Health Care Interpreter Services

Strengthening Access to Primary Health Care

National Report:

An overview of the accomplishments, outcomes and learnings of the SAPHC project

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Prepared by:

Beth Hoen
Kristofer Nielsen
Angela Sasso

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The Project Management Committee Included:

Diana Abraham
Ontario Ministry of Citizenship and Immigration

Marco Fiola
Université du Québec en Outaouais

Axelle Janczur
Access Alliance Multicultural Community Health Centre

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I. Introduction

Why the SAPHC Project

The Health Care Interpreter Services: Strengthening Access to Primary Health Care (SAPHC) project was built on the premise that effective communication is essential to health care quality and access. The Healthcare Interpretation Network (HIN)[1] and Critical Link Canada became increasingly aware that the health of people with Limited English and French Proficiency (LEP/LFP) is compromised by their limited communication with health care providers.

Health care services in Canada are being delivered in an increasingly multicultural, multilingual environment as newcomer settlement in Canada continues. The current patchwork of interpreter services and different levels of understanding of the need for effective communication in health care has led to inconsistencies in how language barriers are addressed in health care settings. Canadian residents with LEP/LFP do not have the same access to universal health care enjoyed by other residents, and the quality of the care they receive may suffer.

HIN and Critical Link Canada are committed to the goal of improving access to primary health care for patients with LEP/LFP. As a partnership, they created the Strengthening Access to Primary Health Care (SAPHC) project. Funded in 2003 by the Primary Health Care Transition Fund, Health Canada, the project set out to:

- Investigate and document the current state of primary health care service delivery to patient populations with LEP/LFP; and
- Examine health care providers' familiarity with services provided by trained interpreters and their opinions about interpreters' roles in primary health care.

The National Report

This report conveys a picture of the extensive activities and important accomplishments of the SAPHC project. It will outline the project process that drew from, and built on, service models, training programs, collaborations and other activities already in place in Montreal, Toronto and Vancouver. The SAPHC project identified solutions and shared information that enabled discussion and synergy about the delivery of interpreter services in primary health care across these three Metropolitan Areas. The report also describes the concrete training and management tools developed for use by health care providers and interpreters and their organizations. By enhancing lines of communication and building momentum toward consensus and advocacy, the SAPHC project has created and furthered a national agenda to improve interpreter services.

This report tells the story of the SAPHC project—its major accomplishments and activities and its legacy of knowledge, experience and momentum for the further development of effective, sustainable and progressive language access strategies to strengthen primary health care access across Canada. The report is organized into the following sections:

Part II. Overview of the SAPHC project: background, descriptions of Canada's population and recent immigration, and key events in the project's process

Part III. SAPHC Project Accomplishments and Learnings: description of what was learned from the literature review, the research findings and concrete results from the SAPHC pilot projects

Part IV. The Past, Present and Future, A National Agenda: Summation and next steps to further the national agenda toward language access.

II. Overview of the SAPHC Project

Background

Fundamental to the project is the tenet that the provision of quality interpreting in the delivery of health care can reduce language barriers and thereby improve communication.

SAPHC initiators have seen negative impacts of poor communication and were aware they have been reported in the literature. These impacts include unneeded admissions and diagnostic testing; delays in seeking care; misdiagnosis; inappropriate treatment; inappropriate and ineffective referral; reduced comprehension and compliance by patients; lack of confidentiality; and failure to obtain informed consent.[2]

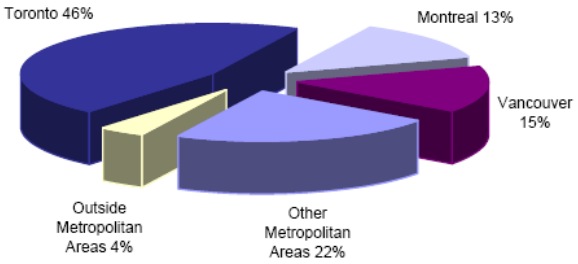
The partners in the SAPHC project recognized that strategies used to address language barriers vary across Canada. Interpreting services range from non-existent to centralized regional and provincial solutions delivered through a multiplicity of service models involving trained and untrained interpreters. These different approaches resulted from a number of factors such as historical development, political decision-making and the patterns and volume of immigration in the recent past.

Canada's Population: Immigrants, Settlement and Language

Shifts in Canada's immigration policy over the past thirty years have resulted in changes in the number and source countries of Canada's immigrants. Between 1991 and 2000, 2.2 million immigrants came to Canada, the highest number in any decade during that century.[3]

Currently, about three quarters (74%) of immigrants settle in Canada's three largest metropolitan areas, a shift from the 1970s when 58% of immigrants came to these three cities. A Statistics Canada longitudinal study of the 164,200 immigrants who entered Canada over a one year period found that settlement in these cities was distributed as follows: 46% settled in Toronto, 15% in Vancouver and 13% in Montreal (shown in the pie chart below).[4]

Immigrant Settlement Locations (2000-01)



The diversity of Canada's current population and this recent immigration have implications for interpreting service needs to address language barriers in health care:

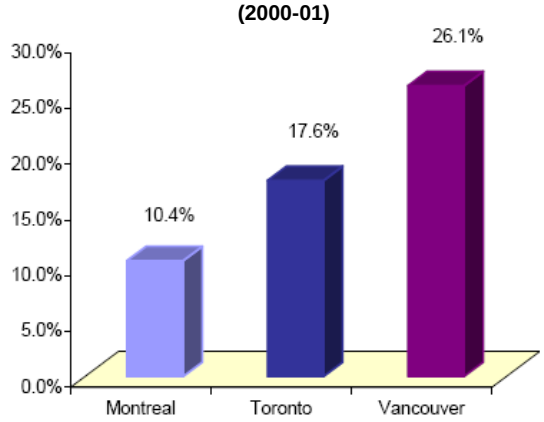
- Within Canada's universal health system, a substantial number of Canadian residents – nearly 500,000 – are likely to have compromised access to, and quality of, health care:

  Of the total population in 2001, 446,000 Canadian residents (1.5%)[5] had no knowledge of French or English. The three metropolitan areas varied: Vancouver, 4.7%; Toronto 3.9% and Montreal, 1.5%.[6]

- An estimated 30,000 newcomers with no knowledge of English or French are added annually:

  Across Canada, about one sixth (18%) of all new immigrants to Canada in 2000-01 had no knowledge of English or French (Vancouver, 26%, Toronto 18% and Montreal, 10%; see graph below).

Proportion of Immigrants with No Knowledge of French or English for Major Metropolitan Areas (2000-01)



- The diversity of newcomers' languages is important in analyzing and planning for interpreter service needs and delivery:

  More than two-thirds (68%) of immigrants were from Asia or the Middle East, continuing a 20-year trend away from European-born immigrants, according to the longitudinal study. This has resulted in a greater diversity of languages spoken among new immigrants across Canada.

  In Montreal, 41% of people with LEP/LFP speak one of three languages and the remainder speak a diversity of other languages; in Toronto, 56% speak one of three languages and, in Vancouver, 83%. (Statistics Canada, 2001).

- Particular populations may be more vulnerable to limitations on their access and health care quality:

  The longitudinal study found that older people are least likely to know an official language: 60% of those 65 or older and 40% of those ages 45 to 64, compared with 18% for all ages.

  About 23% of women had little knowledge of English or French, compared with 13% of men.

The longitudinal study also reported on the experience of immigrants in seeking health care. Of the 122,500 immigrants who tried to get health services, 23% reported at least one problem. Approximately 15% experienced language barriers in accessing health care.

Key Events in the SAPHC Project

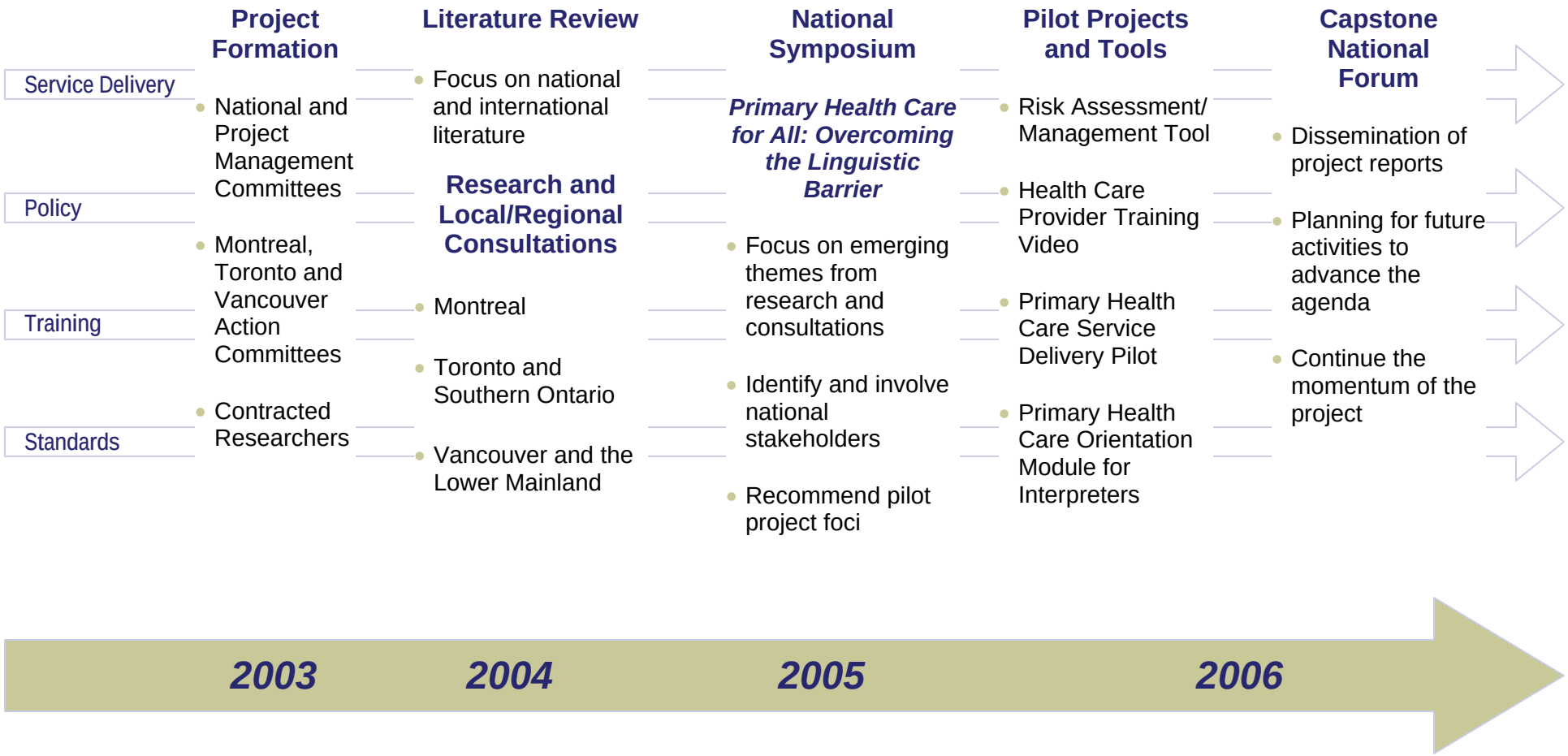
The architects of the SAPHC project recognized that stakeholders were not fully aware of the evolution, challenges, developments and solutions to language barriers across Canada. The project began with a review of Canadian and selected international literature and an investigation of the current state of primary health care service delivery to patient populations with LEP/LFP in the three largest Canadian cities. The focus was on discovering:

- current approaches used by primary health care providers in delivering health care when they do not share a common language with the patient; and
- models of service delivery utilized in the delivery of particular sectors of primary health care.

Over a two and a half year period, the SAPHC project marshalled the expertise, experience and efforts of a broad range of health care and interpreting organizations, providers and other stakeholders. The National Management Committee, local advisory committees, research and pilot projects involved Vancouver, Montreal and Toronto interpreters and interpreter service agencies; health care provider organizations and practitioners; academic institutions; and federal, provincial and regional governments and health authorities.

The flow chart on the following page outlines the major milestones of the SAPHC project.

The SAPHC Project at a Glance



III. Accomplishments and Learnings from the SAPHC Project

The SAPHC project harnessed the experiences and opinions of multiple stakeholders resulting in a number of accomplishments and insights about health care interpreting. The literature review, local research, pilot projects and products are described below.

Literature Review

The literature review focused primarily on Canadian literature, but also included resources from the United States, the United Kingdom and Switzerland.[7]

Communication in Health Care and Interpreting

The review found that spoken language interpreting is mandated as part of the health system in very few jurisdictions, namely, two states in the USA, New Zealand and parts of Australia. Although Canada has a universal health care system, no legislative provisions or court precedents effectively require the availability of interpreting to those who need it. Only the deaf community has had success in the courts in seeking a right of access to interpreting in health care provision.

The international literature reinforces the tenet that the access to, and the quality of, health care are seriously compromised without interpreting services for those who need them. On the other hand, there are inconsistencies in the literature regarding effectiveness, efficiency, costs, outcomes, impacts of interpreter services in health care, as well as best practices, interpreter roles, types of interpretation, and practice models.

In relation to access, Canadian authors and others describe instances of both over- and under-utilization of health services connected with not being able to speak English or French. With regard to quality, medical errors such as misdiagnosis, inappropriate treatment, poor patient comprehension, more test and emergency room visits, less patient compliance, and lower satisfaction were cited in the international and Canadian literature as examples of the negative impacts of poor communication in health care encounters. These results have financial and legal implications for service provider organizations and health care practitioners as well as negative impacts on patients.

Limitations of utilizing family and friends and even health care providers who are untrained in interpreting were commonly reported in the literature (e.g. omissions, additions, substitutions and misinformation that result in medical errors). The review found studies reporting error rates of 31% to 50% by ad hoc interpreters. Moreover, personal relationships between patients and family members or friends may inhibit complete and accurate communication, according to some researchers and authors. Despite the limitations of untrained interpreting, in most jurisdictions there are low levels of trained interpreter service provision even where it is mandated (e.g., in the United States and Switzerland).

Service Delivery Models

The review found four models of interpreter service delivery in the literature:

- Community-based—the interpreter may be trained or not, and may provide service in

a variety of health care contexts. Although hired by an organization, the interpreter is seen as responsible primarily to the patient; roles vary and may include advocacy or cultural brokerage.

- Institution-based—professional interpreter staff or language banks of employees with other jobs provide interpreting; where these are health care practitioners, advantages include their ability to elicit and recognize medically-relevant information; however, interpreting may interfere with their other employee roles.
- Contracted or commercial—independent interpreters with a variety of training are contracted for work as needed; this model was seen as efficient and able to offer many languages.
- Telephone or remote interpreting—useful for medical emergencies and sensitive health issues, one advantage may be its non-intrusiveness if conducted simultaneously; on the other hand interpreters may not have medical knowledge.

Good Practices in Interpreting

Although the research literature reviewed did not identify 'best practices' in interpreting, some authors reported on what is believed to be good practice or success in interpreting. Good practices in health care encounters were: language fluency, medical terminology knowledge, ability to interpret culture, keeping a low profile and having an understanding of the influence of migration on the patient. Successful interpreting encounters were described as slow-paced where easily translatable words and sentences are used and the practitioner checks on his/her and the patients' understanding.

Some authors reported that success in service delivery results from mechanisms for matching and continuity of interpreters with patients, and integrating interpreters into scheduling. Standards of practice, incorporating professional ethics and evaluating interpreter competence promote quality interpreting, according to the literature.

Interpreter Roles

The literature review yielded several conceptualizations of interpreter roles. The most fundamental was the message conveyer or converter—interpreting the basic message. Beyond that, the roles identified were: message clarification (including non-verbal communication); cultural interpretation, brokering or clarification; advocacy; co-therapy; and health care team member.

Training and Standards

The literature emphasized the importance of training (in particular to avoid the adverse effects of poor quality translation), even though it was acknowledged that most interpreters do not have formal training. Few jurisdictions have standards or formal training programs that address what were seen as necessary themes for interpreting competence: the process of migration; role and functions of the interpreter; interpreting techniques; and ethics. Some authors implied or described the interaction among the following: the lack of health care interpreting employment opportunities; the lack of standards; absence of a professional body; limited available training; and low student enrolment. These appear to interact with each other to inhibit the development of the field of health care interpreting. On the other hand, growing support for professionalization by interpreters and European organizations was reported.

For health care practitioners, the literature generally supported training to raise awareness about language barriers and the need for interpreting in health care encounters.

Issues and Challenges

The literature reported challenges in health care interpreting as described above, for example, health care practitioners' lack of recognition of patients' interpreting needs, absence of agreement about cultural interpreting in the interpreter role, lack of available training opportunities, standards and recognition of interpreters as professionals. In addition, in the interpreting encounter itself, age, gender, class and education may impact on the quality or effectiveness of the interpreting. More broadly, in health care interpreting, some authors noted that there has been little attention to power dynamics between the dominant culture and the patient's culture, although some interpreters involve themselves in individual advocacy and broader social action.

Key Learnings

Overall the literature review identified themes particularly relevant to the SAPHC project:

- Lack of legislation and government policy mandating interpreting services in health care is common, although internationally a few jurisdictions have models of mandated access to interpreting.
- The importance of interpreting in addressing language barriers is supported in the literature, especially to avoid the negative impacts of poor communication. The limitations of untrained interpreters are also acknowledged, offering a rationale for the expansion of trained interpreter availability, training of interpreters and health care practitioners, and application of appropriate service delivery models.
- Service delivery models vary across countries with respect to accountabilities, interpreters' roles, who pays and whether encounters are face-to-face or remote.
- Characteristics of good practice and successful interpreting were reported by a few authors, but substantive research identifying benefits and best practices is lacking.
- Fundamental roles of interpreters are clearly identified in the literature, and there is a widespread lack of agreement about cultural interpreting/ clarification/ brokering.
- Content of training and standards generally need further development; there appears to be an interaction between the lack of standards and professionalization, enrolment in training, and employment opportunities.
- Education of health care practitioners is needed to address the importance of communication with patients, the impacts of poor communication and the value of trained interpreters.

Research: Health Care Interpreting in Montreal, Toronto and Vancouver

Overview of the Research and Method

Research conducted to document the status of interpreting service delivery in Canada's three largest cities was conducted in 2004. This research focused on how health care providers address communication with patients with LEP/LFP and their use of interpreter services. The research used a qualitative emergent approach in focus groups and interviews that involved health care interpreters and agencies; health care

practitioners in community-based and hospital settings; and settlement workers and organizations. Reports were created in each city using these research data, other locally generated information and the input of the local advisory committees and other experts in health care interpreting.

Limitations in the research included the following:

- The qualitative emergent approach was chosen as a method of information gathering to include a wide range of informants who have varying levels of knowledge and experience with interpreting. In this research method, informants have the freedom to raise issues of concern to them; as a result, potential researcher bias is reduced. However, in using this method, the research could not be confident of collecting comprehensive information because particular issues may not have been raised by informants in the interviews.
- Participants in focus groups and interviews were selected by local advisory committees with the objective of maximum representation, rather than using random selection or issuing an open invitation. This sampling method may have led to an apparent lack of information about particular issues or aspects of interpreting, because of the knowledge of the informants.
- Local research reports were based on abridged versions of the information collected, rather than full focus group and interview transcripts. The views of the researchers may have affected the process of summarizing the transcripts by themes.

The non-random selection of informants, the use of the emergent approach and the analysis using abridged information may have limited the comprehensiveness and objectivity of the investigation. These are important limitations that must be considered when drawing conclusions from the findings.

The overall report of this research did not present recommendations that could be used to further local and national discussions about next steps. Local advisory committees and representatives used the raw data for community consultations and, in the process of preparing local reports, added factual and historic information about their local context to compliment the findings. In the process of enhancing the reports, additional opinions about the development and direction of interpreting may also have been added. Nevertheless, the findings provide an indication of the status of interpreting in these cities, including the awareness and views of a broad range of informants involved in service delivery to LEP/LFP patients.

Context and Historical Development

Local reports included historical background information, current services and the findings from the research described above. These are summarized for each of the three cities starting with the development and current status of interpreting, including legislation, government and community organization roles; current service delivery; and standards and training.

Montreal, Quebec

Roles in the Development of Interpreting
In the late 1980s, Quebec government policy spearheaded the development of interpreter services in health and social services for people who spoke neither French nor English.

At that time, the legislation governing these services was amended to ensure accessibility of health and social services to people from various cultural communities. The vision of accessibility of the Montreal Metropolitan Regional Health and Social Services Council included an organizational development approach to promote the cultural competency of health and social services. In 1993 the Montreal Health and Social Services Agency (the Agency) opened the Interregional Interpreter Bank (IIB) to serve the Montreal area, enabling access to interpreting by institutions through a centralized, fee-for-service system. The infrastructure to manage interpreting was funded by the government, while the individual health and social service institutions pay for the interpreter services.

Current Services and Policies
The legislation is interpreted as requiring health care providers to ensure that communication with patients is adequate. The Agency communicates provincial and regional government policies about health services accessibility through professional forums, cross-cultural training and staff orientation. A computer application assists with the Agency's assignment of interpreters and billing processes.

Health care institutions decide how they will address patients' communication needs and set out their own policies and procedures. In addition to the contracted fee-for-service interpreting available from the IIB, some hospitals have institution-based employee language banks; others no longer use this practice but hire or contract their own interpreters. Very little use is made of telephone interpreting in Quebec since there are no Canadian providers of this service in French.

Standards, Professionalization and Training
There are no standards for interpreting in Quebec, although interpreting and other mechanisms used for communication with patients are addressed through health care institution accreditation which is mandatory. Accreditation requires institutions to appoint a Service Quality Commissioner who would address issues of quality related to communication with patients.

The Faculty of Continuing Education at the University of Montreal offers a 45-hour training program in interpreting once a year if there are enough registrations. At other times, the Agency provides opportunities for new interpreters to observe experienced interpreters, group support activities, professional development and other resources. Many interpreters come to the IIB with extensive experience and training in interpreting and related fields. Although few community interpreters make a full-time living, the establishment of the IIB has helped to solidify community interpreting as a desirable occupation in Montreal.

Education of health care practitioners about interpreting generally takes place through in-service training or when the practitioner first uses an interpreter. In addition, the video *Une clef pour Babel* (A Key to Babel), written resources and cross-cultural training are used to support providers' work with interpreters.

Toronto, Ontario

Roles in the Development of Interpreting
During the mid-1980s, the Ontario Ministry of Citizenship and Immigration (MCI) began promoting interpreting services through the programs to prevent and address violence against women. The establishment of provincially-funded interpreting programs followed soon after. MCI also worked with

health sector representatives to form the Healthcare Interpretation Network (HIN) in 1990.

Starting in the early 1990s, the Ontario Ministry of Health and Long-Term Care began supporting conferences and training to promote health care interpreting. Although the Ministry funds some interpreting costs through hospital and community health centre budgets, there is no provincial legislation or policy requiring attention to the communication needs of patients with LEP/LFP, nor mandating access to interpreting.

Current health care system restructuring in Ontario involves the establishment of Local Health Integration Networks (LHINs) that will have regional responsibility for planning and, ultimately, for the funding of health care. However, the needs of patients with LEP/LFP have not been highlighted in the planning and early implementation.

Current Services and Policies
Services are provided through a patchwork of contract/fee-for-service interpreting offered by not-for-profit and for-profit agencies, institution-based and telephone service delivery, with some community-based interpreting available through settlement agencies. Health care providers set their own policies and procedures regarding interpreting without benefit of an external legislative or policy framework. Hospitals sometimes have a bank of employees (both health care practitioners and other employees) who receive varying amounts of training. A few large hospitals hire their own interpreters.

Standards, Professionalization and Training
Training for interpreters in Ontario started with some federally- and provincially-funded training of community-based interpreters. In the early-mid 1990s a training curriculum was piloted and further developed through individual hospitals and HIN with support from MCI. The curriculum manual, *Cultural Interpreters Working in a Hospital/Health Care Setting*, is the basis for currently used curricula.

Hospitals and interpreter agencies now offer programs ranging from a few hours to more than 100 hours, some with medical terminology and other specialities. Niagara College has offered a certificate program in interpreting, and, in the fall of 2006, a 180-hour course for community interpreters will be offered in a number of community colleges across Ontario.

Ontario has no widely accepted standards for interpreting. Some agencies and health care organizations have developed their own, generally based on the core competencies in the HIN manual and interpreting literature. The Cultural Interpreter Language and Interpreting Skills Assessment Tool (CILISAT) and the Interpreter Language and Skills Assessment Tool (ILSAT) are the only widely used assessment tools for interpreting competency and potential.

Vancouver, British Columbia

Roles in the Development of Interpreting
In the mid-1990s, immigrant services, health services and colleges in the British Columbia (BC) Lower Mainland formed an action research project called the *Health Care Interpreter Partnership Project* (HCIPP). The project created standards, developed training curriculum, coordinated the translation of health education materials and promoted a three-tiered system of interpreting: community volunteers, bilingual staff members of health care agencies, and professional interpreters. HCIPP was instrumental in raising the profile of interpreting in health care and laid the

groundwork for the development of future interpreter services in the province.

As health care was restructured, the locus of responsibility for interpreting services has shifted: some have become centralized services, while some hospitals maintain their own programs.

Current Services and Policies
Fee-for-service interpreting services are operated at the provincial, health authority, and hospital levels. The Provincial Language Service, a centrally managed service for the BC health system, works with community partners to deliver services locally. Some health authorities operate centralized interpreter services for the continuum of health care services—community health, mental health, acute care and continuing care. A computer-based tracking system is used for dispatching interpreters and preparing utilization statistics for quality assurance and resource management.

Most of the hospital or health authority services involve a centrally coordinated mix of fee-for-service professional interpreters and bilingual staff, although a few have professional interpreters on staff. One of the goals of HCIPP was to include community volunteer interpreters. However, efforts to train and retain a viable pool of volunteers have not been successful due to the logistics of work assignment in a centralized system and the difficulty of ensuring service quality.

Health care providers use some telephone interpreting, although it is seen as a costly alternative with uneven quality.

Some health care organizations' policies have been influenced by the standards for interpreting. Many health care providers are revising their policies in light of their changing roles and accountabilities within restructured health care, so organizational interpreting policies are in a state of flux.

Standards, Professionalization and Training
The health care interpreting standards created by the HCIPP are grounded in the values of accuracy, proficiency, objectivity and confidentiality. They provide guidance to health care practitioners as well as addressing the interpreter. A tool for assessing competence against these standards has not yet been developed.

The most comprehensive training is offered through the Vancouver Community College Interpreter Program: health care interpreting as well as court and community interpreting certificate programs are available. In addition, community-based, ad hoc training in medical and mental health interpreting is available in varying formats, from two-hours to two-days in length. Finally, continuing studies programs in interpreter training are provided in a limited number of languages. Interpreter training across BC is not widely available.

Informants' Perspectives about Health Care Interpreting

This section describes the themes identified through the research that are common to all sites and points out variations by city or province.

Health Care Practitioners' Understanding and Use of Trained Interpreters

Across all metropolitan areas, health care practitioners generally reported positive experiences with trained interpreters. Many appreciated the benefits of effective interpreting and its contribution to health care access and quality. However, some practitioners had little or no experience.

Informants reported that bilingual staff and family and friends are often used instead of trained interpreters, consistent with the literature review findings.

Some informants believed the non-use of trained interpreters may be the result of a lack of comfort with the interpreting process, likely due to a lack of information and experience—a cyclical process. There were also systemic reasons for not using available interpreters, for example, being discouraged from using these services due to cost or lack of availability at the time they are needed.

As reported in the literature, some practitioners lack awareness of potential negative impacts of poor communication, and others assumed that using families, friends or other untrained interpreters would suffice. Informants in all cities emphasized the need to increase awareness among health care providers (organizations and individual practitioners) about the risks associated with poor communication in health care encounters. Practitioners who recognized the potential for negative effects most consistently mentioned the issues of access and informed consent—people with LEP/LFP delay seeking primary care and eventually use emergency care, and are not fully informed about the care they receive because of inadequate communication. Some of these practitioners were well versed in the research or reported anecdotes exemplifying these and other negative impacts, including medical errors.

The real need for interpreter services is difficult to assess because it is masked due to the use of family and friends as interpreters. Increasing awareness of the availability of interpreters is an ongoing task; Montreal informants especially reported they must continually advertise their service.

Service Delivery Models and Roles

Institution-based face-to-face interpreting services are available to some degree across all three metropolitan areas, either through professional interpreter employees or interpreter banks. All sites also reported that bilingual health care practitioners are commonly used because they are readily available, apparently cost-free and often have relevant medical expertise. At the same time, many informants recognized the disadvantages: taking employees away from other duties, uneven quality of untrained interpreters and role confusion. Fee-for-service interpreter services are common, although they are operated under different auspices: Vancouver has both health authority and hospital services, Toronto's services are run by agencies and Montreal's by the metropolitan health and social service agency. Although quality was not often discussed, informants that breached the subject reported more positive than negative experiences.

In Toronto and Vancouver, informants reported the use of telephone interpreting, especially for unscheduled encounters (e.g., in emergency rooms), and discussions of sensitive health issues. Cost was a factor that limits its use and the quality was reported as uneven. In Montreal telephone interpreting is not used much because there are no local French-language services available; informants reported that the IIB is considering expanding telephone service in order to extend 24/7 coverage.

In all three areas practitioners rely on family and friends to provide interpreting, in part because they believe that patients may prefer and feel more comfortable involving someone known to them. Many do not appear to be

aware of the limitations of interpreting by family and friends.

In all areas, interpreting roles were discussed. In Vancouver the topic appeared to have taken precedence over other subjects in the focus groups and interviews. The one area of consensus related to the fundamental task of the interpreter: interpreters are to accurately and impartially convey linguistic meaning (i.e. the 'conduit' approach).

The area of least agreement and clarity related to cultural interpretation (also referred to as cultural brokering, input, and advocacy). Common to all sites was the view that health care practitioners want assistance in understanding the cultural dimensions of their communication with patients. In the absence of other sources, they turn to interpreters for cultural information. Interpreters and interpreter agencies were more cautious about extending their role to include cultural interpreting. BC interpreters are reported to favour separation of the role of cultural brokerage with distinct training provided to interpreters who take on that special role. The interpreter role is defined differently across the three jurisdictions: Montreal includes cultural interpreting in a limited way; Toronto clearly excludes cultural interpreting (based on the definition for Ontario's Violence Against Women Prevention program); and Vancouver finds a compromise (standards include limited reference to cultural sensitivity; informants described differing practices across interpreter programs).

In Vancouver and Montreal especially, cultural competence was emphasized as essential in effective health care delivery. In this context, practitioners are seen as responsible for providing culturally competent and responsive care. The notion is that if a health care practitioner's care is culturally competent, then the demands on interpreters for cultural information are reduced.

Standards and Professionalization

The need for standards emerged as a topic of importance in all cities. Although BC has a set of service and performance standards for health care interpreting, an assessment tool is lacking. As well, the health care field does not consistently adhere to these standards, as evidenced by the extensive use of families and friends.

BC informants believe their standards are both rigorous and feasible to implement in institutions. They support the development of national standards, a national certification program and an appropriate assessment tool, and also argued for adequate funding for training to prepare interpreters to meet the standards. The topic of national standards and certification was not addressed by informants in other cities.

Informants from the three cities appear to agree about the basic values underlying the BC standards: accuracy, proficiency (sometimes called "competence), objectivity (referred to elsewhere as "impartiality") and confidentiality. This agreement extends to the need for a national code of ethics and for proficiency in health care technology. However, as noted in the previous section, there is not widespread agreement about the role(s) of the interpreter in relation to cultural interpreting. This may be the single largest impediment to progress toward more widely accepted standards and professionalization.

Interpreters' interest in the professionalization of health care interpreting is reportedly growing in all three cities. Judging from the experience of BC, the presence of standards is not enough to promote professionalization.

Although BC standards have been in place for about ten years, interpreting is not acknowledged as a profession by health care practitioners and the standards are recognized by only a small number of health care institutions. Overall progress toward professionalization appears to be inhibited by several factors: a lack of recognition of the role in the health care field; low or uneven demand for interpreting services; the lack of Canada-wide standards upon which to build a profession; and limited and inconsistent training content and standards.

If interpreting is to become a profession, the process for implementing standards would need to be addressed (i.e. who would be responsible for assessing interpreters' competence and how would consistency be ensured). Some informants, especially those in Toronto, proposed that interpreting agencies be responsible for assessment of interpreters, an extension of what they now do in hiring or contracting their own employees or interpreter pools.

Industry standards for health care interpreting are absent. Working conditions and pay are inconsistent across interpreter agencies, as cited by Toronto informants in particular. Specific data about working conditions and pay rates were not gathered as part of this project. Montreal informants identified retention of interpreters as an ongoing problem, speculating that the causes are low pay, inconsistent income and the low status of the occupation.

Interpreter Training

All three cities reported community college level training programs as well as community-based training for interpreters. The content of these programs was not examined, but descriptions indicated common elements including interpreting practice/techniques; ethics; roles; knowledge of medical terminology; and other special content areas such as mental health. Although many informants were not aware of training content, informants in all areas supported the training of interpreters and most emphasized the need for ongoing professional development and support.

All sites raised the need to clarify the degree to which cultural interpretation is integral to health care interpreting in order to determine training content in this area. Some programs that focus on cultural interpreting were reported in BC, in particular.

In Toronto and Montreal, some informants noted there is a lack of incentive for interpreters to gain more training since their remuneration is not affected by their training, and employment opportunities are inconsistent. This may underlie the inconsistent enrolment in college-level training noted in the two provinces. On the other hand, Montreal interpreters seeking employment or contracts were reported to already have extensive training and experience, and informants thought formal training may not be relevant to them.

Other issues in training include: the cost of tuition, especially for college level courses in a field where employment is uncertain and pay low; accessibility in areas outside metropolitan areas, especially in BC; and the need for training for languages of lesser diffusion and specialities in medical terminology, mental health and other fields.

Policy and Funding

All cities' informants reported a lack of consistent funding for interpreting. While Quebec supports interpreting as one method

of achieving access to services for people with LEP/LFP, hospitals' budgets are constrained and cost-saving measures such as employee banks are used rather than trained interpreters. This lack of adequate funding is symptomatic of the absence of a policy framework mandating mechanisms to promote adequate communication in health care services, particularly in BC and Ontario. Although Quebec legislation intends to ensure adequate communication for patients, it limits this mandate with the proviso, "to the extent allowed by the resources"[8].

Some informants in all cities emphasized that provincial and organizational policy frameworks need to address cultural competency, not simply communication barriers and access to quality interpreting. They argued that cultural competency is essential in the provision of quality health services and the avoidance of medical errors and higher costs. They also cited the importance of cultural competency in achieving the spirit and intent of universal access required by the *Canada Health Act (1985).*

In all cites access to interpreting services is not consistent across the health care continuum. For example, Vancouver reported services that cover some but not all community health services in their geographic catchment area. An important gap in all areas is private practice: informants reported no mechanisms for compensating interpreters or private practitioners for interpreter services in the context of private practice.

Availability of interpreting is affected by health care restructuring in all three provinces. In the context of health care institution amalgamations and the downloading of accountability for planning and funding, interpreting is one small aspect of health service provision. Informants in all areas reported that health service provider organizations vary greatly in whether they have current and relevant policies and procedures, in particular responsibility centres for access, authorization, administration and tracking, budgeting and payment, and evaluation of quality and impact. Restructuring is reinforcing the need to update or create policies and procedures that ensure access to patients and accountability for organizations.

Key Learnings from the Research and Community Consultations

The culmination of information gathered from the research and in local community stakeholder consultations, has resulted in the identification of several common elements or learnings across all three sites.

First, the development of interpreter services has, to some extent, been based on the collaborative efforts of community-based agencies and government in all three areas. In Toronto, the government support of interpreter services for violence against women prevention initiatives led the way for other community- and institutionally-based initiatives and provided leadership on the development of local standards. In Vancouver, development of interpreter services was coalition-based, where representatives from immigrant services, health services and colleges led the way for the development of service models and standards of practice. And in Quebec, ethnic groups, community service centres and administrators from the Montreal health network pressured the government to resolve the inability of the system to meet the needs of ethnic minorities, resulting in provincial legislation requiring health and social services, among other things, to address linguistic barriers. The conclusion one can draw from this history is that coalitions can have an impact on service development, albeit over time, but only if there is some level of government support along the way.

However, despite the fact that government has played a role in interpreter service development in all three sites, government policies and funding are a patch-work at best, or more often simply non-existent. Access to interpreter services are not prominently mandated, although Quebec does have some proviso for it, resulting in inconsistent and generally unsupported service delivery models. As was apparent from informants, an overarching provincial or even national policy framework is required to unify the use and provision of language support services and contribute to the professionalization of the sector.

Service delivery varies among sites, with Vancouver and Montreal both boasting centralized services, albeit not exclusive, whereas Toronto's service delivery is largely based on institutional or community-based fee-for-service arrangements. Given the lack of professional opportunities for interpreters and the variance in standards, centralized services can be seen as a recommended model, given that they are better situated to create consistency in standards and ensure more stable working conditions for interpreters on their roster, and provide greater diversity of languages and availability of interpreters.

At a more operational level, health care practitioners are generally receptive to working with trained interpreters, but use of trained vs. untrained interpreters was very inconsistent in all three cities, with many relying on patients' family or friends, or bilingual colleagues to bridge the linguistic barrier. Such use of ad-hoc interpreters demonstrates a lack of understanding about the potential negative impacts and risks of poor communication.

Although discussions of the role of the interpreter were prominent in all focus group discussions, agreement on whether the role should include cultural input was lacking. Areas of commonality included the necessity to convey messages accurately and impartially and maintain confidentiality. In all three areas, but BC in particular, the need for cultural interpreting was linked to the broader question of cultural competence in service delivery.

Finally, while BC does have standards of practice, like Quebec and Ontario, there are no means to monitor adherence to such standards, nor are they widespread across the continuum of care. Intersecting the need for improved standards is the growing support for the professionalization of the sector among interpreters and health care practitioners. However, the desire for increased standards of practice and training must be developed in conjunction with improved professional opportunities and remuneration.

Tangible Outcomes of SAPHC

Clarifying the Agenda: a National Symposium

Following the research phase and subsequent local consultations, SAPHC management planned a multi-day symposium to examine various aspects of the health care agenda to determine how advancement of language access in the current health care context could best be positioned. The event, held just outside Toronto in May 2005, brought together 100 delegates from eight provinces and two territories that were involved in primary health care and/or interpreter service delivery.

Participants were involved in presentations and discussions about:

- Language access as a human rights issue
- Making the case for language services in primary health care
- Risk identification and management vis-à-vis linguistic barriers
- Canadian health care context, health care reform and the role of communication in health care quality
- Canadian and European examples of community- and hospital-based models of primary health care provided to people with language barriers.

The two-day symposium concluded with regional sessions about collaborations and next steps. The National Management Committee then integrated this dialogue with the research findings and community consultations to generate pilot project ideas.

SAPHC Products

The National Management Committee selected five pilot projects based on the following criteria:

- A focus on primary health care delivery or health care interpreting
- Contribution to the advancement of the language access agenda
- Evolution from previous SAPHC work
- Consistency with the objectives of the SAPHC project and the Primary Health Care Transition Fund
- Available local capacity to complete the project, and
- Feasibility within the timeframe and budget.

Those projects that were initially approved by the committee are outlined below.

SAPHC Pilot Projects

Risk Assessment/Management Tool on health care access for non- and limited-English speaking populations (Vancouver)

Best Practices Training Module for primary health care practitioners, orienting them to working with an interpreter (Toronto)

Training Video for primary health care service providers: French-language video for inclusion in provider training (Montreal)

Service Delivery Pilot for implementing interpreter services to various primary health care environments (Toronto)

Primary Health Care Orientation Module for interpreters: to be delivered to trainees in a core interpreting program (Toronto).

Assessment for Risk Management (ARM) Tool

The ARM tool is designed for use in a cross-section of primary health care organizations. The National Management Committee judged that it has a strong potential to impact policy and practices in health care delivery. As reported in the research and at the national symposium, many health care providers lack an appreciation for the potential negative impacts of poor communication on health care quality and access, such as medical errors, increased health care costs and poor patient outcomes.

The ARM tool is a questionnaire-based assessment tool founded on the Canadian Council for Healthcare Accreditation standards and drawn from work done by the Winnipeg Regional Health Authority. The ARM project developed a series of matrices that plotted the CCHSA standards according to Health Service Area and related them to risk and impact when viewed through the lens of access for non- or limited-English speakers. From the matrices, the questionnaire was developed that facilitated health care providers to assess and rate their programs with an eye to access.

The ARM tool was piloted at 2 sites in the BC Lower Mainland and was well received. Overwhelmingly the recommendation was to see this kind of tool either integrated into the CCHSA process or mandated as an exercise for health care services.

The final report, inclusive of all tools developed, will be disseminated through the PLS website; the Affiliation of Multicultural Services and Service Agencies (AMSSA); and through SAPHC networks.

Best Practices Training Module

Although the committee identified training health care providers as a key priority in helping to bridge language barriers, this Toronto-based pilot project was not initiated due to time and budget constraints. Resources were focused on the other two Toronto pilot projects, including the testing of interpreter service delivery to previously underutilized primary care environments, and the development and delivery of an interpreter orientation to the primary health care sector.

Video for Primary Health Care Service Providers

The SAPHC project has collaborated with various Montreal-based organizations to develop a French-language video that will be used to train health care providers, primarily physicians, on how to work with interpreters and bridge communication barriers. The project contributed to the development of focus group sessions to validate content.

Service Delivery Pilot for Interpreter Services in Various Primary Health Care Environments

Given the piecemeal use of interpreter services in the primary health care sector, the Toronto Management Committee utilized its existing relationship with the centralized Access Alliance Interpreter Service to provide on-site and telephone interpreter services to two diverse primary health care settings, including a community health centre and a joint walk-in clinic/family practice.

Both of these settings were provided with one centralized booking number to contact when patients with limited- or non-English proficiency were seen by one of their health care providers. Services were provided free of

charge for the pilot period, providing that the service provider, patient and interpreter completed a brief qualitative questionnaire after each interpreted encounter.

While the data collection was not intended to be statistically relevant or comprehensive, it was meant to capture satisfaction information from all three parties (patient forms were translated into the common languages of both pilot sites and were completed apart from the interpreter or the service provider).

Prior to the provision of services, administrative staff were provided with an orientation to the requesting process and health care providers were oriented on 'best practices' for working with interpreters and with multi-lingual/multi-cultural clientele.

Results from the data collection showed that for every patient who had been seen prior to the pilot without a professional interpreter, quality had improved and both the patient and service provider were more satisfied with the outcome when a professional interpreter was utilized. In addition, the pilot demonstrated to both project staff and service providers, that unscheduled, walk-in services, as well as private fee-for-service practices can efficiently and effectively utilize interpreter services, given appropriate adjustments to the service delivery model (e.g. utilizing phone interpreters, maximizing on wait-times, etc.).

Following the pilot period, both sites were offered support in developing their language access strategies and continue the use of interpreter services at a reduced rate.

Primary Health Care Orientation Module for Interpreter Training

This module was developed and tested in order to provide a template for orienting interpreters who will be working in primary health care settings. It is designed to be adaptable for use across Canada and to various settings (ongoing training or stand-alone orientation) and timeframes (from a series of 'lunch and learn' sessions to one or two full days).

The module was developed for interpreters who have had some previous training. Piloted in Toronto, the template was applied in a 70-hour interpreter training program focusing on language and interpreting skills, role and responsibilities, ethical issues and research skills.

The content includes an overview of the primary health care sector and various working environments (e.g., community health centres, private practice, public health); the realities patients may face and issues they bring; and expectations for interpreters working with service providers in primary health care. Guest speakers are recommended: presentations by various health care practitioners and managers help to bring home the realities of the working environment for interpreters. Role play simulations could be included depending on the time available and the experience of interpreters. An evaluation form is included in the package. The piloted module was evaluated as a valuable addition to the training program and guest speakers were seen as offering insights into various primary care settings.

Learnings from the Pilot Projects

The pilot projects addressed a number of issues identified through SAPHC activities, namely:

- Health care providers' and administrators' lack of awareness about the benefits of

interpreting and potential negative impacts of poor communication: the piloted *ARM Questionnaire Tool* demonstrated an effective way for organizations and practitioners to assess risks and ways to address them, and provided a framework for service modifications.

- Health care providers' lack of knowledge about working effectively with trained interpreters: the *French-language Video* will be a useful means of training health care providers on how to best manage communication barriers and work most effectively with an interpreter.
- Under-utilization of interpreter services in primary health care, and more specifically, walk-in/same-day and/or private family practice settings: the *Service Delivery Pilot* demonstrated how to effectively implement interpreter services to various primary health care settings, including those that are structured on a fee-for-service basis and/or in a same-day service environment. Although the pilot demonstrates an efficient service delivery model, it does not offer a solution to the cost barrier.
- Lack of training for interpreters specific to the primary health care setting: the *Orientation Module* was well received by interpreters as a useful introduction to primary health care and prepared them for the many diverse settings and environments in which they may be called to interpret.

Learnings/Overcoming Challenges and Barriers

Management of the Project

The project's management presented challenges arising from the involvement of three sites and the two primary stakeholder groups: interpreters and primary health care providers. Future projects might choose a more flexible and less ambitious timetable, recognizing that communication and relationships take time to develop. As well, local initiatives require time to develop and implement locally appropriate approaches to information gathering and consultation; substantial support and clear expectations are needed regarding their roles and reporting.

More flexible timeframes for information gathering could have better allowed for local differences in how work is accomplished and accommodated in relation to competing activities such as major restructuring and summer holidays.

Another important learning was the need for careful monitoring of contracted services. Clarity about the comprehensiveness and level of detail required for contracted research is essential to ensure useful and useable findings. Moreover, regular monitoring can also contribute to receiving the information needed through arms-length research processes.

Working across Canada

Regional differences across Canada were to be expected. These arose in part from political and historical factors (e.g., differences in the extent of government support and intervention); the evolution of health care in provinces, territories and communities; patterns and sources of immigration, etc. Project management needs to take into consideration regional differences and may need to accommodate different working styles of individuals, at the same time maintaining accountability for the project outcomes. It is important to understand which are differences related to the region, and which are the result of individual working styles.

While some solutions developed to address language barriers have fundamental similarities, they may need to be applied in different ways depending on the status and history in different localities.

Ensuring Sustainability

As the project evolved, it became clear that government policy, priorities and funding impact on the status of health care interpreting will affect the sustainability of project outcomes. Government funding of the project will not guarantee a hearing by politicians and senior officials that will result in action such as policy changes, funding or future projects to develop language access. Including key government stakeholders increased the probability of ongoing impacts past the projects' completion.

IV. The Past, Present and Future: A National Agenda

Primary Health Care Interpreting in Canada in 2006

Despite the many historical differences between the three regions and their respective stages of development vis-à-vis language access services, the SAPHC project has highlighted the common commitment of many stakeholders to eliminate linguistic barriers to primary health care for individuals with limited English/French proficiency. There is a keen appreciation of the need for and value of trained, professional interpreters in ensuring equitable access to health care services for these populations, however, the tools required to operationalize such a vision are still in a developmental stage.

Although advancements in service delivery, standards and training have improved the quality and to some extent usage of interpreter services, the lack of agreement on the role of the interpreter continues to create an unstable foundation for further development of the profession. As such, interpreting is still very much at the preliminary stage of its professionalization. Standards development has been local in scope and lacking a national perspective, funding is sporadic, and overarching policy is non-existent. However, the SAPHC project has made great strides at initiating the ongoing work of reforming the primary health care sector through the many activities, outcomes, products and tools of the project. With further work in the interrelated areas of policy development, funding stability, role clarification, risk management and improved professional opportunities for interpreters, language access strategies will be recognized as a vital aspect of providing health care to linguistically diverse patients.

Next Steps: Building a National Agenda

In order to disseminate the findings of the SAPHC project and continue its momentum, a National Capstone Forum is being planned from May 31st to June 2nd, 2006 in Vancouver. The event will bring together actively engaged individuals from across the country who represent the health and/or immigrant-services sectors to identify next steps and future commitments on how to continue building a national agenda for interpreter services. The intent is to create an ongoing dialogue to share findings and recommendations and continue the work of the SAPHC project beyond its formal end.

Discussions will focus on the four key themes of the project, including service delivery, training, standards, and policy in relation to accessible and equitable health care services for individuals with limited English or French proficiency.

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Endnotes

[1] As the Healthcare Interpretation Network (HIN) has evolved, the name has changed several times, including the Hospital Cultural Interpreter Services Network (HCISN); the Hospital Cultural Interpreters Network (HCIN), and the Health Care Information, Interpretation and Education Network (HCIIEN).

[2] See Bowen (2001), Chapter 6 for a discussion of impacts of language barriers on health care access, quality and outcomes.

[3] See Statistics Canada Web Site for 2001 census data; details are in the Reference List. Comparisons across the century are found in the Statistics Canada (2005a) table: "Population and growth components (1851-2001 Censuses)."

[4] The Longitudinal Study reported in 2003 examined all immigrants to Canada between October 1, 2000 and September 30, 2001.

[5] Statistics Canada (2005c) table "Population by knowledge of official language, by province and territory (2001 Census)."

[6] Statistics Canada (2005b) table "Population by knowledge of official language, by census metropolitan areas (2001 Census)."

[7] See Shahsia and Grégoire, Health Care Interpreter Services: A Literature Review.

[8] The Quebec legislation is the Act Respecting Health and Social Services (R.S.Q., c S-4.2).