New Zealand needs a comprehensive interpreting service

Ben Gray

Abdelfattah Qasem was killed in the Masjid Al Noor mosque on 15 March.[1] He worked as an Arabic interpreter. For survivors in the Mosque community, particularly those from a refugee background with limited English proficiency (LEP), his loss will be keenly felt. It would not have been possible to provide high-quality trauma care after the attacks without professional interpreting services. It is particularly hard to provide psychological services to LEP people without a professional interpreter. The national response to the killings has been heartening, with a commitment to valuing diversity and including minority populations within our community. However, this is aspirational and much work has to be done before we can achieve these goals. In this context The Human Rights Commission on "Give Nothing to Racism" is an important initiative.

New Zealand accepts 1,000 refugees (to be increased to 1,500 from July 2020)[2] per year through our refugee quota system and many others from a refugee-like background through programmes such as the family reunification scheme. Many of these people do not speak English when they arrive. To settle successfully they need interpreter services at least initially for everything they do.

We have tolerated what I view as a form of institutional racism for too long; we do not as of right now provide a professional interpreter for LEP patients when they need. While this paper is predominantly focused on the health sector, the issues raised are clearly relevant to every aspect of society if people with limited English are going to be able to fully participate in our community.

Our study in 2011[3] found that none of the 21 LEP patients presenting to ED had the benefit of a professional interpreter and 65% of surveyed clinicians used interpreters half the time they were needed or less.

The main nationally available service has been the government-run telephone interpreting service Language Line. It has interpreted around 54,000 conversations a year and provided services to most government departments, DHBs and PHOs. The costs were subsidised but not free. This number has not changed in the last six years. Given that at the last census there were 80,000 people who only spoke a language other than English and many more have limited English proficiency, this is a tiny drop in the bucket of need. Language Line will cease to operate on 30 September 2019. Mr Qasem's employer Interpreting New Zealand provides on-site services in Wellington Christchurch and Nelson and telephone services nationally 24/7. Decypher provides on-site and telephone interpreting based in Hamilton. The three Auckland DHBs have their own interpreter services.[4] Funding for health interpreter services comes out of health budgets and of course falls disproportionately more to some providers than others.

It is time that our attitudes to the provision of interpreting services changed. Surely every clinician would acknowledge that it is impossible to provide good care without getting a good history and being able to negotiate an agreed management plan. If the patient is of LEP this cannot be done without an interpreter.

The Code of Patient Rights[5] in right 5 guarantees a right to effective communication:

1. *Every consumer has the right to effective communication in a form, language and manner that enables the*

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> *consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter.*

Despite submissions to update this right it has remained the same since the inception of the code. I would argue that for a patient with LEP, many of the other rights in the code are not available without a professional interpreter. It is impossible for me as a clinician to determine the "competence" of an interpreter without an outside arbiter. By definition I do not understand the language, so how could I judge their competence? Interpreting is a skilled task and the ethical requirements are the same, if not more so, as those that apply to the doctor. For some consultations this can only be addressed by employing a professional interpreter who is trained and accredited in a transparent way and who is a member of a professional organisation that ensures adherance to a code of ethics. Rights 6 and 7, the right to full information and to be able to give informed consent are unmeetable for an LEP patient without a professional interpreter. A clinician could not ascertain whether an LEP patient understood the information provided without a professional interpreter and for significant procedures there would be significant medicolegal risk in proceeding without an interpreter. The code needs to be amended to "*the right to a professional interpreter*".

A specific anomaly is that ACC will only fund an interpreter once a case manager has been appointed. They do not provide funding for an interpreter for the initial consultation following an accident. At that consultation the patient signs a consent form. Without a professional interpreter that consent cannot be valid.

The Ministry of Business Innovation and Employment has a Language Assistance Services Project in progress that is considering these issues.[6] Their recommendations if implemented would significantly improve the availability of interpreters. They have just announced[7] the establishment of a 24/7 telephone interpreting service starting on 16 September, which is a huge improvement on the previous Language Line which was only available during business hours. At the time of writing there are important issues that are not resolved.[8] A particular problem is that the new provider is to provide services to organisations eligible to use collaborative contracts under the New Zealand Government Procurement. Primary Health Organisations are not eligible for this, although (outside of Auckland) they are major current users of Language Line. While the project plan[6] includes a recommendation that "The Ministry of Health consider in conjunction with DHBs a consistent approach to the funding of interpreters in the primary care sector throughout the country", there has been no announcement regarding progress on this recommendation.

The proposed model of a provider that contracts with multiple 'clients' who provide services to LEP patients has large transaction costs compared with a centrally funded service that can be accessed without cost by those publicly funded or contracted services that need them, as is the model for the Auckland primary care interpreting service.[4] There has been much criticism[9] of our large number of DHBs and PHOs and the costs these incur. Our study of interpreter policies showed that all DHBs have policies on interpreter use, but there was a wide variation in quality with some clearly not following recommended practice.[10] Rolling out a funding model is an opportunity to use a consistent and more efficient model.

As discussed in the chapter in Coles Medical Practice on interpreting[11] there will be times when a telephone interpreter is not sufficient so we need to develop capacity in on-site interpreters; a task that is plausible in the main centres but much more difficult if we settle refugees in smaller provincial centres.

It is time we followed the Australian lead. They have had a federally funded Translating and Interpreting Service[12] that has provided free telephone and on-site interpreting services for the past 46 years. They have a training and accreditation system to ensure adequate standards of interpreting and ethics.

There is also a lot of work to be done by the professions on working with interpreters, for we know from the Australian experience[13] that even if there is a long-standing fully funded service it is not automatically used. While there are times when working with a family member may be acceptable,[14] we need to develop the

clinical skill of determining what form of language assistance is needed for each consultation.[11] There will always be many consultations where a professional interpreter is the required option.

The Christchurch shootings have highlighted that some of the minority communities in New Zealand are not able to be "one of us" because of some of the barriers to better engagement with the wider community. Issues of racism, religious intolerance and discomfort with difference are challenging to address, even if a lot of money were put into programmes. By contrast, a comprehensive fully funded language assistance service is entirely doable and would make a significant difference. It is important that there are tangible changes resulting from the outpouring of goodwill that occurred. A comprehensive centrally funded language assistance service would be a fitting memorial for Abdelfattah Qasem and tangible proof that we as New Zealanders genuinely value diversity and wish to enable all people irrespective of language ability to participate fully in our society.

Competing interests:
Nil.

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