Instead, concepts must be transformed from a source language into equivalent concepts in a target language, often involving substantial rearrangement of word order so that the target language version is accurate and complete. Clearly, such a transformation process is not required in direct communication.

In the SWSAHS study (see section 1.3), it was found that staff frequently referred to interpreting when they were in fact describing a process of facilitating communication, that is direct communication with a patient on behalf of another health care provider. Improved understanding of this distinction is central to a *Bilingual Health Staff Communication Strategy.*

5.1.5 Valuing staff and the importance of choice and negotiation

The SWSAHS research found that 'bilingual staff are perceived by both bilingual and monolingual groups as an asset that is underutilized and largely unrecognised by the health care system'[xxv]. Bilingual staff can, and do, fulfil valuable roles within the health system.

A number of the case examples illustrate the importance of choice and negotiation, in effective management and support of bilingual staff. Staff must be able to choose whether or not, and when, to use their language skills. Further, use of this skill may have an impact on both the individual's workload and the workflow of the team with whom they work. Managers therefore need to negotiate with the staff member, in the first instance, about the nature of their communication role and whether there needs to be limits or boundaries around that role.

5.2. The need for language assessment tools

Reference has been made (in section 3 and section 4) to language assessment processes. Clearly, if NSW health services adopt a more standardised and pro-active approach to utilising bilingual staff, valid tools for assessing language proficiency are needed. Currently, there is no tool available for testing the proficiency of health professionals in languages other than English.

SWSAHS, in partnership with SESAHS and the Language Testing Research Centre (LTRC) at the University of Melbourne, is currently conducting a research project for the development of such tools. The LTRC have considerable expertise in this type of test design, as well as expertise in health services communication. It is intended that two instruments be designed - a self-administered test for simple social use, and a complex/technical language test for those bilingual health staff who consider they are more proficient and wish to be tested. It is envisaged that passing this test would allow staff to use their language, *in the course of their normal work*, in more complex areas such as assessments, diagnosis and consents (if this is what they would do in English).

It is considered important that any tools developed are easy and inexpensive to administer, but nevertheless adequate to deal with the complexity of health care language and the communication needs of varying disciplines.

5.3. Potential Concerns

A number of concerns have been raised about use of bilingual staff or active employment of bilingual staff.

Is this discriminatory?

The idea of positive recruitment into EEO groups is not new. The current EEO Outcomes Framework provides for the targeting of mainstream positions for women, people with a disability, Aboriginal people and Torres Strait Islanders and people whose first language was not English[xxvi].

The Anti-Discrimination Act (1977) has always made provision for targeting positions or services for particular groups and the Anti-Discrimination Board has therefore also provided detailed guidance to employers, on where it is acceptable to target jobs or services and where applications are required for exemptions to the legislation[xxvii].

Exemptions are not required for interpreter positions or multicultural health worker positions. Exemptions are also not required for targeted positions that are listed in a public

sector agency's EEO Management Plan (as approved by ODEOPE). Exemptions do need to be requested in situations where being of a particular of a particular race or ethnic group is not essential to performing the job. The ADB advises that applications for exemption need to show that targeting the job will help redress past or present injustices experienced by the particular group.

Will it undermine the use of Interpreters?
This discussion paper asserts that direct communication between bilingual health professionals and non-English speaking background (NESB) clients in a common language is the optimal means of service delivery. However, this assertion is made within the context of recognising complementary staff roles and with the explicit expectation of compliance with the Standard Procedures for the Use of Health Care Interpreters (Departmental Circular 94/10).

Consistent with this paper, Health Care Interpreter Services are concerned that health care providers are vigilant in ensuring communication with NES patients and clients is adequate. This means that NSW Health and Area Health Services should be continuously attentive to whether HCIS resources are adequate for the level of demand, since use of bilingual staff is unlikely to ever meet the health care needs of all NES patients and clients.

Will work practices have to change?
This depends upon the role delineation adopted and upon the extent to which health service managers have currently been addressing the issue of language use by bilingual staff. If managers want to make good use of the skills available within their workforce to improve patient or client outcomes, then changes in work practice will make good sense.

Is it legal? What about consents?
Apart from Anti-discrimination considerations (as discussed above), there are valid concerns about medico-legal issues relating to poor communication with NES patients or clients. This paper suggests that a formal recognition that bilingual health professionals exist and can provide valuable care in their particular LOTE, needs to be accompanied by a clear understanding of the roles they can play and a means of assessing their proficiency in the relevant language.

It has already been noted that consent obtained without adequate bridging of the communication gap between provider and client, is unlikely to be informed.

Therefore, as well as proposing that language proficiency be assessed by validated assessment tools, this paper also proposes that the task of obtaining consent be limited to those staff assessed as proficient in their LOTE at the complex level and for whom obtaining consents is a part of their normal role.

Otherwise, interpreters remain the appropriate method of obtaining informed consent with NES clients, as indicated in the Standard Procedures for Use of Health Care Interpreters (Departmental Circular 94/10). A *Bilingual Health Staff Communication Strategy* would not, for example, sanction the use of a nurse to interpret for a doctor seeking consent from a patient.

What rights do bilingual staff have?
While use of staff language skills has significant benefits for both clients and providers, there are implications for the bilingual staff member and the team in which they work.

Unless in an identified position (where the use of a community language is explicitly part of recruitment and selection), bilingual staff can expect the support of their manager in determining the nature of their communication role and what limits need to be placed on that role. It is, further, important that bilingual staff have the right to call an interpreter in situations they consider beyond their level of skill or which are sensitive.

What rights do patients have when their language needs are not met?
It is NSW Health policy that health care clients have a right to an interpreter (as indicated in the Standard Procedures for Use of Health Care Interpreters, 94/10). This derives from duty of care obligations upon health professionals, including to ensure that:

- communication is accurate;
- all relevant information relating to treatment, potential risks and side-effects etc, are disclosed; and
- consent to a procedure or treatment is informed.

As for other aspects of health care provision, clients have a right to make a complaint if their language needs are not met, through Area Health Service complaints handling processes and/or the Health Care Complaints Commission.

5.4. The role of Managers in implementing the Strategy

Development of a *Bilingual Health Staff Communication Strategy* will have an impact, to varying degrees, on the work of health service managers. It could represent anything from the opportunity to standardise existing practice, to a radical shift in how work is conceptualised and organised. For some managers, it will represent 'business as usual'; that is, managers are experienced in managing and supporting bilingual staff and have recruited into identified positions. For others, it may mean a fundamental rethinking about how language skills can be an asset to the service they manage.

While health service managers are undeniably busy people who operate with limited resources, these various roles fit comfortably with managers who attend to quality improvement and to a focus on patient or client outcomes.

5.4.1 Analysing language needs of clients and language skills of staff
It is expected that data collection work in relation to population, service users and staff language skills, would be undertaken by the Area Multicultural Health Coordinator, Human Resource Managers or Area Planning Unit staff (or possibly by each, in collaboration). Managers, however, would need to analyse this information in relation to their own service and identify gaps between the staff profile and analysis of client needs.

5.4.2 Defining and supporting the roles of bilingual staff
For many managers, this would then extend to work in relation to defining the roles of bilingual staff and organising to match the language needs of clients with available bilingual health staff. It would also involve overseeing the process of staff undertaking language assessment.

This would be accompanied by the need to negotiate the roles and workload of bilingual staff, to support these staff in this regard, and to ensure the team understands the nature and purpose of this work. Rostering difficulties may be encountered, particularly in inpatient settings. The considerable benefits that can be expected from use of bilingual staff will only be fully realised if time is invested in discussion and clarification of these issues and staff are effectively supported.

5.4.3 Recruitment and selection practices

For some managers, responsibility would further extend to identifying positions and active recruitment of bilingual staff (as per the proposed role delineation, see section 3.1). In doing so, managers would need to consult with their Area Multicultural Health Coordinator and Human Resources Manager.

This will involve tasks such as review of job descriptions when vacancies occur, to consider the inclusion of language skills as essential or desirable; attention to recruitment methods (for example, where to advertise a particular position); and attention to the interview and/or orientation process (for example identifying the bilingual skills of new staff, and their willingness to use their skill). Managers will also need to be aware of the danger of equating linguistic competence with sensitivity to cultural issues. The following cautionary note made in a recent US report recommending standards for cultural competence in health care makes this point:

> *'Bilingual-bicultural staff will have greater likelihood of facilitating communication directly with patients whose language they are proficient in, and may be more sensitive to certain cultural issues. However since country of origin, acculturation levels, social and educational standing may vary considerably among individuals, this sensitivity cannot always be assumed'*[xxviii].

This same report recommends that cultural competence training be provided to these staff, as is recommended for other staff.

It is proposed that guidelines accompany the adopted policy, to provide practical assistance in implementing these tasks.

5.5 What are the Benefits?

The benefits of improved use and increased employment of bilingual staff can be significant, particularly for health care consumers. The SWSAHS study has already established that communication with a NES patient in their language goes a long way towards easing the anxiety and isolation of patients in acute care settings.

For patients and clients, the benefits also include increased understanding of diagnosis and treatment, which may lead to improved compliance with treatment and hence to increased satisfaction with services provided, and improved clinical outcomes. For service providers, costs may be reduced (tests undertaken, staff time), and staff workload and stress may also be reduced.

As has been acknowledged by NSW health services over some 20 years of EAPS implementation, delivering culturally competent health care requires a comprehensive approach. No one strategy, within a complex and diverse system of care, can provide the 'answer'. However, the role of bilingual health professionals in providing culturally competent care deserves far greater recognition than has been given to date. As stated at the

outset of this paper, more attention needs to be paid to the clinical context of language use in order to ensure that effective communication occurs between providers and NESB clients. Bilingual health professionals have a vital role to play in this regard.

This Discussion Paper has attempted to canvass the major issues, in terms of both policy and practice, for organisations and individual providers. Area Health Services and other key stakeholders are therefore asked to respond to the issues raised and proposed elements of the strategy, so that an effective and achievable policy can be developed.

APPENDIX 1A: CULTURAL DIVERSITY & HEALTH CARE – THE POLICY CONTEXT & QUALITY CARE

Attention to cultural diversity and health care is motivated and/or obligated by government policy, legislation and concern to deliver quality care. In this sense, several purposes are served by effective utilisation of bilingual staff. The main considerations are:

- Social justice & NSW Ethnic Affairs Policy
- Employment equity & managing for diversity
- Providing culturally competent health care

Social justice & NSW Ethnic Affairs Policy
Since 1983 NSW government agencies have been required to prepare Ethnic Affairs Priority Statements (EAPS) and report annually on progress in their implementation. At this time, the term *mainstreaming* was also introduced to make explicit the expectation that 'mainstream Government structures … do the changing and adapting to reach all members of the community more effectively'[xxix]. The intention was that government services not marginalise efforts to improve service provision to people of NESB by relying upon 'special' staff and programs, but rather modify their structure and operations to meet the needs of an increasingly diverse population.

NSW Health translated these requirements into two main policy principles:
- The right of equality of access to health services regardless of ethnic origin or linguistic skill;
- The responsibility of the health system to respond appropriately to the specific needs of different groups in the community, including ethnic minority groups.

Today, the *Principles of Cultural Diversity* form the cornerstone to NSW Ethnic Affairs Policy, which also has a legislative base – the Ethnic Affairs Commission Act. These principles encompass ideas about people having opportunities to participate in public life; about respect for difference in culture, language and religion; promoting access to services; and valuing and utilising the population's cultural and linguistic assets (See Attachment 1: Principles of Cultural Diversity).

Employment of bilingual staff is, therefore, one important means of increasing the ability of the mainstream workforce to deliver services to a diverse population and is a demonstrable act of utilising the cultural and linguistic assets of the state's population. Bilingual staff may serve to foster respect for cultural and linguistic difference and assist the organisation to accommodate diversity, in its service provision. In some instances, purposeful employment of bilingual staff can also be used (and has been used) to increase access to health services.

Employment equity & managing for diversity
In NSW, equal employment opportunity (EEO) is enshrined in the Anti-Discrimination Act, which requires government agencies to:
- Eliminate and ensure the absence of discrimination on grounds covered by the Act; and
- Promote equal employment opportunity for women, members of racial, ethnic and ethno-religious minority groups, Aboriginal and Torres Strait Islander people and people with a disability.[xxx]

While EEO is commonly thought of as removal of barriers to employment and/or to promotion, positive recruitment from the specified groups is also included and is by no means a new idea. The need for organisations to actively recruit from the EEO groups has been recognised by the Anti-Discrimination Board for some time, with guidelines first issued on this in 1990[xxxi]. Prior to this, the NSW Public Service Board (now defunct) also issued guidelines on the identification of positions requiring cross-cultural skills in 1987[xxxii]. The NSW government promoted this strategy as serving both to implement *mainstreaming* and to increase employment opportunities for people of non-English speaking background.

Currently, the EEO Outcomes Framework includes a *diverse and skilled workforce* as a program outcome, with the key result that 'diversity in the workforce reflects the diversity of the NSW community'[xxxiii].

Culturally competent health care

Besides policy and legislative requirements, health services and individual health professionals are motivated by a desire to deliver high quality care. The term 'culturally competent health care' is increasingly being used in Australia and overseas, as a shorthand way of expressing the skills, knowledge and approaches required to accommodate language and cultural differences in a sensitive and meaningful way.

Cultural sensitivity has been defined *as "an awareness of the nuances of one's own and other cultures*".[xxxiv] The same authors define **cultural competence** as *"a set of academic and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among and between groups."*[xxxv] There is no simple 'formula' for cultural competence; it is often easier to illustrate by what it isn't, than what it is. Cultural competence does not imply a need to know other cultures, in any detailed sense, and it certainly isn't about assuming that a set of beliefs, values or customs apply uniformly or rigidly to people from a particular birthplace or language group. It, rather, implies openness to the fact that values and beliefs may not be shared between provider and client and recognition that an individual's needs and preferences are shaped by a complex interplay between, for example, life experiences, gender, religion, class and culture.

It is important to recognise that cultural competence has meaning for both health care organisations and individual providers. A recent USA report recommending standards for cultural competence in health care, while acknowledging the range of definitions available in the literature, adopted the following definition:

> *'Cultural and linguistic competence is a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behaviour that include the language, thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups. 'Competence' implies having the capacity to function effectively as an individual and an orgnisation within the context of the cultural beliefs, behaviours and needs presented by consumers and their communities'*[xxxvi].

Certainly, the use of strategies to overcome language barriers is central to providing culturally competent health care. Since communication is the cornerstone to most health care encounters, the presence of a language barrier seriously jeopardises diagnosis and treatment. It is also a factor in under-utilisation of health services. The consequences of failure to overcome the language barrier have been investigated and documented in a number of studies, and can be summarised as follows:

- **Poor exchange of information**, which can lead to misdiagnosis and/or poor understanding for the patient of their diagnosis and treatment;
- **Increased costs**: Limited communication in the diagnostic interview may lead to increased reliance upon tests, or conversely a failure to recognise the need for a particular test. There is evidence of a higher rate of resource utilisation - increased use of diagnostic tests and length of stay - in Emergency Departments, associated with a language barrier between provider and patient. Language barriers have also been associated with longer workdays for RMOs.
- **Compromised Care**: Poor understanding of diagnosis and treatment may effect compliance with treatment. Language barriers have also been associated with patient dissatisfaction, poor clinical outcomes and ineffective patient education.
- **Ethical and medico-legal problems**: It is highly likely that consent obtained without adequate bridging of the communication gap, by the use of professional interpreters, is not informed.
- **Increased work and stress for staff** was found in an American study of the impact of language barriers on residents[xxxvii]. Increased length of workdays, increased daily stress and reduced teaching effectiveness were all evident.
- **Isolation** created by the inability to communicate with health workers or others has been noted within the hospital environment and in the community.
- **Decreased use of health services** has been documented in Australia and overseas, stemming from both language barriers and cultural differences.

APPENDIX 1B: ROLE DEFINITIONS - HEALTH CARE INTERPRETERS, MULTICULTURAL HEALTH STAFF & BILINGUAL STAFF

Health Care Interpreters are staff employed within the health system for their proficiency in a particular community language (or languages) and English, and their professional interpreting skills. Health Care Interpreters in NSW are required to have at least 'para-professional' accreditation (formerly 'Level 2') from the National Accreditation Authority for Translators and Interpreters (NAATI). Health Care Interpreters are also expected to have undertaken further training in medical terminology and other aspects of health care.

Interpreting is 'the oral rendering of the meaning of the spoken word from one language to another'. *Translation* 'is concerned with the written conversion of a text from one language into another language'[xxxviii]. The difference between interpreting and direct communication is often not well understood. It appears that this is particularly so where one person requests another to communicate to a third person, in a different language. In the case of interpreting, the interpreter must receive and understand a message from one of the parties, expressed in a particular language. The interpreter must then rapidly convert the message into another language and finally transmit this to the other party[xxxix].

The process is rarely one of substituting words in one language for words in another. Instead, concepts must be transformed from a source language into equivalent concepts in a target language, often involving substantial rearrangement of word order so that the target language version is 'accurate, complete, idiomatically appropriate and conveys wherever possible the same subtleties and nuances as the original'[xl]. Clearly, such a transformation process is not required in direct communication.

Multicultural Health Staff are staff employed in designated positions within Multicultural Health Services and include, for example, Multicultural Health Workers, Multicultural Health Promotion Officers, Ethnic Obstetric Liaison Officers and Bilingual Counsellors. These staff are usually employed to work with a specific language or cultural group. They undertake a range of tasks to ensure that local non English speaking communities have access to health services and information, and that health services are responsive to local needs.

Bilingual and Multilingual Health Staff are staff employed within the health system for their expertise and skills in a particular area of health service provision, including nurses, doctors, allied health staff, clerical and administrative staff. In addition to expertise in health service provision, bilingual staff speak one or more languages other than English (LOTE). The position was not targeted to a specific non-English speaking community and therefore having a language other than English was not specified in the advertisement as an essential criterion. These staff will not have had their skill in a language other than English tested at interview. Other interviewees who were not bilingual would not be culled from the interview process.

An Identified Position (also termed 'targeted' or 'designated' positions) is a position for which the ability to use one or more cross-cultural skills is recognised as being an **essential** job component. In the context of this paper, the cross-cultural skill referred to is the ability to speak a language other than English with varying degrees of fluency and the positions are in mainstream services. There may be other cross-cultural skills that are an essential component of the job. For example the ability to write in another language, a knowledge/understanding of cultural issues, the ability to provide specific tasks in a cultural context.

These skills are essential because:

- The job involves delivery of services to people of a particular race or background;
- The services are to promote well-being of people of a particular race or background; and
- The most effective way of providing these services is if a person of the same race or ethnic background provides them.

Cross-cultural skills are those skills necessary for effective work in a multicultural society. The term encompasses a variety of abilities and special knowledge. Cross-cultural skills can be identified for employment purposes at three levels:

a) Knowledge/understanding of cross-cultural issues. Depending on the nature of the position identified (whether it involves direct contact with the public or supervising staff or policy advice, etc.) a candidate may be required to have a knowledge or understanding of **general** issues (eg. Issues affecting people of non-English speaking background, commitment to multiculturalism, knowledge of multicultural issues) and/or **specific** issues (eg. Understanding of employment/welfare/housing needs of people of non-English speaking background; understanding of issues involving EAPS; knowledge of mental health needs of refugees).

b) Practical skills to do specific tasks in a cross-cultural context. These are usually communication skills requiring the ability to speak or write with varying degrees of fluency a language or languages other than English.

c) Experience in specific tasks. For some positions, experience may be preferable to mere knowledge/understanding of cross-cultural issues or untested practical skills in cross-cultural communication (eg. Experience in working with Khmer speakers with intellectual impairment). In general care should be taken in specifying experience as a requirement for identified positions since this criterion may unjustifiably limit the applicant pool.

Source: Public Service Board of NSW, 1987, *Job Skills to Serve A Multicultural Society*

Communication Roles

The above role definitions, as well as the proximity of staff to client care and a number of other aspects of service delivery, impact on the type of communication roles staff can fulfil. The table on the following two pages describes features of the communication skills and roles for Interpreters, Multicultural health staff and 'Communication facilitators' (bilingual health staff).

Table 3: Communication skills and roles of Interpreters, Multicultural Health Staff and Bilingual Staff

Feature	Interpreter	Multicultural Health Staff	Bilingual Staff (as Communication Facilitators)
• Language skills • Other language facilitation skills	NAATI accredited Paraprofessional Level Or Professional Level Skills of simultaneous and/or consecutive interpreting.	Quals overseas Assessed at selection panel (language specific oral and written test) Or NAATI accredited Paraprofessional level or Professional level	Quals overseas Or NAATI accredited Paraprofessional level or Professional level Or Social language self-assessment Higher language skills assessment (OET)
Nature of communication/interaction • Communication between direct care giver and client • Dyadic (meaning two persons involved and direct face-to-face communication). There may also be another person present but not directly involved in the communication. • Triadic (three way communication, where the facilitator assists two other parties to communicate; the direct lines of communication are between persons other than the facilitator).	Triadic communication (estimate 100% of communication)	Communication between direct care giver and client (estimate 95% of communication) Dyadic (estimate 5% of communication)	Communication between direct care giver and client (estimate 99% of communication) Dyadic (estimate 1% of communication)
Nature of the relationship to the client • Limited • Developing throughout the course of their episode of care • Beyond the current episode of care	Limited	Limited Developing throughout the course of their episode of care Beyond the current episode of care	Limited Developing throughout the course of their episode of care
Patient/client responsibilities • No direct/indirect client health care responsibilities • Direct care provider • Case Manager • Advocacy	No direct/indirect client health care responsibilities	Direct care provider Advocacy Case Manager[1]	Direct care provider Case Manager Advocacy
Relationship with other health care providers • Health care provider is the client	Health care provider is client	Consultant (gives advice to other health care staff)	Consultant (gives advice to other health care staff)

[1] In some cases, such as Bilingual Counsellors

Feature	Interpreter	Multicultural Health Staff	Bilingual Staff (as Communication Facilitators)
• Assists in health care provision through communication • Consultant (gives advice to other health care staff) • Shared responsibility for clients		Shared responsibility for clients	Shared responsibility for clients Assists in health care provision through communication
Nature of the contact • Intermittent • Continuous • Expected to be of short (days)duration • Expected to be of long (weeks) duration	Intermittent	Intermittent and continuous Expected to be of short duration Expected to be of long duration	Intermittent and continuous Expected to be of short duration Expected to be of long duration
Scope of Language Use • Social • Social/Technical • Written and verbal consent • Formal interpretation	Formal interpretation	Social/Technical	Social Social/Technical Written and verbal consent[2]

[2] If this falls within the normal role of the staff member

APPENDIX 2

SOUTH WESTERN SYDNEY AREA HEALTH SERVICE
BILINGUAL STAFF IN MAINSTREAM HEALTH SERVICES RESEARCH PROGRAM
POLICY DEVELOPMENT RERENCE GROUP

Terms of Reference

1. To oversee and give direction and support to the implementation of the project and ensure that the objectives of the project are met.
2. To advise on aspects of research methodology.
3. To develop policy relating to bilingual staff and identified positions, for submission to NSW Health Department.
4. To ensure that time frames for the project (policy development) are met.

Membership

Professor Maree Johnson	South West Sydney Centre for Applied Nursing Research
Ms Cathy Noble	Area Coordinator, Ethnic Health Services, SWSAHS
Ms Clair Matthews	Ethnic Health Service Manager, Liverpool Health Service
Dr Anna Whelan	Associate Professor of Cross-Cultural Health, SWSAHS/UWS

[The above members constitute the Research Team for the project]

Mr David Small	Health Services Policy Branch, NSW Health
Ms Michelle Spillane	Corporate Services Branch, NSW Health
Ms Carlie Spencer	Portfolio Manager and Adviser on Women=s Employment, Office of the Director of Equal Opportunity in Public Employment (ODEOPE)
Ms Mira Savich	Manager Area Human Resources Development Service, SWSAHS
Ms Jane Gordon	Area DON, Wentworth Area Health Service
Ms Lee Lin Boon	Manager, Health Care Interpreter Service SWSAHS
Ms Katarzyna Stack	Representative of Interpreters
Ms Gai Moore	Area Multicultural Health Coordinator, NSAHS
Ms Maria Stefanou	Health Care Interpreter Service, CSAHS
Ms Trudy Mills-Evers	Area Multicultural Health Coordinator, Hunter AHS
Mr Sam Choucair	Area Multicultural Health Coordinator, SESAHS

Duration of Reference Group and Frequency of Meetings

The Reference Group will meet at a frequency to be determined, over the period June 1998 - December 1999.

Project Objectives: Policy development for Area Health Services and NSW Health Department

- Further explore the process and content of the interactions of bilingual mainstream staff with clients, from the perspective of Interpreters and other Ethnic Health staff;
- Develop a policy document relating to the role of bilingual staff in mainstream health services, which focuses primarily on use of a language other than English (LOTE) at work and identification of positions (cross-cultural skills);
- Differentiate between functions of bilingual health staff, Ethnic Health staff and interpreters in their role as communicators.

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[xxxvii] Chalabian & Dunnington, op. cit..

[xxxviii] NAATI, *Interpreting and Translation in Australia A Concise Guide for Employers*, http://www.naati.com.au.

[xxxix] NAATI, 1984, *Walking A Tightrope - Interpreting For Professionals*, Open Channel Production, Canberra.

[xl] Ibid.