



DEAF VICTORIA & EXPRESSION AUSTRALIA

Health Advocacy Project & Deaf Regional Health Project

DESKTOP REVIEW

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LIST OF ABBREVIATIONS

ASL	American Sign Language
ASLIA	Australian Sign Language Interpreters' Association
AUSIT	Australian Institute of Interpreters and Translators
BSL	British Sign Language
CHL	Critical Health Literacy
DHH	Deaf or Hard of Hearing
DHHS	Department of Health & Human Services
DRH	Deaf Regional Health
ED	Emergency Department
GP	General Practitioner
HCIS	Health Care Interpreting Services
HPV	Health Purchasing Victoria
ILC	Information, Linkages and Capacity Building
ITC	Interpreting and Translating Centre
LEP	Low English Proficiency
LSP	Language Service Provider
MBS	Medicare Benefits Schedule
NAATI	National Accreditation Authority for Translators and Interpreters
NABS	National Auslan Booking Service
NDAP	National Disability Advocacy Program
NDIA	National Disability Insurance Agency
NDIS	National Disability Scheme
NESB	Non-English Speaking Background
NHS	National Health Service
NRS	National Relay Service
NZSL	New Zealand Sign Language
PBS	Pharmaceutical Benefits Scheme
PROM	Patient Reported Outcome Measure
TIS	Translating and Interpreting Service (TIS National)
UTS	Unable To Service
VRI	Video Remote Interpreting

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Executive Summary

Background

The Deaf and hard of hearing community includes people who are Deafblind and those with varying degrees of hearing impairment. Reasonable adjustments to facilitate equitable service access vary according to multiple factors, including primary language. Adjustments may include interpreters, lip-reading, use of hearing aids, access to hearing loops, and Auslan, plain English or visual resources, amongst others.

Deaf people commonly use sign language as a preferred language for face-to-face communication. Australian Sign Language (Auslan) is the recognised language of the Australian Deaf community. Auslan has its own distinct syntax and grammar and is composed of precise handshapes, facial expressions and body movements that can convey both concrete and abstract information. Many Auslan users ascribe their experiences as one that aligns with cultural and linguistic identity. According to the 2016 Census, there were 3,130 persons in Victoria who used sign language at home.¹ Sustainable access to quality interpreting services is essential to the equitable social and economic participation of individuals who use Auslan as their primary language.

Objectives

Funded by the Victorian Disability Advocacy Futures Grants program, the **Deaf Victoria Health Advocacy Project** seeks to explore new models of accessing mainstream health for Victorians who are Deaf or Hard of Hearing.

Funded by the National Disability Insurance Agency, Information, Linkages and Capacity Building (ILC) grant, Expression Australia's **Deaf Regional Health Project** will support the delivery of activities which to ensure people who are Deaf or hard of hearing are well supported in hospitals and health centres.

Desktop review

This report provides a review of the current policy context and service delivery, together with the identification of the core components of service models as identified by a literature review and jurisdictional scan. This provides the foundational knowledge upon which the service models will be built. Key review findings are outlined below.

Legislative & policy context

Key findings include:

- It is recognised that people from culturally and linguistically diverse backgrounds may find it difficult to navigate unfamiliar services, require additional services, and/or face discrimination.
- Government departments and agencies have a responsibility to ensure people who are Deaf or Hard of Hearing are provided clear information and assistance, when needed, particularly to enable informed decision making and consent.
- Victorian Government and Commonwealth Government legislation clearly outlines the responsibility for equitable access to services by Victorians who are Deaf or Hard of Hearing. Under such legislation, the failure to identify the need for, or to promote the availability of, an appropriate language service may have legal consequences.

1. It is recognised that Census reported Is considered underrepresented, noting Auslan may be the primary language but not used at home.

- Government policy supports the delivery of culturally and linguistically appropriate services through the provision of certified interpreters and accessible information. Service agencies require strategies to address access and equity issues and ensure people's overall needs are met. Further, Departments are required to deliver cultural competence training and assess the effectiveness of service delivery.
- Disability advocacy is a critical safeguard to prevent abuse and neglect and to uphold, promote and protect the rights of people with disability.

Funding & accountability

Key findings include:

- The Commonwealth and State Government share the responsibility for funding access to Auslan interpreting services in the health sector.
- In public health services, the hospital staff are responsible for booking appointments. For private medical appointments, the service is responsible for booking interpreters under the National Auslan Booking Service (NABS),² whilst the patient is responsible for scheduling interpreters under the National Disability Insurance Scheme (NDIS).
- A clearly defined process is required to ensure clarity for both patients and public/private health service staff.

Interpreter service access in healthcare

Key findings include:

- Departmental and funded organisations are responsible for ensuring clients can effectively communicate at all critical information points.
- Hospitals have an obligation to ensure all clinicians and administrative staff are provided cultural competence training and patients who require interpreters are provided with certified practitioners.
- Access to Auslan interpreters is variable across the Victorian public health system. Core drivers of this variability include:
 - ▶ Patient awareness of their rights and capacity to self-advocate;
 - ▶ Hospital implementation of accessibility practices; and
 - ▶ Access to certified interpreters.
- It is reported that in the absence of access to a certified interpreter, adhoc communication methods are employed, including writing notes, lip-reading and/or family or friends.
- Failure to provide language services exposes government agencies and their clients to significant social and economic risks and can have a significant impact on the quality of life for Deaf clients. Such impacts may include reduced or adverse health outcomes, and increased cost of treatment.

Auslan interpreting service demand

Key findings include:

- In 2016/17, there were 12,883 interpreting service hours delivered in the Victorian health setting, representing 16.8% of the total service demand, and a 6.2% per annum increase from 2014/15.
- Video Remote Interpreting (VRI) has great potential to improve access to interpreters, particularly for regional and rural residents in after hours and/or emergency situations. Barriers encountered by Deaf people in accessing telehealth must be overcome.

2. NABS predominantly provides fee for service Auslan interpreting for medical appointments for individuals not eligible for the NDIS. The patient may also facilitate the booking.

Advocacy

Key findings include:

- Disability advocacy strengthens the capacity of people with disability to speak for themselves by actively supporting and encouraging self-advocacy.
- Self-advocacy plays a significant role in enabling people with a disability to develop skills that ensure that their rights and interests are respected and realised. Due to Deaf cultural norms, Deaf individuals may have limited self-advocacy capacity. Empowering those with hearing loss and teaching self-advocacy skills has great potential to improve quality of care and health outcomes.
- The National Disability Advocacy Program provides access to disability advocacy that promotes, protects and ensures full and equal enjoyment of all human rights for people with disability.

Deaf Victoria receives funding from DHHS and the Office of Disability to provide advocacy, information and referrals about issues to strengthen community participation and quality of life for Deaf and hard of hearing Victorians. Deaf Victoria is currently designing a model for a responsive and timely on-call advocacy service for Deaf patients accessing health care services and a Peer Advocacy Framework. Further work is required to review approaches to strengthen the engagement of health services with funded advocacy services.

Literature review

Key findings include:

- Deaf individuals experience unique communication barriers in accessing healthcare.
- Health literacy is recognised as a fundamental skill required in maintaining health and accessing local healthcare. Patients with low English proficiency may demonstrate a poorer understanding of chronic conditions and adoption of changes in lifestyle, reduced comprehension of diagnoses and treatment and poor adherence to medical advice. Many Deaf Australians lack access to preventative and ongoing health care information. This is due to a lack of available information in Auslan, together with limited opportunities to gather information through social networks and other informal pathways. As such, the capacity to self-manage health care is limited for these individuals.
- Due to an increasing complexity of the health system, help to navigate the system is becoming of greater importance for consumers, carers and health professionals.
- Communication is key to enabling patients to decide among different options of care, strengthening autonomy and capacity for self-management. Effective communication between patients and healthcare providers is essential to the provision of high quality, patient-centred health care. The quality of communication with healthcare providers is a major contributor to patient satisfaction and ongoing health care access.
- The use of terminology in health communication can be a complex issue. Misunderstandings may arise when patients do not fully understand the terms used by their healthcare practitioners.
- Healthcare providers and interpreters must explicitly clarify their mutual expectations before they start conducting a health care encounter, with decisions based on the expectations of the deaf patient, giving them opportunity to be involved in the process
- There is a significant body of research relating to the risks of ad-hoc interpreter use and misunderstandings of the role of the professional interpreter.
- The use of interpreters cannot be addressed by increasing interpreter availability alone. There are several factors influencing health care experiences across service types, including in primary care and emergency care, diagnostic services, and inpatient services. Increasing interpreter use requires interventions targeted at both individual physicians and the practice environment.

- Communication barriers can lead to poorer personal empowerment, social inclusion, self-efficacy and autonomy and may also lead to low self-esteem, symptoms of anxiety, depression and greater mental health issues.
- Ineffective communication may result in patients experiencing fear, mistrust, frustration and embarrassment. As a result of dissatisfaction with their health care, patients may avoid and delay seeking health services or not seek care until they are very sick, then presenting when a condition is more advanced.
- In addition to the significant impact on the quality of life for Deaf patients, a failure to ensure optimal communication exposes government agencies and their clients to significant social and economic risks.
- Improved access to health information and communication support has the potential to significantly enhance health care experiences and outcomes for the Deaf community. Recommendations to improve the quality and safety of care provided to hospitalized patients include initiatives to enhance **health literacy**, **cultural competence of hospital staff**, **communication support** and **health service systems**.
- Public health entities must work together with sign language users to address inequities in health information access.

Jurisdictional review

Key service model components employed across relevant jurisdictions include:

- **Promotion** of patient rights relating to communication needs and interpreter access.
- An **Interpreter Card** that lets healthcare providers know an interpreter is required.
- Patient information and resources, including:
 - ▶ Communication tools (to complement interpreters during for example, an inpatient ward admission);
 - ▶ A visual pain scale to help healthcare workers comprehend the severity of symptoms reported in the absence of an interpreter; and
 - ▶ Communication alert sign for staff to put on patient bedside chart and stickers to alert staff.
- Provision of **accessible information**, including videos where appropriate and sight translation of documents that support patients to manage their own health and make informed decisions.
- Clear hospital **policies, procedures and processes** relating to interpreter engagement and staff accountability for interpreter booking. Considerations include:
 - ▶ Scheduling extended medical appointments where an interpreter is required;
 - ▶ Communication needs should be recorded in the patient's record (with a visible alert); and
 - ▶ Communication needs should be shared with other services when the patient is referred to secondary care services.
- Hospital **staff orientation programs** and **in-service training** programs relating to assessing access needs, cultural awareness training for relevant staff, including practical training on how to book and work with interpreters.
- Use of **Video Remote Interpreting and app-based technology** to enhance access, particularly in emergencies (e.g., emergency departments, birth units, intensive care units).
- Routine **monitoring** of service access and quality, together with patient reported outcomes and satisfaction.

Key service model components

The identified components of service model that may drive high quality, accessible health care for patients who are Deaf or hard of hearing are outlined in Figure ES-1.

Figure ES-1: Service model components to strengthen health care access & outcomes



2. Context & objectives

2.1. BACKGROUND

The Deaf and hard of hearing community includes people who are Deafblind and those with varying degrees of hearing. Reasonable adjustments to facilitate equitable service access vary according to multiple factors, including English and Auslan proficiency. Adjustments may include interpreters, lip-reading, use of hearing aids, access to hearing loops, and Auslan, plain English or visual resources, amongst others.

Deaf people commonly use sign language as a preferred language for face-to-face communication. Australian Sign Language (Auslan) is the recognised language of the Australian Deaf community. Auslan has its own distinct syntax and grammar and is composed of precise handshapes, facial expressions and body movements that can convey both concrete and abstract information. Many Auslan users ascribe their experiences as one that aligns with cultural and linguistic identity. According to the 2016 Census, there were 3,130 persons in Victoria who used sign language at home.³ Sustainable access to quality interpreting services is essential to the equitable social and economic participation of individuals who use Auslan as their primary language.

In 2014, Deaf Victoria commissioned an inquiry into the access of Auslan Interpreters in Victorian hospitals. The project interviewed 72 Deaf or hard of hearing people about their experiences. Key issues identified included:

- A lack of Auslan interpreting support and reliance on alternative methods of communication, including family members;
- Inadequate skillset of Auslan Interpreters and inconsistent interpreter booking systems; and
- Ineffective complaints processes.

The review found that access to Auslan interpreters in Victorian hospitals was largely dependent on the knowledge of frontline staff, in-house interpreter booking officers and language service providers, and the ability of Deaf patients to advocate for themselves. The review made four recommendations:

1. *Roll out National Auslan Booking Service (NABS) to cover all medical services in Australia or, the use of Auslan-specific interpreting Agencies for all Hospitals in Victoria.*
2. *Compulsory and ongoing professional development around booking of interpreter services for all frontline medical staff and the development of best practice guidelines for interpreter booking procedures.*
3. *Interpreting Agencies, the Australian Sign Language Interpreters' Association (ASLIA) and National Accreditation Authority for Translators and Interpreters (NAATI) develop continual professional development around medical interpreting, quality assurance and annual assessment of the skills of Auslan interpreters.*
4. *Skype interpreting on iPads to be used in emergency service departments in all Victorian hospitals.*

There has been significant reform in the sector since the review, with the roll-out of the National Disability Insurance Scheme (NDIS) and the NAATI Certification Scheme, and the community exposure to video remote interpreting (VRI) during the COVID-19 global health emergency.

3. It is recognised that Census reported is considered underrepresented, noting Auslan may be the primary language but not used at home.

2.2. PROJECT OBJECTIVES

2.2.1. Deaf Victoria Health Advocacy project

Funded by the Victorian Disability Advocacy Futures Grants program, the Deaf Victoria Health Advocacy Project seeks to explore new models of accessing mainstream health for Victorians who are Deaf or hard of hearing.

The objective of this project stream is to build on the 2014 *Inquiry into access to Auslan Interpreters in Victorian Hospitals* and the subsequent Victorian Equal Opportunity & Human Rights Commission *Signs for Health* project recommendations to identify the core components of a service model that supports high quality, accessible health care.

This will complement additional project work led by Deaf Victoria to bring about change to the inclusion of Deaf consumers in the health and hospital sector and empower consumers to share their stories with the broader Deaf community to improve awareness and service access.

Other project streams seek to:

- Provide a model for responsive and timely on-call advocacy service for Deaf or Hard of Hearing patients accessing hospitals and other health care services;
- Deliver a series of education workshops in metropolitan and major regional centres to educate consumers about accessing health services, with a particular focus on appropriate uses of NDIS funding to access health services in Victoria; and
- Research and design a Peer Advocacy Framework for future implementation.

Deaf Victoria have identified the following critical points for focus:

- Self-presentation or presentation via Ambulance to hospital emergency departments (EDs) or urgent care centres;
- Inpatient care, including all points from admission to discharge; and
- Birthing.

In addition, the service model review is to consider communication with Deaf relatives for patients receiving care who may not be Deaf.

2.2.2. Expression Australia Deaf Regional Health project

Funded by the National Disability Insurance Agency (NDIA), Information, Linkages and Capacity Building (ILC) grants aim to: share information; make connections between people, groups and communities; and build capacity - that is, help people develop skills and abilities.⁴ A fundamental principle of the ILC grants is need for people with disability, government and communities to work together to achieve genuine and meaningful community inclusion.

Expression Australia has received an ILC grant to support the delivery of activities which enhance the awareness of hospital staff in regard to inclusive and accessibility practice, including communication, to ensure Deaf or Hard of Hearing people who are well supported in hospitals and health centres.

The Deaf Regional Health project (DRH) aims to ensure Deaf or Hard of Hearing people can access services from key hospitals and health centres in regional Victoria and Tasmania in a way that meets their language & disability needs. DRH will build capacity to ensure that:

4. <https://www.vic.gov.au/disability-information-linkages-and-capacity-building>

- Health gateway systems (both intake and triage) are accessible to Deaf or Hard of Hearing people;
- Providers' accessibility processes are understood and utilised internally and by Deaf or Hard of Hearing people; and
- Key contacts within health providers have the capacity to maintain and grow accessibility capacity for Deaf or Hard of Hearing people within their organisations.

The initial service model design requires activities to identify and understand:

- Key support systems for Deaf or Hard of Hearing people accessing health providers;
- The experience of workers & users relating to the accessibility systems of hospitals and health centres for Deaf or Hard of Hearing people;
- What works well & what needs improvement from both a user and provider perspective;
- Opportunities for improvement;
- Accessibility & inclusion gaps;
- Current resources, including health & awareness resources, and language/technology resources; and
- Professional development needs for interpreters in health settings.

The key project objective is to facilitate the DRH program design. The project requires a co-design approach with regional Deaf or Hard of Hearing communities and health providers to ensure the DRH project addresses local needs.

2.3. REPORT OBJECTIVE

This report provides a review of the current policy context and service delivery, together with the identification of the core components of service models as identified by a literature review and jurisdictional scan. This provides the foundational knowledge upon which the service models will be built.

3. Legislative & policy context

The following section considers the legislative and policy frameworks under which Victorian public health services operate.

3.1. NATIONAL LEGISLATION

Relevant Commonwealth legislation is outlined in Table 3-1.

Table 3-1: Commonwealth legislation

LEGISLATION	OVERVIEW
Australian Human Rights Commission Act 1986	<p>Gives effect to Australia's obligations under several international conventions/declarations, including:</p> <ul style="list-style-type: none"> The <i>International Covenant on Civil and Political Rights</i>, Article 27 which states: 'In those States in which ethnic, religious or linguistic minorities exist, persons belonging to such minorities shall not be denied the right, in community with the other members of their group, to enjoy their own culture, to profess and practise their own religion, or to use their own language'; and The <i>Convention on the Rights of Persons with Disabilities</i>, which states: 'These rights shall be granted to all disabled persons without any exception whatsoever and without distinction or discrimination on the basis of race, colour, sex, language, religion, political or other opinions, national or social origin, state of wealth, birth or any other situation applying either to the disabled person himself or herself or to his or her family.'
Disability Discrimination Act 1992	<p>The objects of this Act are:</p> <ol style="list-style-type: none"> to eliminate, as far as possible, discrimination against persons on the ground of disability in the areas of: <ol style="list-style-type: none"> work, accommodation, education, access to premises, clubs and sport; and the provision of goods, facilities, services and land; and existing laws; and the administration of Commonwealth laws and programs; and to ensure, as far as practicable, that persons with disabilities have the same rights to equality before the law as the rest of the community; and to promote recognition and acceptance within the community of the principle that persons with disabilities have the same fundamental rights as the rest of the community.
Disability Services Act 1986	<p>The <i>Disability Services Act</i> provides a comprehensive framework for the funding and provision of disability support services, including grants for advocacy services (Part II, Division 3)</p>
National Disability Insurance Scheme Act 2013	<p>This Act provides for the NDIS, comprising:</p> <ol style="list-style-type: none"> the provision of services or activities that are in the nature of coordination, strategic or referral services or activities; and funding for persons or entities to enable them to assist people with disability to participate in economic and social life; and individual plans under which reasonable and necessary supports will be funded for certain people, called participants. <p>The Act outlines the principles relating to the participation of people with disability, including that the NDIS is to:</p> <ol style="list-style-type: none"> respect the interests of people with disability in exercising choice and control about matters that affect them; and enable people with disability to make decisions that will affect their lives, to the extent of their capacity.

3.2. NATIONAL STANDARDS

Multicultural Access and Equity Policy

The Commonwealth of Australia (Department of Social Services) 2015 *Multicultural Access and Equity Policy Guide*⁵ acknowledges an obligation on Australian Government departments and agencies to ensure their programmes and services are accessible by all eligible Australians, responsive to their needs, and deliver equitable outcomes for them, regardless of their cultural and linguistic backgrounds. *The Guide does not explicitly include or exclude non-spoken languages.*

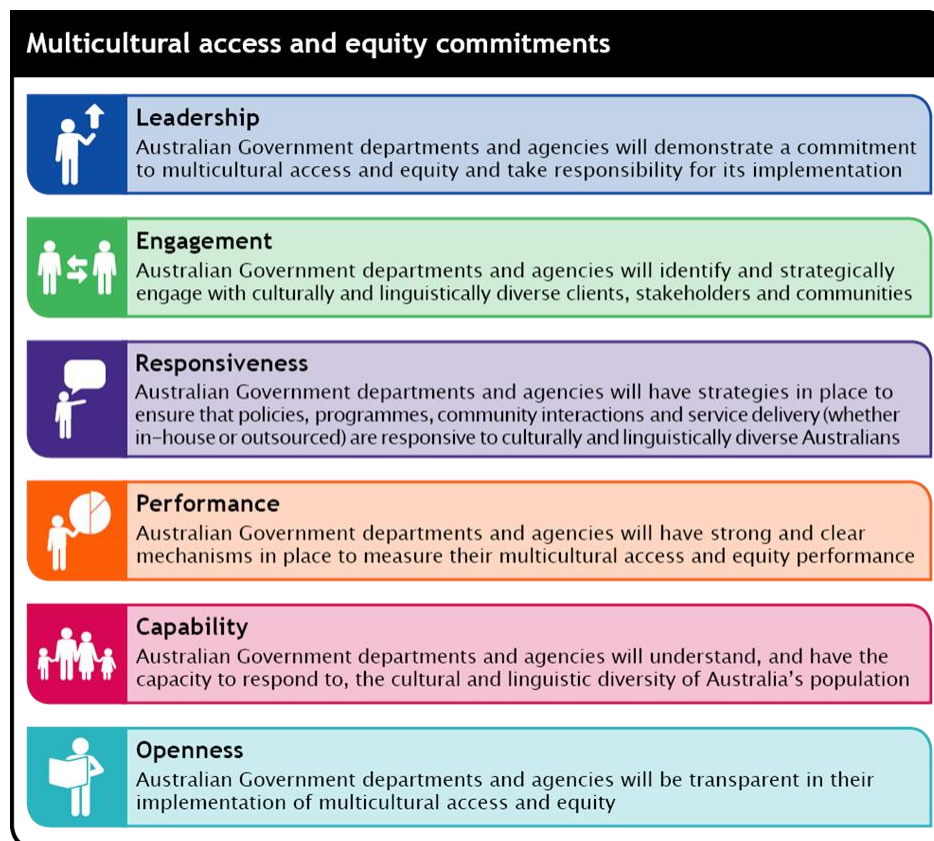
5. <https://www.homeaffairs.gov.au/mca/PDFs/multicultural-access-equity-policy-guide.pdf>

Access – means that barriers of culture and language should not impede the delivery of Australian Government programmes and services to those who are entitled to receive them.

Equity – means that Australian Government programmes and services should deliver outcomes for culturally and linguistically diverse Australians on par with those for other Australians.

The *Multicultural Access and Equity Policy* requires Australian Government departments and agencies to apply six commitments to all relevant activities, including those conducted on behalf of government by contractors and service delivery partners (Figure 3-1).

Figure 3-1: Multicultural access and equity commitments



Commonwealth and State and Territory government access and equity policies require government agencies, and bodies funded by government, to provide language services if a person has difficulty expressing themselves fully in English, or understanding English fully – particularly in contexts when miscommunication has implications for a person's rights, health or safety. A convention across policies is that the government agency, or third party service provider, is responsible for providing a certified interpreter free of charge; and should take steps to ensure certified interpreters are available when required.

My Healthcare Rights (2019)

In 2019 the Australian Commission on Safety and Quality in Health Care launched '*My healthcare rights*', the second edition of the Australian Charter of Healthcare Rights. The Charter describes the rights that consumers, or someone they care for, can expect when receiving health care. These rights apply to all people in all places where health care is provided in Australia. This includes public and private hospitals, day procedure services, general practice and other community health services.

⁶ Key principles of the Charter are outlined in Table 3-2.

6. <https://www.safetyandquality.gov.au/sites/default/files/2019-06/Charter%20of%20Healthcare%20Rights%20A4%20poster%20ACCESSIBLE%20pdf.pdf>

Table 3-2: Charter principles

PRINCIPLE	I HAVE A RIGHT TO:
<i>Access</i>	<ul style="list-style-type: none"> Health care services and treatment that meets my needs
<i>Safety</i>	<ul style="list-style-type: none"> Receive safe and high quality health care that meets national standards Be cared for in an environment that makes me feel safe
<i>Respect</i>	<ul style="list-style-type: none"> Be treated as an individual, and with dignity and respect Have my culture, identity, beliefs and choices recognised and respected
<i>Partnership</i>	<ul style="list-style-type: none"> Ask questions and be involved in open and honest communication Make decisions with my healthcare provider, to the extent that I choose and am able to Include the people that I want in planning and decision-making
<i>Information</i>	<ul style="list-style-type: none"> Clear information about my condition, the possible benefits and risks of different tests and treatments, so I can give my informed consent Receive information about services, waiting times and costs Be given assistance, when I need it, to help me to understand and use health information Request access to my health information Be told if something has gone wrong during my health care, how it happened, how it may affect me and what is being done to make care safe
<i>Privacy</i>	<ul style="list-style-type: none"> Have my personal privacy respected Have information about me and my health kept secure and confidential
<i>Give feedback</i>	<ul style="list-style-type: none"> Provide feedback or make a complaint without it affecting the way that I am treated Have my concerns addressed in a transparent and timely way Share my experience and participate to improve the quality of care and health services

3.3. VICTORIAN LEGISLATION

In some instances, failure to identify the need for, and promote the use of, appropriate language services may have legal consequences. Victorian Government departments and funded organisations must comply with legislation outlined in Table 3-3.

Table 3-3: Victorian legislation

LEGISLATION	OVERVIEW
Charter of Human Rights and Responsibilities Act 2006 (Vic)	The Charter is designed to protect and promote human rights, including cultural rights. The Charter specifies that: <i>'all persons with a particular cultural, religious, racial or linguistic background must not be denied the right, in community with other persons of that background, to enjoy his or her culture, to declare and practise his or her religion and to use his or her language.'</i>
Disability Act 2006	The <i>Disability Act 2006</i> provides a legislative framework for the provision of high quality services and supports for people with disabilities. Key objectives include: advance community inclusion; promote and protect rights of those with disability; and deliver high-quality services. The <i>Disability Amendments Act 2019</i> provides amendments to the <i>Disability Act 2006</i> to aid Victoria's obligations under the <i>NDIS Quality & Safeguards Framework</i> .
Equal Opportunity Act 2010	The <i>Equal Opportunity Act 2010</i> protects people from discrimination on the basis of their individual attributes in certain areas of public life such as employment, education and the provision of goods and services. The objectives of the Act include to: <ul style="list-style-type: none"> Eliminate discrimination, sexual harassment and victimisation, to the greatest possible extent; Further promote and protect the right to equality set out in the <i>Charter of Human Rights and Responsibilities Act 2006</i>; Encourage the identification and elimination of systemic causes of discrimination, sexual harassment and victimisation; and Promote and facilitate the progressive realisation of equality. The Act includes a 'positive duty obligation' which means that departments and agencies need to take proactive and reasonable steps to address causes of discrimination, regardless of whether a complaint has been made or not.
Multicultural Victoria Act 2011	The Victorian Parliament recognises and values the cultural, religious, racial and linguistic diversity of the people of Victoria.

3.4. VICTORIAN GOVERNMENT POLICY

There are several Victorian Government policies that provide overarching guidance in relation to responsibilities to support equitable service access for Victorians who are Deaf or hard of hearing.

Absolutely Everyone: State Disability Plan 2017-2020

Absolutely Everyone sets the Victorian Government's vision for an inclusive Victoria which supports people with a disability to live satisfying everyday lives.⁷

There are five principles that underpin the plan:

- **Autonomy.** Autonomy is about having the capacity and support to make your own decisions. It is the freedom to decide upon your own beliefs and relationships;
- **Opportunity.** Opportunity is a part of being treated fairly and means having the chance to take advantage of a situation;
- **Human-rights.** The *Victorian Charter of Human Rights and Responsibilities Act* protects a range of human rights, respecting the rule of law, human dignity, equality, and freedom;
- **Diversity.** Human rights belong to all people without discrimination and the diversity of the people of Victoria enhances our community; and
- **Accountability.** We have developed this plan as a framework for delivering concrete actions and real outcomes for people with a disability to hold us accountable.

The Plan recognises that care must have adequate access to Auslan interpreters to overcome communication difficulties. One of the key priorities of *Absolutely Everyone* is to strengthen the disability advocacy sector.

Victorian Advocacy Futures Plan 2018-2020

The vision for the Victorian Disability Advocacy Futures Plan 2018–2020 is:

*'A thriving independent disability advocacy and self-advocacy sector led by and for people with disability that reflects their diverse voices and takes action to uphold and promote their rights, wellbeing and interests.'*⁸

The plan has four outcome areas:

- **Inclusion** – disability advocacy is inclusive of everyone;
- **Connection** – disability advocacy is strong, connected, and powerful;
- **Responsiveness** – disability advocacy is responsive and timely; and
- **Sustainability** – disability advocacy grows into the future.

The plan notes that disability advocacy is a critical safeguard to prevent abuse and neglect and to uphold, promote and protect the rights of people with disability.

Victorian Disability Advocacy Program

The Victorian Disability Advocacy Program supports disability advocacy agencies to undertake three types of advocacy:

- **Self-advocacy** – undertaken by someone with disability who speaks up and represents themselves. Support and training for self-advocacy is available through community-based groups;
- **Individual advocacy** – a one-on-one approach, undertaken by a professional advocate, relative, friend or volunteer, to prevent or address instances of unfair treatment or abuse; and
- **Systemic advocacy** – working for long-term social changes to ensure the collective rights and interests of people with disability are served through legislation, policies and practices.

7. <https://www.statedisabilityplan.vic.gov.au>

8. <https://www.statedisabilityplan.vic.gov.au>

Using Interpreting Services, Victorian Government Guidelines on Policy and Procedures

The *Victorian Government Guidelines on Policy and Procedures* defines three main points at which clients require access to language services:

- When required to make significant decisions concerning their lives;
- When being informed of their rights; and
- Where essential information needs to be communicated to inform decision making, including obtaining informed consent.

These guidelines also specify that interpreters should be NAATI Certified Interpreters (including both certified and provisionally certified interpreters) where possible and note that organisations must not directly or indirectly discriminate against people who have limited English proficiency or use sign language. Discrimination includes:⁹

- Refusing to provide a service;
- Providing a poor quality service; and/or
- Having unreasonable requirements, conditions or practices within the organisation that disadvantages clients because of their race, disability or other attributes.

The Guidelines also note that:

*'the government and its funded agencies have a duty to ensure that members of the public understand the information that is being provided to them, and should provide appropriately trained and credentialed interpreters when required. **Duty of care** may be breached if a staff member unreasonably fails to provide, or inform a client of their right to an interpreter. Government and its agencies can fulfil their duty of care by taking reasonable steps to actively identify whether language assistance is required and acting accordingly'.*

Departments are required to develop 'cultural diversity plans' to enhance the provision of culturally sensitive service delivery, involving three key aspects:

- Providing *cultural competency training* for staff;
- Ensuring that information on services is *readily accessible* to culturally and linguistically diverse communities; and
- Assessing the *effectiveness of service delivery* to culturally and linguistically diverse communities.

Department of Health & Human Services (DHHS) policies

Key directions of the Department of Health & Human Services (the department) are outlined below.

Strategic Plan

The department's *Strategic Plan*¹⁰ (2019) states:

'We can provide quality, safety assurance and improvement by ensuring our staff have appropriate qualifications and the people managing our services have the right mix of skills to ask the right questions and closely monitor the quality and appropriateness – including cultural safety and language needs – of care provided'.

9. <https://www.vic.gov.au/guidelines-using-interpreting-services/victorian-government-policy#victorian-government-policy>

10. Available: <https://dhhs.vic.gov.au/publications/department-health-and-human-services-strategic-plan>

Cultural Diversity Plan

The department's *Cultural Diversity Plan 2016-19*¹¹ provides a framework to embed cultural diversity in all of its' services, programs and policies.

The plan recognises that providing culturally responsive, competent, respectful and accessible services is a core responsibility of the department and the services it funds and delivers.

'The legislative framework that underpins the department's services provides for a person and family-centred approach to service delivery that responds to the needs of people from culturally and linguistically diverse communities. This framework also protects human rights and equal opportunity and aims to eliminate discrimination'.

Improving language services utilisation is a key outcome area of the framework. The following objectives outline the department's plan to work towards equitable and responsive services and programs:

- Facilitate better access to services for people from culturally and linguistically diverse backgrounds by overcoming barriers associated with eligibility, communication, navigation, discrimination and relevance;
- Use a range of communication strategies to provide information about the department's services and programs in languages other than English, to support people to make the best choices for their health and wellbeing;
- Improve the planning, allocation and efficient delivery of language services according to need across all parts of the health and human services system; and
- Promote and support the implementation of cultural responsiveness measures in service quality standards and accreditation systems that apply to services funded by the department.

Language Services Policy

The department's *Language Services Policy (2017)* details implementation support measures to ensure people with low English proficiency, or who use a form of sign language, have access to high quality services. Department-funded organisations and services are encouraged to develop local language services policies and procedures consistent with this policy.

Cultural Responsiveness Framework: Guidelines for Victorian Health Services

The department's *Cultural Responsiveness Framework (2009)* describes cultural responsiveness as the capacity to respond to the health care issues of diverse communities. It thus requires knowledge and capacity at different levels of intervention: systemic, organisational, professional and individual.

'Cultural responsiveness is viewed as a viable strategy to improve the links between access, equity, quality and safety, better health outcomes for culturally and linguistically diverse populations and as a strategy to enhance the cost effectiveness of health service delivery'.

Departmental policies/guidelines relating to various service streams and program areas highlight the need to embed language services into service delivery.

11. Available: <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/dhhs-delivering-for-diversity-cultural-diversity-plan-2016-19>

3.5. OTHER GUIDANCE

Good medical practice: a code of conduct for doctors in Australia

The Australian Health Practitioner Regulation Agency (AHPRA) Medical Board of Australia October 2020 Code of Conduct describes what is expected of all doctors registered to practise medicine in Australia.¹² It sets out the principles that characterise good medical practice and makes explicit the standards of ethical and professional conduct expected of doctors by their professional peers and the community. Section 4.3 outlines the principles of effective communication.

Effective communication is an important part of the doctor-patient relationship. It involves:

- Listening to patients, asking for and respecting their views about their health, and responding to their concerns and preferences;
- Encouraging patients to tell you about their condition and how they are currently managing it, including any other health advice they have received, any prescriptions or other medication they have been prescribed and any other conventional, complementary or alternative therapies they are using;
- Informing patients of the nature of, and need for, all aspects of their clinical management, including examination and investigations, and giving them adequate opportunity to question or refuse intervention and treatment;
- Discussing with patients their condition and the available management options, including their potential benefit and harm and material risks;
- Endeavouring to confirm that your patient understands what you have said;
- Responding to patients' questions and keeping them informed about their clinical progress;
- Taking all practical steps to ensure that arrangements are made to meet patients' specific language, cultural and communication needs, and being aware of how these needs affect patients' understanding; and
- Familiarising yourself with, and using whenever necessary, qualified language interpreters to support the flow of communication between you and your patients. . Government-funded and fee-for-service interpreter services are available.

Key findings:

- It is recognised that people from culturally and linguistically diverse backgrounds may find it difficult to navigate unfamiliar services, require additional services, and/or face discrimination.
- Government departments and agencies have a responsibility to ensure people who are Deaf or hard of hearing are provided clear information and assistance, when needed, particularly to enable informed decision making and consent.
- Victorian Government and Commonwealth Government legislation clearly outlines the responsibility for equitable access to services by Victorians who are Deaf or hard of hearing. Under such legislation, the failure to identify the need for, or to promote the availability of, an appropriate language service may have legal consequences.
- Government policy supports the delivery of culturally and linguistically appropriate services through the provision of certified interpreters and accessible information. Service agencies require strategies to address access and equity issues and ensure people's overall needs are met. Further, Departments are required to deliver cultural competence training and assess the effectiveness of service delivery.
- Disability advocacy is a critical safeguard to prevent abuse and neglect and to uphold, promote and protect the rights of people with disability.
- There is a noted lack of information relating to legislative requirements available in accessible formats, including Auslan, plain English, or visually (e.g., pictograms, picture cards).

12. <https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx>

4. Funding models

The following provides an outline of existing funding models for Auslan interpreting services.

4.1. STATE FUNDED HEALTH SERVICES

Language services in state-funded healthcare services are funded by the relevant state government.

*'The government and its funded agencies have a **duty of care** to anyone who is reasonably likely to be affected by their activities. Failure to satisfy duty of care can have legal consequences. In relation to language services, the government and its funded agencies have a duty to ensure that members of the public understand the information that is being provided to them and should provide appropriately trained and credentialed interpreters when required. Duty of care may be breached if a staff member unreasonably fails to provide or inform a client of their right to an interpreter'.¹³*

The *Victorian Government Report in Multicultural Affairs 2017/18*¹⁴ outlines the expenditure by departments and their entities on language services. Table 4-1 outlines the expenditure across the health and human services portfolio in 2017/18. Language-specific data is not available.

Table 4-1: DHHS, language services expenditure, 2017/18

SERVICE	EXPENDITURE	DESCRIPTION/OUTCOME
Victorian Health Services	\$28,600,000	Languages services are funded as part of activity-based funding arrangements for Victorian health services and hospitals.
Community Health Services	\$2,900,000	Direct funding is provided to community health services that are large users of language services.
Dental Health Services	\$891,000	Direct funding is provided to the Royal Dental Hospital Melbourne and public dental services.
Health Services Programs	\$1,955,187	This credit line is a centrally-funded and administered contract for the provision of language services across eligible health programs and funded agencies. This includes agencies across community health, mental health, drug and alcohol, rural health, community care, and refugee health.
Human Services Programs	\$3,050,054	The credit line enables facilitates access to language services by human services agencies, including agencies across housing and homelessness, child family protection, children and families, safety and disability services.
Other programs	\$93,612	Other key initiatives include: <ul style="list-style-type: none"> Home and Community Care for Younger People direct funding Family Safety Victoria – language services at The Orange Door Smoke free outdoor dining fact sheets Seniors concessions Information and Companion Card line Seniors and Companion Card issues Patient Review Panel Language Allowance
Total	\$37,489,853	

4.2. AMBULANCE ATTENDANCE & TRANSPORT

Ambulance Victoria responds to emergency and other calls for medical help from those in need. Ambulance Victoria acknowledges each customer has the right to access an interpreter if required.

Victorians who are Deaf or hard of hearing can use the National Relay Service (see below) to request an Ambulance.

13. <https://www.vic.gov.au/guidelines-using-interpreting-services/victorian-government-policy>

14. <https://www.vic.gov.au/sites/default/files/2019-08/Victorian-Government-Report-in-Multicultural-Affairs-2017-18.pdf>

National Relay Service

- The National Relay Service (NRS) is a government initiative, funded by the Department of Infrastructure, Transport, Regional Development and Communications, that allows people who are deaf, hard of hearing and/or have a speech impairment to make and receive phone calls.
- There are a number of connections that can be accessed by phone or web. The NRS is available 24 hours a day with an additional video relay service offered between 7am and 6pm (EST) between Monday and Friday. The video relay service is intended to be the equivalent of a telephony service and is not intended to be used as a video interpreting service for pre-arranged appointments.
- It is reported that the NRS has significant wait times and has been criticised for inaccessibility.

For ambulance attendances, it is understood that family members or friends most commonly provide communication assistance. There is minimal, if any, use of certified interpreters. The risks associated with potential miscommunication by paramedics or patients in this context are significant.

4.3. COMMONWEALTH FUNDED MEDICAL SERVICES

There are two funding streams for Deaf people to access interpreting services for private non-hospital medical appointments: NABS and NDIS.¹⁵

NABS

NABS has historically been funded by the Commonwealth Government Department of Social Services to provide interpreting services to people who use sign language for **private healthcare** appointments.¹⁶ This includes:

- Private medical practitioners providing services that are rebatable under the Medicare Benefits Schedule (MBS), including associated services such as the provision of test results; and
- Pharmacists dispensing Pharmaceutical Benefits Scheme (PBS) medications.

Health services covered by NABS include:

- Allied health (Audiology; Chiropractic; Medical Imaging; Dietetics; Exercise Physiology; Occupational Therapy; Optometry; Orthoptics; Osteopathy; Physiotherapy; Podiatry; Psychology; Speech Pathology);
- Dental;
- GP and non-GP Specialists (e.g., Endocrinologist; Gynaecologist/Obstetrician; Paediatrician; Psychiatrist); and
- Other services (e.g., Acupuncture; Aboriginal Health Worker; Diabetes Education; Family Planning; Iridologist; Mental Health Worker; Naturopath; and Remedial Massage).

NABS is funded to deliver services for:

- People under 65 years who are not eligible for NDIS;
- People 65 years and older; and
- Deaf parents/carers for private medical and healthcare appointments for their children aged 0-18 years old.

NABS continues to provide fee for service Auslan interpreting for medical appointments for individuals not eligible for the NDIS.

In the above settings, the reception staff of the treating practitioner schedules the Auslan interpreter at the time of booking an appointment. The patient may also facilitate the booking.

¹⁵ Deaf Australia, 2020

¹⁶ Sign language services to Deaf Indigenous people are provided for both public and private health care appointments.

NDIS

Since April 2020, people under the age of 65 years are required to select their preferred registered interpreting provider in their NDIS plan to access sign language interpreting services. Registered NDIS Providers, including Support Coordinators, can register with TIS National to allow NDIS participants and their carers access to NDIS funded interpreters.¹⁷

NDIS participants who have interpreter services included in their NDIS plan may use their funds in various settings, including GP or specialist appointments. They can **not** however be used in public hospitals of where covered by the National Relay Service.

When interpreting services are included in their plan, participants are educated about how bookings are to be facilitated during their planning meeting with their Local Area Coordinator or NDIA planner.

The planner will also take into consideration the 'reasonable and necessary criteria' in Section 34 of the *NDIS Act 2013* to determine access to assistive technology – this would include consideration of devices to facilitate video conference 'telehealth' appointments.

It is the **individual's responsibility to book their own interpreter**. This is because they may have a preferred interpreter and individual requirements they need to discuss with the interpreter.

Interpreters are pre-booked directly or via an interpreting service/agency. Deaf Australia note that:

'The Deaf individual is often required to 'negotiate' between the doctor's office and the interpreter or interpreter agency to ensure times/dates correspond with an interpreter's availability. This exercise can be especially draining for individuals who require an urgent medical appointment'.¹⁸

If they are unsure whether the service they are booking will provide an interpreter, the individual should enquire.

Access to interpreter providers varies according to the participant plan:

- Participants with agency managed plans must use an NDIS registered provider, with pay rates specified in the NDIS Price Guide; and
- Participants with self-managed plans have the option to use providers who are not registered with the NDIS, with pay rates agreed in the participants service agreement with the provider.

Quality assurance of registered providers is provided by the NDIS Quality and Safeguards Commission. The Commission is an independent agency established to improve the quality and safety of NDIS supports and services. It regulates NDIS providers, provide national consistency, promote safety and quality services, resolve problems, and identify areas for improvement.

4.4. IDENTIFIED CHALLENGES

Deaf Australia have identified the following key challenges regarding the booking and funding of interpreter services across the health system:¹⁹

- Deaf people who use Auslan are often required to organise interpreting services. This process is however not clearly defined;
- The responsibility on a Deaf person to organise an interpreter for private medical appointments has been difficult due to the lack of available appropriately skilled interpreter practitioners; and
- If a Deaf person needs to access health services via video conferencing platforms, there is an expectation that Deaf people use their own internet data, devices, and equipment to enable the video connection with the interpreter. The additional expenses are borne by the Deaf person.

17. <https://www.ndis.gov.au/understanding/language-interpreting-services>

18. Deaf Australia, 2020

19. Deaf Australia, 2020

Key findings:

- The Commonwealth and State Government share the responsibility for funding access to Auslan interpreting services in the health sector.
- In public health services, the hospital staff are responsible for booking appointments. For private medical appointments, the service is primarily responsible for booking interpreters under NABS, whilst the patient is responsible for scheduling interpreters under the NDIS.
- A clearly defined process is required to ensure clarity for both patients and public/private health service staff.

5. Interpreter services

The following provides a summary of key considerations relating to Auslan interpreter provision in Victorian public health services.

5.1. ACCOUNTABILITY

Departmental and funded organisations are responsible for ensuring clients are made aware of:

- Their right to communicate in their preferred language;
- When and how to ask for an interpreter;
- Provision of an interpreter is at no cost to the client; and
- That interpreters are professionals and confidentiality is part of their code of conduct.

In 2014, the Victorian Auditor-General's Office recommended that DHHS:²⁰

- Develop and report annually on their **cultural diversity plans** in consultation with the Office of Multicultural Affairs and Citizenship and the Victorian Multicultural Commission; and
- Include in their reporting of progress on cultural diversity plans explicit reference to:
 - ▶ How **culturally appropriate training** for staff has been incorporated into the delivery of services for culturally and linguistically diverse communities;
 - ▶ How information/data has been used to **increase accessibility of services** for culturally and linguistically diverse communities; and
 - ▶ The effectiveness of service delivery to culturally and linguistically diverse communities as an integral part of **program evaluation**.

5.2. INTERPRETER ACCESS

Critical access points

Critical information points in healthcare may include:

- Providing information to the treating physician, including clinical histories;
- Consenting to assessments and diagnostic tests;
- Receiving results of investigations and procedures;
- Understanding diagnosis and prognosis;
- Making informed consent and decisions regarding health care and development of treatment plans;
- Understanding prevention and treatment plans, and how to manage a condition, including medication requirements;
- Understanding how to prepare for procedures and admission requirements;
- Engaging with a variety of hospital staff (e.g., doctors, nurses, allied health, food services, cleaners) throughout an inpatient stay;
- Understanding discharge/post-op instructions, including knowing what symptoms to report and when to return for follow-up;
- Throughout an outpatient clinic episode of care; and
- Engaging with reception staff regarding appointments.

20. <http://www.audit.vic.gov.au/publications/20140529-Migrants-Services/20140529-Migrants-Services.pdf>

The following are critical points defined in the DHHS *Language Service Policy* at which people require access to information in their preferred language:

- The client is being informed of their rights (e.g., privacy, confidentiality) and responsibilities (for example, fees);
- The client is required to make significant decisions concerning their lives (e.g., provision of test results, medication regimes, other interventions, undertaking assessment and care planning, conducting assessment outcomes);
- Essential information needs to be communicated and understood to inform decision making (e.g., procedures and referral options); and
- Giving informed consent (e.g., to treatment, release of information, power of attorney and guardianship matters).

Assessing the need for an interpreter

A client's English proficiency should not be assumed to be at a sufficient level. Although a Deaf or hard of hearing person may demonstrate fluency in written or spoken English, they may need, or prefer, to communicate in Auslan through an interpreter. Departmental services and funded organisations are responsible for providing appropriate language services. Engaging an interpreter is recommended if:²¹

- Requested by the client - the client prefers to speak in his/her own language or the client speaks English as a second language, and is in a stressful, complex or unfamiliar situation;
- The client cannot comprehend or respond to basic questions in English, the client is difficult to understand, or can only respond in a limited way; or
- The client relies on family or friends to communicate.

Wherever possible the need for an interpreter should be determined prior to an appointment. It is important that staff who make the appointment ask if an interpreter is required. Various active and direct approaches can be employed to improve access to services:

- The identification of clients who require language services should be included in referral information and should be a part of standard initial contact with clients;
- Where specific language services are required by a client, such as an interpreter, this information should be systematically recorded as part of the client's record, with appropriate flags to alert others about the client's needs; and
- An effective method for assessing English proficiency is to conduct a short, informal interview with the person, asking for basic details about their reason for attending and their background.

There are no known models of in-house employment of Auslan interpreters in Victorian health services. Rather, interpreters are booked through contracted language service providers (LSPs).

Booking the interpreter

To book an onsite interpreter, the following information is required:

- Client's name, date and time the interpreter is required and anticipated duration of booking;
- Type of appointment (e.g., a medical or legal appointment) and the nature of the matter to be discussed (e.g., aged care health assessment, family violence police interview);
- Address where the interpreter is required to attend and the name and telephone contact details of the person the interpreter needs to report to; and
- Preferred gender of the interpreter (if relevant) and the interpreter's name if a specific interpreter is required for continuity of care reasons.

21. State of Victoria, *Using interpreter services – Victorian Government Guidelines on Policy and Procedures*.

It is reported that the system is inflexible, with very little opportunity to negotiate a time that enables an available interpreter to attend with a Deaf or hard of hearing patient.

Language service providers

To maintain a consistently high quality of service, LSPs are contractually obligated to:

- Ensure all interpreters meet the minimum continuous education requirements of NAATI;
- Promote quality of service by providing ongoing professional development opportunities for interpreters and translators to upgrade their skills and qualifications;
- Give preference to filling a job request with an interpreter who has been trained and/or has relevant experience; and
- Provide access to counselling or de-briefing sessions as required for interpreters involved in stressful and distressing occasions of service.

Identified challenges

Key identified barriers to interpreter access include:

- Inadequate understanding by the Deaf patient of their rights;
"It is crucial that non-English speakers are informed and empowered to use language services."²²
- Inadequate staff training in relation to culturally appropriate service delivery; and
- Interpreter supply, that is, difficulty in accessing:
 - ▶ Interpreters with the appropriate credentials and experience (e.g., mental health), particularly for onsite services in regional and rural locations;
 - ▶ Interpreters of the appropriate gender (e.g., for obstetric/maternity visits); and
 - ▶ Interpreters who work with people who are Deaf and blind.

It is reported that in the absence of access to a certified interpreter, a Deaf patient may rely on other communication methods, including: writing notes; gestures; lip-reading; and/or family or friends.

Use of family & friends

The inappropriate use of family members as a substitute for certified interpreters poses a risk to individuals and service providers. In these situations, communication may be distorted or changed because of a lack of language competence or bias on the part of the family member. The DHHS *Language Services Policy* states that family members, carers, and other support persons should not be used in the place of a professional interpreter because of: potential breaches of confidentiality; possible misinterpretation; conflict of interest; potential loss of objectivity; conflict of roles; or unintended harm or exposure to emotionally distressing information. Further, children acting as interpreters in some situations may lead to further trauma for the child, including negative emotional and psychological well-being.

5.3. INTERPRETER QUALITY

Interpreter competencies

NAATI Certified Interpreters (formally 'Professional Interpreters') are recommended for any high risk or specialised service. Core competencies are outlined below.

22. Federation of Ethnic Communities' Councils of Australia (2016) Australia's growing linguistic diversity: An opportunity for a strategic approach to language services policy and practice. Available: <http://fecca.org.au/publications/australias-growing-linguistic-diversity>.

Table 5-1: NAATI Competencies – Certified Interpreter²³

COMPETENCY	DESCRIPTOR
Transfer	Transfers complex, non- specialised messages from a source language into a target language using spoken or signed language that accurately reflects the meaning.
Language	Comprehends and produces two languages (spoken or signed, and written) in a variety of complex situations/contexts, appropriately using complex, but non- specialised language and commonly and uncommonly used expressions.
Intercultural	Understands how culture and language interact, identifies significant and nuanced culturally-specific information in spoken or signed language, and is able to apply this to the interpreting task.
Thematic	Knows about and understands a broad range of complex but non-specialised contexts, topics and current events, including where specialists in a domain speak or sign with a non-specialist audience.
Ethical	Has full and detailed knowledge and understanding of the relevant Code of Ethics, and is able to apply this to situations in interpreting practice, client interactions and other professional activities.
Research	Can use a variety of tools and methods to search for information, including some specialist resources, and is able to extract and manage complex information from research and apply it to the interpreting process.
Service Provision	Operates in the interpreting industry and manages interactions with clients to provide services.
Technological	Knows and is able to use technology required for interpreting processes, including telephone interpreting, video and onscreen interpreting.
Typical Domains & Situation Types	All situations in which a Certified Interpreter interprets, and dialogues, speeches and presentations in community interpreting settings including health (e.g. a clinician-patient consultation at a medical centre), legal (e.g. a client seeking a solicitor's advice), community (e.g. a speech at a community council meeting), immigration/ settlement (e.g. visa issues at an airport), education (e.g. during school lessons), social services (e.g. discussion about alleged welfare fraud), financial (e.g. a client applying for a loan), housing (e.g. dispute at a tenancy tribunal), business (e.g. at a business meeting), employment (e.g. dispute about breach of employment contract), insurance (e.g. making an insurance claim), consumer affairs (e.g. enquiry about consumer rights).

Under current procurement arrangements, there is extensive utilisation of provisionally certified interpreters in potentially complex situations. With an excess of booking opportunities, minimal difference in remuneration and recognition of skills and experience, there are minimal incentives for provisionally certified interpreters to undertake further certification testing.

Further, due to existing testing availability, Auslan interpreters are not currently able to gain additional certification as a Certified Specialist Health Interpreter. Specialist Health Interpreters are experienced and accomplished interpreters who have completed training and undertake continuous professional development in health interpreting. They are highly competent language users who understand specialised terminology, have extensive knowledge of the health domain, and a sophisticated understanding of their role as members of a healthcare team.

Interpreter ongoing development

As the national peak organisation representing the interests of Auslan and Deaf Interpreters in Australia, ASLIA provide a significant proportion of professional development activities. On average, one event per year will be targeted at skills required in the health setting.

23. <https://www.naati.com.au/information-guides/descriptors-for-interpreting/>

Table 5-2: ASLIA Professional Development Activities – Health²⁴

ACTIVITY TITLE	CONTENT	HOST	FORMAT	COST	TIMING	NAATI PD POINTS
Certified Interpreter Online Forum – Mental Health Interpreting	ASLIA (WA) presented a series of online forums for Certified Interpreters to discuss case studies. These forums are for those who may be looking towards the NAATI Specialist Certifications, or have many years of experience at the Certified Interpreter level.	ASLIA (WA)	Livestreamed online forum	\$30 (ASLIA member event only)	Sep 2020	Cat 1.4 (10)
Medical Interpreting in the Era of COVID-19	This online workshop sought to prepare interpreters to work in medical settings while remaining safe and avoiding infection exposure. Concepts taught during this session include: infectious diseases, personal protection equipment, contact precautions, droplet precaution, airborne precautions, specific information about COVID-19 protocols and what to do before/after medical assignments to reduce the risk of infection.	ASLIA (Qld)	Livestreamed online forum	\$40 (ASLIA member) \$80 (non-member)	Sep 2020	Cat 1.4 (10)

Key findings:

- Departmental and funded organisations are responsible for ensuring clients can effectively communicate at all critical information points. Health service staff require cultural competence training to ensure client needs are adequately identified and met through engagement of certified interpreters.
- Identified barriers to interpreter access include inadequate understanding by the Deaf patient of their rights and inadequate interpreter supply. It is reported that in the absence of access to a certified interpreter, adhoc communication methods are employed, including writing notes, lip-reading and/or family or friends.
- Failure to provide language services exposes government agencies and their clients to significant social and economic risks and can have a significant impact on the quality of life for Deaf clients. Such impacts may include reduced or adverse health outcomes, and increased cost of treatment.

24. <https://aslia.com.au/pd-and-events/calendar/>

6. Previous reviews

The following provides an outline of the key findings from relevant reviews.

Access of Auslan Interpreters in Victorian Hospitals, Deaf Victoria (2014)

Hospitals and the healthcare system are highly complex systems for any Victorian to navigate. In 2014, Deaf Victoria commissioned an inquiry into the access of Auslan Interpreters in Victorian hospitals. As noted in section 1, the reviewers interviewed 72 Deaf patients in relation to their experience in the Victorian hospital system. The report documents case studies with limited or absent access to certified interpreters due to one or more of the following factors:

- The Deaf patient and their family were not aware of their rights and unable to self-advocate;
- A breakdown in communication between hospital staff and the Deaf patient and their family;
- The hospital staff were unaware of accessibility requirements and processes to implement these; and
- Inflexibility of the hospital interpreter booking policy and procedures.

The review recommended changes to the Auslan interpreting booking systems and procedures in Victorian public hospitals and identified the need for continuous professional development of interpreters and hospital staff.

Signs of Health, Victorian Human Rights and Equal Opportunity Commission (2016)

The Victorian Equal Opportunity and Human Rights Commission conducted a further inquiry in 2015-16. Several further recommendations were made which led to the development of **Signs for Health**, a web-based information resource which provided information:

- For Victorian hospital staff to assist with providing safe, high-quality healthcare for patients who are Deaf, hard of hearing or Deafblind. This includes information on providing Auslan interpreters and other communication supports for patients as well as information about associated legal obligations; and
- For patients who are Deaf, hard of hearing or Deafblind on their rights to an interpreter when they go to hospital.

The website is no longer active.

Targeting Zero (2016)

In 2016, the Victorian Minister for Health commissioned a Review of Hospital Safety and Quality Assurance in Victoria. As reported in *Targeting zero: Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care, State of Victoria* the October to December 2015 data from the Victorian Healthcare Experience Survey shows that of the four per cent of people who needed help understanding English while in hospital, half didn't have access to an interpreter²⁵, and that:

“of those who did have access to an interpreter, only a handful had access to a hospital or telephone interpreter, with most relying on relatives or friends, rather than a professional”.²⁶

25. In this context, 'interpreter' refers to both qualified and adhoc interpreters.

26. <https://www.dhhs.vic.gov.au/publications/targeting-zero-review-hospital-safety-and-quality-assurance-victoria>

The review recommended that:

- DHHS monitors the Victorian Healthcare Experience Survey to ensure all public hospitals are providing interpreter services to patients who require them;
- When the Victorian Healthcare Experience Survey shows a hospital may not be complying with its requirement to provide accredited interpreter services to patients who need them, the department treats this as a serious performance issue and manage it accordingly; and
- Hospitals must ensure all clinicians are aware of their ability and obligation to request professional interpreter services when required.

Why Auslan Interpreting Matters (2015)

The Auslan Interpreting Industry Forum Victoria brought key stakeholders together into a network dedicated solely to addressing the systemic issues affecting the Auslan interpreting industry and increasing the number of NAATI accredited Auslan interpreters in Victoria. Identified issues included:

- Poor engagement of stakeholders outside the Deaf sector;
- Low awareness of the availability of Auslan interpreting services and processes for accessing these services;
- Poor planning and coordination across Government in relation to provision of Auslan interpreting;
- Limited understanding of the overall demand for Auslan interpreting;
- Reactive responses by Government to funding of Auslan interpreting;
- Inconsistent remuneration of interpreting across Government, industry and community sectors;
- Limited career development opportunities and pathways;
- Poor quality and availability of Government support and funding for ongoing education or training;
- The need for consistency in access to interpreting services state-wide; and
- The need for complaints or grievance protocols or ombudsman support for clients and interpreters, and formal professional supervision of interpreters.

Strategies identified to ensure a more coordinated response to the issues in the interpreting industry included:

- More effective use of community development practice frameworks;
- Stakeholder mapping and partnership development;
- Community awareness raising;
- Training and development;
- Promotions, marketing, communications;
- Leadership development; and
- Systemic funding support for interpreting.

Key findings:

- Hospitals have an obligation to ensure all clinicians and administrative staff are provided cultural awareness training and patients who require interpreters are provided with certified practitioners.
- Access to Auslan interpreters is variable across the Victorian public health system. Core drivers of this variability include:
 - ▶ Patient awareness of their rights and capacity to self-advocate;
 - ▶ Hospital implementation of accessibility practices; and
 - ▶ Access to certified interpreters.
- Strong partnership and collaboration are required to overcome long-standing issues impacting on Auslan interpreter supply.

7. Auslan interpreting service demand

The following provides an outline of the demand for Auslan interpreter services in the health sector.

7.1. HEALTHSHARE VICTORIA

HealthShare Victoria (HSV) (formerly Health Purchasing Victoria) is charged with key legislative functions under the *Health Services Act 1988* to:

- Supply or facilitate supply of goods and services;
- Provide advice and support;
- Monitor compliance;
- Foster improvements in use of systems and e-commerce;
- Maintain useful data and share data with health services; and
- Ensure probity (the quality of having strong moral principles, honesty and decency) is maintained in the purchasing, tendering and contracting of public hospitals.

Data provided from HSV for the 2019 calendar year indicates a total of 1,045 Auslan service hours delivered across metropolitan and regional health services. This equates with 20 hours per week across the 17 services data was available for.²⁷ Based on historical usage trends, this usage is lower than expected.

7.2. HISTORIC SERVICE DEMAND

In 2018, the Vicdeaf Workforce Capacity project assessed the total Auslan interpreting services delivered to the Victorian Deaf community over the 2014/15 to 2016/17 financial years by seven LSPs.²⁸ In 2016/17, there were 12,883 service hours delivered in the health setting, representing 16.8% of the total service demand, and a 6.2% per annum increase from 2014/15.

7.3. VIDEO REMOTE INTERPRETING

The department *Language Services Policy* states that face-to-face interpreting should be provided for complex, lengthy or legally binding matters that need discussion, whilst remote interpreting is particularly useful in emergency situations where immediate assistance is required.²⁹

Auslan-English interpreting has traditionally been delivered onsite. Since 2009, there has been an increased availability of VRI. VRI utilises two-way video conferencing technology via a high-speed telephone broadband service. There are a range of software tools available, ranging from encrypted videoconferencing equipment to the use of MHealth Direct, Skype/Microsoft Teams, Webex, Zoom and other similar programs through personal devices including handheld devices, laptops, or desktop computers.

VRI has great potential to improve access to interpreters, particularly for regional and rural Victorians³⁰ in after hours and/or emergency situations. Through VRI, sign-users can access

27. Alfred Health, Austin Health, Ballarat Health Services, Dental Health Services Victoria, Eastern Health, Hepburn Health Service, Latrobe Regional Health, Melbourne Health, Mercy Public Hospital, Monash Health, Northern Health, Peninsula Health, Peter MacCallum Cancer Institute, Royal Victorian Eye & Ear Hospital, St Vincent's Hospital, The Royal Children's Hospital & Western Health.

28. Auslan Connections (Vicdeaf); Auslan Services; Central Auslan Booking Service (CABS); Echo Interpreting; National Auslan Interpreter Booking Service (NABS); National Interpreting & Communications Service (NICSS); and OnCall Interpreters & Translators Australia.

29. Department of Human Services (2014) *Language Services Policy*. Available: www.dhs.voc.gov.au/languageservices

30. Of the persons in Victoria who signed at home in 2016, 717 (23.1%) were in regional Victoria where access to certified interpreters is limited.

services and information previously unavailable due to location, limited access to interpreters or time constraints.³¹

Table 7-1: VRI considerations

	ADVANTAGES	DISADVANTAGES
ONSITE	<ul style="list-style-type: none"> Auslan is a 3D language; Improved communication through greater interpersonal interaction, and understanding of non-verbal cues; More engaging for clients and greater alignment with person-centre care approach; Ensures client privacy; Clients can be technology-averse, including the elderly, those with cognitive impairment, and clients with complex needs (e.g., for clients who have experienced sexual assault, trauma or abuse, seeing the interpreter improves feeling of safety and trust); Embraced by practitioners, who have interpreter waiting at time of consultation; and Enables the use of visual aids (e.g., for explaining a medical procedure). 	<ul style="list-style-type: none"> The effective utilisation of interpreter capacity is compromised through the high demand for onsite services which reduces the availability of professional interpreters and creates operational wastage through travel time and associated charges.
REMOTE	<ul style="list-style-type: none"> Immediate access to interpreters in emergency situations, and for those that are not able to be pre-booked or required after hours; Appropriateness for less complex (more 'transactional') short duration services; Greater assurance of confidentiality. In small communities, where people from the same cultural/linguistic group may be familiar to one another, an interpreter based outside of the local community may be more appropriate. This is particularly important for health-related issues, domestic violence and sexual assault situations; Improved access in regional and rural service locations where onsite service delivery incurs lengthy delays in availability and significant travel expense. and Improved industry efficiency. Remote interpreting can increase access to professional interpreting services, reduce transport demands on interpreters and the associated costs. Further, VRI bookings are charged incrementally in 30-minute increments and can be pre-booked or available on demand. 	<ul style="list-style-type: none"> Lack of enforced quality standards relating primarily to confidentiality and call drop-outs; Acceptance by clinicians/practitioners; and Reduced ability for rapport building between end-user and interpreter in stressful situations.

Further research should investigate appropriateness of video-conferencing as it relates to task complexity.³²

In 2010, the Victorian State Government invested in the Auslan VRI Service with the intended aim to minimise the barriers of distance, time and cost involved with providing Auslan interpreters, especially in regional and rural areas across Victoria. Sites included the University Hospital Geelong, Bendigo Health and Latrobe Community Health Service.

It is noted that there have been concerns across the health sector regarding privacy using commercial platforms.³³ The ability to enable 3-way connections between the Deaf patient, doctor and interpreter have seen increased use during the COVID-19 pandemic. Recent physical distancing requirement have had a significant impact on the way services are delivered.

Following the declaration of a State of Emergency in Victoria on 16 March 2020, Auslan Connections saw a significant increase in the uptake of VRI and a corresponding reduction in unable-to-service (UTS) bookings (Table 7-2).

31. Orima Research, 2004

32. Lee et al., 2018

33. Deaf Australia, 2020

Table 7-2: Auslan Connections service profile, 2019/20

BOOKINGS	Q1	Q2	Q3	Q4
Completed VRI (% of completed)	1.3%	1.9%	3.5%	69.1%
UTS (% of total)	9.8%	7.5%	9.1%	3.3%

Learnings from this period demonstrate the potential impact of further investment in VRI. It is also important to learn about the barriers encountered by Deaf people in accessing telehealth during this period. These include:³⁴

- Unfamiliarity with VRI, equipment and internet functionality;
- Lack of home access to required equipment and internet services/data connectivity;
- Unclear booking processes;
- Confusion regarding funding of the service for Deaf persons ineligible for NDIS funding; and
- Ongoing challenges regarding the availability of skilled and credentialed Interpreters.

Ongoing access to VRI also must consider access to devices and NBN functionality, and the associated cost implications for service providers and users.

Key findings:

- In 2016/17, there were 12,883 Auslan interpreting service hours delivered in the health setting, representing 16.8% of the total service demand, and a 6.2% per annum increase from 2014/15.
- VRI has great potential to improve access to interpreters, particularly for regional and rural Victorians in after hours and/or emergency situations. Barriers encountered by Deaf people in accessing telehealth must be overcome.

34. Deaf Australia, 2020

8. Advocacy

The following provides an outline of advocacy services in the context of the Victorian Deaf and hard of hearing community.

8.1. WHAT IS ADVOCACY?

Advocacy for people with disability can be defined as speaking, acting or writing with minimal conflict of interest on behalf of the interests of a disadvantaged person or group, in order to promote, protect and defend the welfare of and justice for either the person or group by:³⁵

- Acting in a partisan manner (i.e. being on their side and no one else's);
- Being primarily concerned with their fundamental needs;
- Remaining loyal and accountable to them in a way which is empathic and vigorous (whilst respecting the rights of others); and
- Ensuring duty of care at all times.

On 30 May 2008, all Disability Ministers agreed to bring about improvements to disability advocacy under the National Disability Agreement. The following principles guide provision of advocacy for people with disability in Australia:¹

- Disability advocacy operates under relevant Commonwealth, State and Territory legislation and the principles of the United Nations Convention on the Rights of Persons with Disabilities and other relevant United Nations Rights Treaties, to protect and promote the legal and human rights of people with disability;
- Disability advocacy promotes the interests and wellbeing of people with disability and promotes their full and valued inclusion as contributing and participating members of the community;
- Disability advocacy seeks to influence positive systemic changes in legislation, policy and service practice and works towards promoting inclusive communities and awareness of disability issues;
- Disability advocacy promotes leadership and capacity building by people with disability;
- Disability advocacy ensures that views represented meet the individual preferences, goals and needs of people with disability;
- Disability advocacy strengthens the capacity of people with disability to speak for themselves by actively supporting and encouraging self-advocacy;
- Disability advocacy recognises and respects the diversity of people with disability;
- Disability advocacy ensures that the rights of people with disability to privacy, dignity and confidentiality are recognised and upheld; and
- Disability advocacy will foster effective strategic alliances to develop capacity to identify and respond to the needs of people with disability.

Approaches to disability advocacy can be categorised into six broad models being:

- **Citizen advocacy:** matches people with disability with volunteers;
- **Family advocacy:** helps parents and family members advocate on behalf of the person with disability for a particular issue;
- **Individual advocacy:** upholds the rights of individual people with disability by working on discrimination, abuse and neglect;
- **Legal advocacy:** upholds the rights and interests of individual people with disability by addressing the legal aspects of discrimination, abuse and neglect;
- **Self-advocacy:** supports people with disability to advocate for themselves, or as a group; and
- **Systemic advocacy:** seeks to remove barriers and address discrimination to ensure the rights of people with disability.

35. <https://www.dss.gov.au/our-responsibilities/disability-and-carers/program-services/for-people-with-disability/national-disability-advocacy-program-ndap>

Self-advocacy

Self-advocacy plays a significant role in enabling people with a disability to develop skills that ensure that their rights and interests are respected and realised. For people with a disability self-advocacy is about:

- Speaking on one's own behalf;
- Understanding rights;
- Making real choices; and
- Learning new skills.³⁶

Due to Deaf cultural norms discussed in section 9.1, Deaf individuals may have limited self-advocacy capacity.

'Even when patients want help, they do not know what to ask for and choose to remain silent rather than appear "stupid." Patients may pretend they understand treatment or avoid decision making due to lack of information'.³⁷

In addition to cultural norms, internalised audism may play a role in the limited self-advocacy skills of Deaf individuals.

"Audism refers to the notion that one is superior based on one's ability to hear or behave in the manner of one who hears."³⁸

When audism is internalised by a Deaf person, they may look to behave as a hearing person, as opposed to embracing Deaf identity and culture.³⁹ Within the healthcare setting, this may see Deaf patients seek and accept care most appropriate for hearing patients, instead of self-advocating for care most appropriate for them.

Empowering those with hearing loss and those from CALD backgrounds, in addition to teaching self-advocacy skills, has great potential to improve quality of care and health outcomes. There are several resources that have been developed to support strengthening self-advocacy and peer advocacy skills, particularly as it relates to the NDIS and patients with mental illness.

8.2. NATIONAL DISABILITY ADVOCACY PROGRA

The National Disability Advocacy Program (NDAP) provides people with disability with access to effective disability advocacy that promotes, protects and ensures their full and equal enjoyment of all human rights enabling community participation. The policy and implementation of the NDAP is guided by the principles and objectives of key legislation, conventions, agreements and frameworks.⁴⁰

The target group for advocacy support provided by NDAP agencies consists of people with a disability that:

- Is attributable to an intellectual, psychiatric, sensory or physical impairment or a combination of such impairments;
- Is permanent or likely to be permanent; and
- Results in a substantially reduced capacity of the person for communication, learning or mobility, and the need for ongoing support services.

36. <https://providers.dhhs.vic.gov.au/disability-advocacy-and-self-help>

37. Richardson, 2014

38. Bauman, 2004

39. The Deafhood Foundation

40. Including but not limited to: the United Nations Convention on the Rights of Persons with Disabilities; the National Disability Strategy; the National Disability Agreement, the National Disability Advocacy Framework; and the *Disability Services Act 1986*.

NDAP agencies can assist with issues that may arise with the NDIS or with service providers. There is no Deaf-specific NDAP agency in Victoria.

8.3. DEAF VICTORIA

Deaf Victoria is a not-for-profit organisation led and managed by Deaf and hard of hearing people. Deaf Victoria receives funding from DHHS and the Office of Disability to provide advocacy, information, and referrals about issues to strengthen community participation and quality of life for Deaf and hard of hearing Victorians.⁴¹

Key issues relating to the healthcare setting raised by community members with Deaf Victoria include:

- **Interpreter access:** no/limited interpreter access, and avoidable delays due to interpreter access (particularly in regional areas);
- **Health service procedures:** information about interpreting support was not shared between services, hospital refused to provide an interpreter, patient forced to use family member/friend/child to interpret, and requirement to self-advocate for access;
- **Interpreter concerns:** occupational health & safety or potential ethical breach, and misadministration (double booked, changed service requirements not communicated and failure to receive payment for complete service time); and
- **Complaints processes.**

Improved data capture is required to quantify the reported frequency of the above issues.

Deaf Victoria is currently designing a model for an on-call advocacy service for Deaf patients accessing health care services and a Peer Advocacy Framework. An '**Advocacy Pack**' has also been developed that includes:

- Correspondence regarding legislative requirements and rights-based approach;
- Health service staff guide that lists where and how to procure services such as interpreters, live captioning and other supports;
- Complaint and complaint escalation templates; and
- A (visual) Fact Sheet that explains patient rights and healthcare responsibilities.

Further work is required to review approaches to strengthen the engagement of health services with funded advocacy services.

8.4. VEOHRC

The Victorian Equal Opportunity and Human Rights Commission (VEOHRC) is a statutory authority in the Australian state of Victoria. Key functions and services under Victoria's human rights laws include undertaking independent reviews, investigations, and advocacy activities to address systemic issues and promote human rights.⁴²

A review of enquiries and complaints relating to healthcare access by Deaf or hard of hearing Victorians since July 2013 reveal: 4 enquiries, 3 of which relate to Auslan interpreter access. It is notable that there are several enquires relating to services in other service settings declining to pay for reasonable adjustments; and 2 complaints relating to availability of hearing loops and captioning.

The VEOHRC deliver training sessions relating to the *Charter of Human Rights and Responsibilities Act 2006 (Vic)* to public authorities as a means of designing and delivering accessible and equitable

41. <https://www.deafvictoria.org.au/about-us/>

42. <https://www.humanrights.vic.gov.au/about-us/our-services/>

services through a rights-based approach. Over the three years to June 2020, 68 education sessions in the health sector were held with 1405 participants.

Key findings:

- Disability advocacy strengthens the capacity of people with disability to speak for themselves by actively supporting and encouraging self-advocacy.
- Self-advocacy plays a significant role in enabling people with a disability develop skills that ensure that their rights and interests are respected and realised. Due to Deaf cultural norms, Deaf individuals may have limited self-advocacy capacity. Empowering those with hearing loss and teaching self-advocacy skills has great potential to improve quality of care and health outcomes.
- The National Disability Advocacy Program provides access to effective disability advocacy that promotes, protects and ensures full and equal enjoyment of all human rights for people with disability.
- Further work is required to review approaches to strengthen the engagement of health services with funded advocacy services.

9. Literature review

The following provides an overview of published and grey literature relating to hospital access by patients who are Deaf or hard of hearing. Findings relating to accessibility of health care for people of low English proficiency (LEP) are also provided where relevant.

9.1. CONTEXT

While services for Deaf people have often been provided within the context of 'disability'-related access services, many Deaf people identify deafness not as a disability, but as a culture. As such, they wish to preserve both their culture and language.⁴³ Deaf Australia note that people who are Deaf require 'ways to live as healthy Deaf people in an environment designed for hearing people'.⁴⁴

Interactions with the healthcare system can be physically and emotionally challenging for any patient and their carer/families. It is reported that Deaf patients experience heightened anxiety when they visit a doctor, with fear of not being understood or receiving the wrong medication.⁴⁵ Communication barriers may be exacerbated by learned behaviours and interpersonal factors, including a lack of independent thought, over-protectedness, a non-questioning attitude, and limited assertiveness.^{46,47}

'The Deaf community has experienced a history of disadvantage which makes poor access the accepted norm. The habit is often to view communication access of any kind not as a right, but as a charity. Although many sections of the Deaf community have a much greater awareness of their rights, there are still many Deaf people who view any effort to accommodate their needs as an imposition on the "hearing" people, and a cause for gratitude'.⁴⁸

Deaf individuals experience unique challenges and barriers, especially when it comes to health care.

It is important to note that the Deaf or Hard of Hearing population is a heterogeneous group. Factors that must be considered with this population include the degree of hearing, age of onset, and preferred language.⁴⁹ The literature reports a common misconception regarding the proficiency of sign language users to understand written English. As such, patient communication is often limited to interpreter access for in-depth appointment types and/or provision of written information in English.

The provision of English information brochures relating to medical treatment, medication use and side-effects, procedure of follow-up care (e.g., post-surgical dressing) etc. contributes to the perception of disempowerment for patients using Auslan as their first language. The accumulation of communication failures over time excludes Deaf patients from the possibility of learning to manage their health issues autonomously.⁵⁰

'Due to complex individual, interpersonal, and systemic factors, Deaf... individuals often receive inadequate, inappropriate, and unethical health care'.⁵¹

New Zealand has successfully implemented Deaf New Zealand Sign Language (NZSL) as one of their three official languages, supported by the *New Zealand Sign Language Act, 2006*. NZSL users have emphasised that recognition of their cultural identity is central to improving their health care experiences and feel greater satisfaction from their health consult having received that recognition.⁵²

43. <https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-accessibility/language-barriers.html>

44. Australian Association of the Deaf, 2004

45. Scheier, 2009

46. Smeijers et al., 2011

47. Kuenburg et al., 2016

48. Deaf Society, 2015

49. Meador & Zazove, 2005

50. Sirch et al., 2017

51. Dimitra et al., 2014

52. Witko et al., 2017

9.2. HEALTH LITERACY

Health literacy is an important concept that is recognised as a fundamental skill required in maintaining health and accessing the local healthcare system.⁵³

'Health literacy means people can obtain, understand and use the health information and services they need to make appropriate health decisions. Healthcare providers and the health system should provide information and improve interaction with individuals, communities and each other to respond to and improve health literacy'.⁵⁴

The *Victorian 2014 Consultation on Health Literacy* project found four overarching themes:⁵⁵

- Build the capacity of consumers, carers and community members to influence the health literacy agenda and outcomes;
- Enhance the communication capabilities of health professionals and health services;
- Systematise the development and provision of health information; and
- Implement policies and systems to improve Victorians' health literacy.

The review recommended greater provision of state-wide health literacy training for community members and that training should include: rights and legal obligations; privacy and confidentiality, health literacy concepts and practices; patient feedback systems and processes; support and entitlement systems for patients; quality sources of health information; local and state-wide organisations relevant to health literacy; navigation models; and effective advocacy.

'To develop strong critical health literacy (CHL) skills, the individual should be able to integrate knowledge about human health rights with health advocacy goals to make appropriate health-related actions at both individual and community levels. CHL can also include self-efficacy in making decisions as well as supporting other people in making appropriate health choices'.⁵⁶

Actions to promote health literacy must aim to overcome the disadvantages and barriers experienced by many groups and should accord with the Victorian Government's cultural responsiveness policy. The review participants noted over-reliance on providing translated written health information as the main supplement to verbal communication for culturally and linguistically diverse communities.⁵⁷

Health literacy for the Deaf community

Many Deaf people in Australia lack consistent access to preventative and ongoing health care information. It is important to be aware of the English literacy levels of patients. The average Deaf person generally experiences a lower level of English literacy, a smaller fund of health care knowledge, and fewer health education opportunities than his average hearing counterparts'.⁵⁸

English literacy

'Many healthcare providers are not often aware of inadequate literacy among patients causing them to overestimate the patients' knowledge of medical conditions, disease prevention, and existing therapeutic options. Therefore, they may not make appropriate health educational advice during medical encounters'.⁵⁹

53. How How, 2011

54. Hill, 2014

55. <https://www2.health.vic.gov.au/about/participation-and-communication/health-literacy>

56. Kushalnagar et al., 2018

57. <https://www2.health.vic.gov.au/about/participation-and-communication/health-literacy>

58. Napier & Kidd, 2013

59. Naseribooriabadi et al., 2017

A 2013 Australia study sought to gain insight into how Deaf Australians who use Auslan as their primary language perceive their English literacy and if they feel that they can sufficiently access preventative and ongoing health care information. Through 72 semi-structured interviews with Deaf Auslan users, the study found:⁶⁰

- Deaf people experience barriers in accessing preventative and ongoing health care information because of their English literacy skills and the lack of available information in Auslan; and
- Deaf people rely heavily on General Practitioners, television, family and friends. Their experiences in accessing information concerning their own health are generally problematic, in that they often feel they have a lack of information, have barriers to accessing information or do not sufficiently understand the information that they receive.

'English literacy is often poor among the Deaf due to lower education levels which negatively impacts their health literacy or their ability to acquire, process and understand health information. As a result, their personal empowerment, self-efficacy, autonomy and health also suffer'.⁶¹

Health care knowledge

Mainstream health knowledge is absorbed via conversations on radio and television and written word in leaflets and websites, amongst other sources, whilst access for members of the Deaf community is mainly limited to the written word in leaflets, websites, and television subtitles. When compared with hearing peers, the Deaf community are at a disadvantage due to reduced exposure and incidental knowledge.⁶² Research demonstrates that over 90% of people who are Deaf grow up in hearing families and therefore miss out on overhearing health-related conversations and printed health education materials are written at high reading levels. Further, healthcare practitioners may not be educating Deaf patients at a level that meets the patient's expectations, with messages getting lost in translation and patients are not able to retain the information.⁶³

A 2004 United States study investigated the knowledge, attitudes, and health care experiences of 45 Deaf women. The study found:⁶⁴

- A lack of health knowledge was evident, including little understanding of the meaning or value of cancer screening, mammography, or pap smears; purposes of prescribed medications, such as hormone replacement therapy; or necessity for other medical or surgical interventions;
- Negative experiences and avoidance or non-use of health services, largely due to the lack of a common language with healthcare providers and previous exposure to insensitive behaviours; and
- Increased access to health information were reported with practitioners who used certified interpreters. Positive experiences also included practitioners who demonstrated sensitivity to improving communication.

A review of 73 papers from 1987 to 2016 was conducted to understand factors influencing health literacy among Deaf community. The review found that:

- Inadequate health literacy may result in: low participation in screening programs; inadequate use of preventive health services; and inability to participate in self-care activities and comply with medical advice; and
- Facilitators to accessing health information and health care services include: providing Auslan interpreters; training health providers about Deaf culture; and developing Deaf-tailored programs in health education.

60. Napier & Kidd, 2013
61. Terry, Le & Nguyen, 2016
62. Scheier, 2009
63. Orsi et al, 2007
64. Steinberg et al., 2004

'Improved access to health information may be achieved with specialized resource materials, improved prevention and targeted intervention strategies, and self-advocacy skills development'.⁶⁵

Health education interventions conducted using native sign language, open captioning, images and videos may result in better comprehension of health-related issues.⁶⁶

Access to health promotion

Health promotion actions at the community level are especially valuable for the Deaf community. Approaches to improve health literacy for the Deaf community include:⁶⁷

- Availability of social network sites with accessible health information, and implementing interactive health literacy activities through social media to enhance health awareness and self-advocating health care techniques;
- Facilitating discussions with health-literate peers who share a common language; and
- Engaging health-literate Deaf people as agents to stimulate growth in health knowledge and critical health literacy skills among low-literate Deaf peers.

At a health practitioner level, insight into Deaf Auslan users' experiences of accessing health care information reveals confirms the importance of:⁶⁸

- Practitioners being aware of the information access needs of Deaf patients;
- Interpreters being provided for all medical consultations;
- Healthcare information being delivered in Auslan through the creation or translation of brochures, which could be made available through websites or on DVD.

Other tailored health promotion initiatives identified include:^{69,70}

- Establishment of a national online database of Auslan health-related information;
- Establishment of a Deaf Health Information Worker role in community service organisations;
- Development of a health care information video in Auslan that explains the concepts and role of patients in preventative health and health maintenance;
- Establishment of a health-specific, video-based, remote interpreting service to replicate other telehealth services; and
- Training Auslan interpreters in basic medical concepts and sign language-fluent healthcare workers to deliver interventions.

It is noted that further work is required to understand the experiences of sub-groups in the Deaf community that might have different informational needs.⁷¹ For example, adolescents seek health information from a various sources including family, peers, health care providers, media, and the internet. Despite the internet's exponential growth and the growth of online health information-seeking behaviour among adolescents, reliable information devoted specifically to Deaf adolescents who communicate primarily in sign language is rare.⁷²

A 2005 study sought to identify the health education priorities for Deaf communities. Community analysis including a mail survey and interviews with Deaf adults identified cardiovascular health as the top priority. The *Deaf Heart Health Intervention* was developed using a train-the-trainer, community health worker model seeking to improve self-efficacy for nutrition, physical activity, stress and smoking cessation.⁷³ Similar programs may provide effective for a range of conditions.

65. Steinberg et al., 2004

66. Naseribooriabad et al., 2017

67. Kushalnagar et al., 2018

68. Napier & Kidd, 2013

69. Ibid

70. Naseribooriabad et al., 2017

71. Napier & Kidd, 2013

72. Smith et al., 2012

73. Jones et al., 2005

Self-management

'The need to empower the patient, to increase his/her responsibility in the self-management of one's own health, is well recognised today'.⁷⁴

For patients to feel empowered and advocate for their health, they need to understand available options and the decisions they can make.⁷⁵ Under the Integrated Conceptual Model for Health Literacy, being health literate requires not only accessing health information but also understanding and utilising health information to appraise and use health-related information to maintain and improve health.⁷⁶ Individuals who can find, understand and use health information from reliable sources are more likely to participate in their own medical decision-making.⁷⁷ There is a reported need to strengthen improve the self-efficacy and self-management capacity of the Deaf community.⁷⁸

'Personalised teaching strategies aimed at developing patient empowerment and progressive competence in the field of health promotion, illness prevention and chronic condition management should be designed and tested'.⁷⁹

Navigation

Due to an increasing complexity of the health system, help to navigate the system is becoming of greater importance for consumers, carers and health professionals. There are many navigation models in place at various health services. These include:⁸⁰

- A liaison role between patients, their family/carers and health and social services;
- The provision of information on services, entitlements and sources of support; and
- Assistance with physical movement around a service.

The *Victorian 2014 Consultation on Health Literacy* project found that:⁸¹

- Specialised roles as navigators or experts on service availability may facilitate timely access to services;
- The role of service navigator may be occupied by health professionals, consumer or carer advocates;
- Community members already play a critical role in assisting consumers navigate services. Training and recognition of these community members is required; and
- Various databases also support service navigation, including Health Translations.⁸²

More community information relating to availability of navigators and online resources may be of benefit.

Health vocabulary

Auslan Signbank was designed to address the question of language standardization in Deaf communities by facilitating the sharing of information and language attitudes within the Auslan-using community. The project facilitated linguists, Auslan interpreters, health care professionals and members of the Deaf community to develop a web-based interactive, multimedia dictionary and database of Auslan.

74. Sirch et al., 2017

75. Orsi et al., 2007

76. Kushalnagar et al., 2014

77. Naseribooriabadi et al., 2017

78. Sirch et al., 2017

79. Ibid

80. <https://www2.health.vic.gov.au/about/participation-and-communication/health-literacy>

81. Ibid

82. <https://healthtranslations.vic.gov.au/>

Despite an under-developed health lexicon in Auslan, Deaf people possess a variety of strategies for expressing health concepts including fingerspelling, creating simple cryptography signs and using partly or non-lexical strategies such as depiction, pointing and gesturing.⁸³

'The use of terminology in health communication can be a complex issue. Misunderstandings may arise when patients do not fully understand the terms used by their healthcare practitioners'.⁸⁴

The Medical Signbank project was established in 2008 to directly grow the lexicon of Auslan for health terms.⁸⁵ Medical Signbank displays encyclopedic explanatory video clips of English vocabulary items that are commonly used in the medical domain. It was used to create an effective, accepted, and shared sign vocabulary for the discussion of medical and mental health issues by Deaf clients and health professionals in interactions mediated by Auslan interpreters. It was designed to enable Auslan interpreters and their clients to: share signs they have developed to deal with medical or mental health terms; add feedback on new signs; and report on medical or mental health terms in English for which they do not have a sign.⁸⁶

Findings from a recent review undertaken on Deaf Women's Health Vocabulary, indicate variation in health-related vocabulary, and as such, the use of depicting signs and constructed action can also be effective ways to communicate information.⁸⁷

Resources

A 2014 United States study sought American Sign Language (ASL) users' perspectives on the navigation of ASL-accessible websites, finding the health information that they needed, and perceived ease of understanding ASL video content. The results from 32 ASL users suggest that simply making a health website accessible in ASL is not enough. An ASL accessible health website must also be user-friendly and easy to navigate.⁸⁸

Pictograms are descriptive symbols that help to convey information regarding medication and health. Adding pictures to written and verbal language has been shown to increase patient retention, comprehension, recall, and adherence. Culture-specific and education level-specific pictograms may be essential for the effective communication of health information. The use of pictograms to communicate health information to people with language barriers or limited health literacy may also improve patient understanding and increase the efficiency of treatment of such individuals. Pictograms for use in the dispensing of medication have been developed to communicate information such as dose, route, frequency, precautions for medications, and to communicate potential side effects of medication to patients.⁸⁹

9.3. COMMUNICATION APPROACHES

The safe delivery of health care requires communication between the patient and their healthcare provider/s. Communication is key to enabling patients to decide among different options of care, strengthening autonomy and capacity for self-management.

Interpreter access

The following provides a summary of the key issues relating to Auslan interpreter provision in the healthcare setting.

83. Major et al., 2012

84. Ibid

85. Ibid

86. Johnston & Napier, 2010

87. Major et al., 2020

88. Kushalnagar et al., 2014

89. Richler et al., 2012

Ad-hoc interpreter utilisation

Published studies report positive benefits of professional interpreters on communication (errors and comprehension), utilization, clinical outcomes and satisfaction with care. In each area, use of professional interpreters is associated with improved clinical care to approach or equal that provided for patients without communication barriers.⁹⁰

'Interpreting is a challenging and complex task and should be done by qualified, trained professionals, not by children, relatives, or bilingual staff'.⁹¹

There is a significant body of research relating to the risks of ad-hoc interpreter use. This commonly refers to use of family members or bilingual (Auslan fluent) staff.

Key findings include: ^{92,93,94,95}

- Research suggests that around 50% of the information translated by an un-certified interpreter or family member is misinterpreted or omitted, leading to poor comprehension and reduced compliance with medication instructions;
- The presence of adhoc interpreters may inhibit discussion and reporting of sensitive issues such as domestic violence, substance abuse and sexually transmitted diseases;
- Uncertified interpreters are not bound by a professional code of ethics requiring confidentiality, impartiality and accuracy; and
- Relying on children as interpreters may result in emotional distress due to exposed to sensitive, confidential and complex information, which can comprise their well-being.

'Trained interpreters generally result in better health processes, outcomes, and use of services'.⁹⁶

A survey of medical practitioners in Swiss public healthcare services found that respondents' first choice was to use ad hoc interpreters, either family members or bilingual (Auslan fluent) staff, and to call a professional interpreter only when these strategies are unavailable. The research found that making professional interpreter services available to hospital staff did not automatically lead to a decrease in use of ad hoc interpreters, noting a 'normalization' of this practice, with practitioners emphasizing that practical and time constraints limited their ability to call on professional interpreters. The researchers recommended:

'A need to raise clinicians' awareness of the risks and benefits of different interpreting strategies available to them and facilitate use of professional interpreting services through information and training'.⁹⁷

Role of the interpreter

In Australia, NAATI's role is to set and maintain high national standards for the translating and interpreting sector⁹⁸ whilst the national association for the translating and interpreting profession, Australian Institute of Interpreters and Translators (AUSIT), is responsible for setting the standards for ethical conduct of interpreters and translators via the Code of Ethics which sets out the general principles that govern the practice of the profession.⁹⁹ It is noted that for Auslan interpreters, the ASLIA Code of Ethics¹⁰⁰ generally supersedes the AUSIT Code of Ethics.

90. Karliner et al., 2007

91. Olson & Swabey, 2017

92. Alexander et al., 2012.

93. Flores, 2005

94. Dimitra et al., 2014

95. White et al., 2018

96. Flores, 2005

97. Bischoff & Hudelson, 2010

98. <https://www.naati.com.au/about-us/>

99. <https://ausit.org/code-of-ethics/>

100. <https://aslia.com.au/wp-content/uploads/ASLIA-Code-of-Ethics-1.pdf>

Despite this, there is no commonly accepted understanding of an interpreter's function and limited consensus among healthcare providers, patients, and interpreters about the role in healthcare settings.

'Different roles of interpreters sometimes can be traced back to explicit requests brought forward by health care professionals. On the one hand, interpreters are requested to interpret everything and only what has been said; on the other hand and in practice, they are encouraged to keep the interview short and to keep patients on track'.¹⁰¹

Whilst healthcare workers are responsible for the content of any interaction, they never know to what extent an interpreter will translate the content of a consultation and if information is added or omitted and cannot assume a shared understanding of the role.¹⁰²

'Unless health professionals adjust their vocabulary to either explain or avoid technical terms when communicating with lay people, miscommunication and misunderstanding often result. In an interpreter-mediated interaction, health professionals may assume they can assign responsibility for these important linguistic adjustments to the interpreter. This assumption may not be warranted. They may not realize either the need for alternative wording and rephrasing in their own language output in order to accommodate an easier interpretation into the target sign language or the need to allow sufficient time for the sign language interpreter to make the necessary adjustments to accommodate the mismatches'.¹⁰³

As such, providers and interpreters must explicitly clarify their mutual expectations before they start conducting a health care encounter.¹⁰⁴

'Providers may want an interpreter to assume the role of conduit, active participant, or a combination of the two, depending on the situation and/or personal preference. Three specific dimensions shape providers' expectations and needs of interpreters: interpreter as patient ally, interpreter as health care professional, and interpreter as provider proxy. Providers in different specialties may share different preferences in these dimensions depending on their therapeutic objectives and communicative needs. Because these dimensions may not be compatible with one another, providers need to be aware of their competing demands and develop effective strategies to prioritize and communicate their needs when working with medical interpreters'.¹⁰⁵

A 2012 United States study explored the tensions, challenges, and dangers when a utilitarian view of interpreter is constructed, imposed, and/or reinforced in healthcare settings, that is, when interpreters are conceptualized as instruments in the process, providing utility without influencing the content or dynamics of provider-patient communication. Through interviews with medical interpreters and healthcare providers, the study found that this approach may compromise the quality of care by silencing patients' and interpreters' voice, objectifying interpreters' work, and exploiting patients' needs. The study found that both providers and interpreters can learn from and co-evolve with each other, allowing them to maintain control over their expertise and to work as collaborators in providing quality care.¹⁰⁶ It is important to note that the US model is commonly based on employment of interpreters in high demand languages.

Clinicians' use of interpreters

'The use of interpreters is a complex issue that cannot be addressed by increasing interpreter availability alone'.¹⁰⁷

A 2014 study explored healthcare providers' decision making about interpreter use through individual interviews and specialty specific focus groups (nursing, mental health, emergency medicine, oncology, and obstetrics gynaecology). Four factors influence providers' choice of interpreters, as outlined in Table 9-1.¹⁰⁸

101. Sleptsova et al., 2014

102. Ibid

103. Johnston & Napier, 2010

104. Sleptsova et al., 2014

105. Hsieh et al., 2013

106. Hsieh & Kramer, 2012

107. Hsieh, 2014

108. Ibid

Table 9-1: Factors influencing providers choice of interpreters¹⁰⁹

FACTORS	CORRESPONDING DIMENSIONS
Time constraints	<ul style="list-style-type: none"> Disruption to providers' schedule and priorities Increased responsibilities and competing demands
Alliances of care	<ul style="list-style-type: none"> Management of patient empowerment and patient receptiveness Facilitation of provider agenda
Therapeutic objectives	<ul style="list-style-type: none"> Clinical complexity Clinical urgency Patient privacy
Organizational-level considerations	<ul style="list-style-type: none"> Resource limitations Ethical guidelines

Key findings included: ¹¹⁰

- Providers actively engage in calculated use of professional interpreters, employing specific factors in their decision-making processes;
- Providers' understanding of time is complex and multidimensional, including concerns about disruptions to their schedules, overburdening others' workloads, and clinical urgency of patient condition, amongst others;
- When providers make specific choices due to time pressure, they are influenced by interpersonal, organizational, therapeutic, and ethical considerations. For example:
 - Providers manage the delicate balance between patient empowerment (e.g., encouraging autonomous decision-making and active participation) and patient receptiveness (e.g., feeling comfortable and agreeing to accept the proposed treatment), which may not always be compatible with one another and may be best achieved through different types of interpreters; and
 - Providers make calculated decisions on what was considered minor (e.g., pain management) versus major procedures (e.g., discharge instruction) and tried to weigh various options related to asking for interpreter assistance (e.g., wait for a professional interpreter versus provide some pain medication immediately).
- Organizational resources and guidelines need to be consistent with institutional policies and professional norms. Otherwise, providers risk making flawed assessments about the effective and appropriate use of interpreters in bilingual health care.

A 2008 study of 20 internal medicine resident physicians in the United States found that resident physicians viewed communication mainly as a means of gathering necessary clinical data, and less as an opportunity to address the concerns of their hospitalized patients. This **physician-centred communication** has important implications for rapport building and the connection between physicians and patients that lies at the heart of the therapeutic relationship. Resident physicians in the study described complex reasons for their underuse of professional interpreters. ¹¹¹

Findings suggest that increasing interpreter use will require interventions targeted at both individual physicians and the practice environment. Quality improvement initiatives must focus on integrating language services into the hospital environment while changing organizational and professional norms about communication with patients with of low English proficiency. ¹¹²

The reviewers recommended that hospitalized patients with low English proficiency should have a conversation in their preferred language with their treating physician at least daily. Meeting this standard will require substantial changes in the hospital practice environment. Such changes are most likely to be successful if they are endorsed by senior hospital leadership and are viewed as patient safety and quality improvement efforts. ¹¹³

109. Ibid

110. Ibid

111. Diamond et al., 2008

112. Ibid

113. Ibid

A 2011 New Zealand study of 141 clinicians' perceptions of the communication difficulties experienced with low English proficiency patients found that even when clinicians are aware of policy, of how to obtain interpreters, and of the increased clinical risk in the situation, this does not necessarily lead to high levels of interpreter use with LEP patients. Although 20% of study respondents felt that communication difficulties significantly affect care, and 84% knew how to access professional interpreters, only 14% report always using an interpreter. This study shows that there is a clear mismatch between actual practice and the relatively high levels of awareness of policy, methods of accessing interpreters and the significance of communication difficulties for quality of care. Approaches to change clinician behaviour may include: improving systems; monitoring (and reporting) interpreter use; and cultural competence training, including training in interpreter use.¹¹⁴

Further understanding the patterns of interpreter use is critical to the design and implementation of interventions to improve the quality of hospital care for patients facing communication barriers.

A 2018 study by Monash Health aimed to characterise patterns of interpreter service use in medical inpatient wards and explore clinician experience of language discordance. The study found that:¹¹⁵

- Day to day communication was difficult;
- Doctors' are the highest users of professional interpreters during early hospital admission to obtain a comprehensive early, accurate and complete medical history;
- Language discordant clinical encounters resulted in the delivery of care where clinicians accommodated for a deficient clinical history by ordering large numbers of tests, engaging adhoc interpreters, not communicating regularly or providing key messages directly to patients; and
- All clinicians reported 'saving' their information for when an interpreter had been booked. The consequence of this was that patients received a lot of information in one interpreter session, possibly from more than one clinician. Clinicians perceived chronic disease education to be an essential component of effective preparation for discharge in general medicine and expressed concern regarding the capacity of patients to recall the large amounts of information provided quickly and in a short space of time. In contrast, English speaking patients were reported to receive the same information over several sessions and have their knowledge verified.

A 2013 study of 234 hospitalized Spanish and Chinese speaking patients in San Francisco found that interpreter use varied by type of clinical contact but was overall more common with physicians than with nurses. While interactions with nurses may be shorter and more routine than interactions with physicians, they frequently involve critical communication such as assessing a patient's pain level or checking for medication allergies. It was reported that nursing staff "get by" without an interpreter or barely speaking at all.¹¹⁶

Potential explanations for infrequent interpreter use among nurses, including:¹¹⁷

- The view that communication is a less critical part of many of their routine interactions with patients (e.g., giving a medication or changing a patient's dressing); and
- The acute hospital setting presents a particularly difficult access challenge due to the 24-hour nature of care, time pressures, and the brevity of many interactions.

A retrospective analysis of health administrative data for adult overnight-stay patients admitted to a public hospital in a region of significant cultural and linguistic diversity in Sydney revealed:¹¹⁸

- Whilst an interpreter was identified at hospital admission as being required in 15.7% of episodes of care, one was provided in only 3.7% of episodes, mostly to obstetric patients; and
- 16% of inpatients received interpreters service compared to 71% of hospital outpatients.

114. Ibid

115. White et al., 2018

116. Schenker et al., 2011

117. Ibid

118. Blay et al., 2018

The study found that a minority of low English proficiency patients admitted to hospital in a region of significant cultural and linguistic diversity receive a healthcare interpreter. Reasons for selecting adhoc interpreters over professional healthcare interpreters included: ¹¹⁹

- The need to book a healthcare interpreter as opposed to immediate access to family members;
- Availability of healthcare interpreters;
- Health practitioners' time constraints.
- Confidentiality;
- Familiarity with the patient and family members;
- Confidence in one's own language skills;
- Difficulty in assessing the need for an interpreter; and
- Lack of knowledge of the interpreter service or booking system.

These findings are in alignment with a 2014 review of the supply and demand for Auslan interpreters across Australia which found the reasons for a professional interpreter not being accessed for appointment with a health professional (other than a doctor) included: ¹²⁰

- Lack of locally available interpreters;
- The Deaf person being unaware that s/he could use an interpreter in such situations
- Insufficient knowledge of booking procedures;
- Inability to arrange interpreters at short notice, difficulties with booking interpreters or cancellations; and
- Cost.

'Those who need but do not get interpreters have a poor self-reported understanding of their diagnosis and treatment plan'. ¹²¹

In 2015, Vicdeaf held an informal focus group with community to members discuss the NDIS. This analysis highlights the need for better education and training for health professionals regarding booking and utilisation of interpreter services within the hospital setting. The group recommended that future efforts should aim to implement measures to improve training of hospital staff in the booking of Auslan interpreters, as well as the quality of after-hours services. ¹²²

'There is a need for systematic and transformative change that addresses utilisation of professional interpreters as well as embedded healthcare culture and practices leading to less interaction with patients with limited English proficiency and reliance on family members as informal interpreters'. ¹²³

Summary

NABS notes that the benefits of working with an Auslan interpreter include: ¹²⁴

- Equal access to medical information and services;
- Adhering to current government policy on inclusivity and policy accountability;
- Increased confidence in communication for both the medical practitioner and the Deaf client;
- Protection of medical practitioners' legal responsibilities; and
- Communication of diagnostic and medical information to enhance health advice, diagnosis and patient outcomes

Key benefits of engaging certified Auslan interpreters are outlined in Figure 9-1 below.

119. Ibid

120. Orima Research, 2014

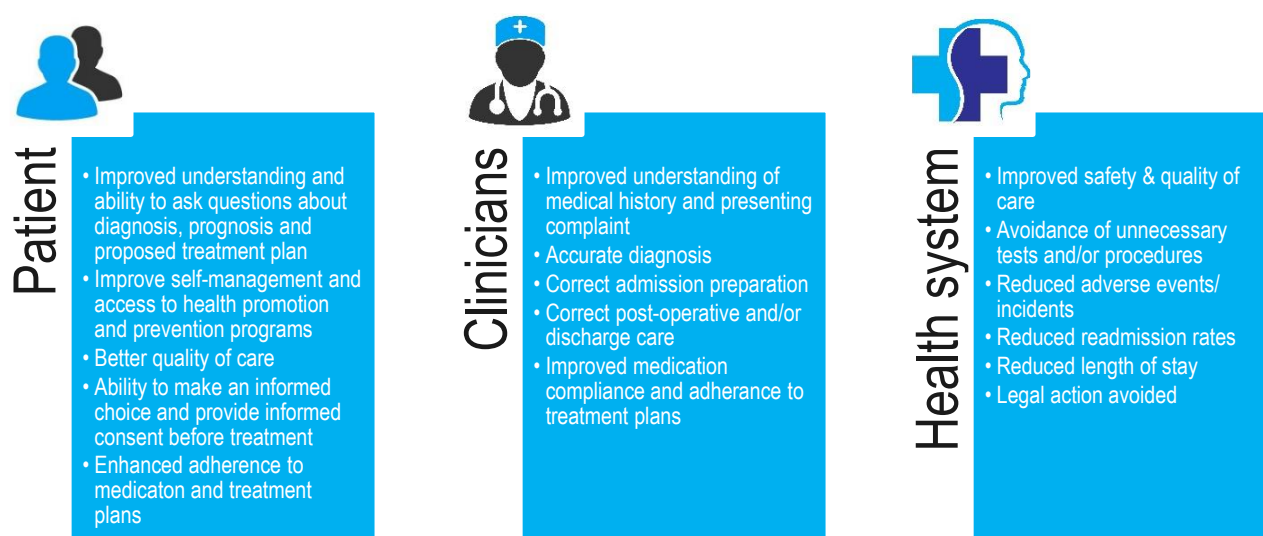
121. Flores, 2005

122. Massa et al., 2015

123. White et al., 2018

124. <https://s3-ap-southeast-2.amazonaws.com/wh1.thewebconsole.com/wh/2877/images/Facts-about-Deafness.pdf>

Figure 9-1: Benefits of Certified Interpreter use



The sustainable supply of certified Auslan interpreters to meet demand is an ongoing challenge for service providers across sectors. Noting the rollout of the NDIS has significantly increased service demand, Deaf Australia have highlighted the need for:¹²⁵

- Strategies to address the current issues where interpreter practitioners are migrating into community settings, leaving Deaf people vulnerable or unable to access essential services; and
- Strategies to ensure that certified interpreters and non-certified personnel are differentiated in the NDIS price guide.

Communication methods

Deaf individuals may employ many different methods of communication including written language, spoken language, lip-reading, cued speech, and sign language.¹²⁶ Many providers inaccurately assume that Deaf sign language users are generally proficient in both lip reading and/or reading English potentially resulting in poor provider-patient communication and trust.¹²⁷ In the healthcare setting, there is a need to establish, as soon as possible, the preferred communication channel for patients. Table 9-2 provides considerations relating to the patients' preferred communication method.

Table 9-2: Considerations for healthcare workers, per patient preferred method¹²⁸

METHOD	CONSIDERATIONS FOR HEALTHCARE WORKERS
Sign language	<ul style="list-style-type: none"> Ensure as much freedom as possible for patients to utilise their hands (e.g., consider intravenous access to non-dominant hand)
Lip-reading	<ul style="list-style-type: none"> Do not talk behind patient or away from a light source Lower or remove the surgical mask Maintain eye contact Do not yell, exaggerate pronunciation beyond the normal movement of the lips Maintain the natural rhythm and tone Do not speak too quickly or too slowly Be patient and prepared to repeat or use facial expression, if necessary
Written communication	<ul style="list-style-type: none"> Use short sentences that are simple but complete Avoiding technical words Highlight the key words

125. Deaf Australia, 2019

126. Yates, 2017

127. McKee et al., 2015

128. Sirch et al., 2017

Consideration must also be given to privacy concerns, for example, a patient may prefer for a physical examination to be thoroughly explained in advance of the examination so that the interpreter is not required during the examination. Further, it is important to consider the privacy needs of adolescents and carefully navigate with the patient at what age a professional interpreter is preferred.¹²⁹

Other communication supports

New technologies and services may strengthen service access for Deaf patients, including:¹³⁰

- Ability to make appointments online or via text;
- Technology that enables voice messages to be converted to text and vice versa; and
- Ability to receive follow-up care (e.g., pathology results) via VRI with an interpreter.

A 2017 United States study of Chinese and Spanish speaking patients found that the placement of a dual-handset telephone at the bedside in every room increased rapid access to professional interpreters and improvements in patient reported informed consent.¹³¹

Though technology might offer some promising solutions, it is important to realise that these might not work for everyone.

9.4. COMMUNICATION BARRIERS IN HEALTHCARE

Effective doctor-patient communication is a central clinical function in building a therapeutic doctor-patient relationship. The main goals of doctor-patient communication are creating a good interpersonal relationship, facilitating exchange of information, and including patients in decision making.¹³² Further, effective communication between patients and healthcare providers is essential to the provision of high quality, **patient-centred health care**.¹³³ Language discordant clinical encounters may critically compromise health outcomes.¹³⁴

*'Good doctor-patient communication has the potential to help regulate patients' emotions, facilitate comprehension of medical information, and allow for better identification of patients' needs, perceptions, and expectations'.*¹³⁵

Health care may require verbal, written and behavioural communication between patients and healthcare professionals. As such, there is a need to ensure culturally competent care, accommodation of patient needs and strategies to mitigate communication barriers.¹³⁶

*'Discontent and mistrust, the sense of neglect and apathy experienced by Deaf patients does not stem only from the fact that healthcare workers do not know their language, but also the fact that they do not easily recognise their needs'.*¹³⁷

A 2004 United States study conducted semi-structured group interviews with 26 Deaf and hard of hearing adults to understand perceptions of health care experiences. Key concerns included:¹³⁸

- Different perceptions of providers and patients about what constitutes effective communication;
- Communication problems during physical examinations and procedures;
- Medication safety and other risks posed by inadequate communication; and
- Difficulties interacting with office staff, including problems with telephone communication and in waiting rooms.

129. Smeijers et al., 2011
130. Power & Power, 2004
131. Lee et al., 2017
132. Ha & Longnecker, 2010
133. Diamond et al., 2008
134. White et al., 2018
135. Ha & Longnecker, 2010
136. Sirch et al., 2017
137. Sirch et al., 2017
138. Lezzoni et al., 2004

Consideration is given below to factors influencing health care experiences in primary care and emergency care, diagnostic services, and inpatient services.

Primary care & emergency care

A 2002 study in the United Kingdom found that Deaf people have substantially poorer access to primary care and emergency services and experience difficulties at several stages, including:¹³⁹

- Making appointments and communicating with receptionists;
- In waiting rooms, knowing when they had been called;
- Understanding health professionals and making themselves understood; and
- Obtaining all the information they require; and
- After a consultation understanding what they were supposed to do next, or the purpose or correct application of medication prescribed for them.

Several studies report higher ED utilisation by Deaf patients when compared to the hearing population. A 2005 United States study identified several potential contributing factors, including:¹⁴⁰

- Lower health literacy may result in a heightened concern for certain symptoms;
- Communication breakdowns that limit capacity to navigate the healthcare system effectively and self-manage health care; and
- Increased accessibility to Auslan interpreters in the ED setting.

Diagnostic services

Informed consent is a fundamental tenet of the healthcare system. It has long been legally recognized for its importance to the ethical practice of medicine, and it is increasingly being recognized as a key constituent of quality and patient safety. Informed consent is a process of information exchange that by its very nature requires dialogue between patient and provider.¹⁴¹

A 2003 study of 203 adult Deaf patients in the United States demonstrated cancer screening rates similar to those of the broader population. The study found that even in the presence of similar screening rates, Deaf persons may still be greatly lacking in their knowledge and purpose of these tests thus hindering their ability and right to make informed decisions about their body and their health.¹⁴²

'Informed decision making requires that a patient first understand the disease or condition for which the screening is available and being offered. Second, the patient must understand the test used to screen for the condition or disease, as well as the risks, benefits, alternatives and limitations of the test. Finally, informed decision making requires that a patient is able to weigh the information provided and make a decision based upon his/her preference'.¹⁴³

A 2007 retrospective chart review for eligible Chinese and Spanish speaking patients who received common invasive procedures (thoracentesis, paracentesis or lumbar puncture) revealed that these patients are less likely to have documentation of informed consent, despite availability of onsite professional interpreter services. The authors recommended that hospital quality initiatives should consider monitoring informed consent for LEP patients.¹⁴⁴

139. Reeves et al, 2002

140. McKee et al., 2015

141. Schenkyer et al., 2007

142. Orsi et al, 2007

143. Orsi et al, 2007

144. Ibid

Another service area in which communication barriers may prohibit optimal care is when receiving verbal instructions by radiographers to undertake medical imaging. Recommendations for improved care included the installation of equipment that gives visual signals for breath holding along with cultural awareness training and extended appointments.¹⁴⁵

Inpatient services

During an admitted stay in hospital, the exposure to communication with the healthcare team is protracted and can become, therefore, more critical.¹⁴⁶ The hospital ward is not prepared and designed for vulnerable patients.

Problems that Deaf patients may encounter in a hospital setting include:^{147,148}

- Limited health literacy and knowledge of rights regarding access to communication support;
- Limited communication capacity (e.g., immobility of hands, inaccessibility of intercom systems on hospital wards, lack of widespread use of sign language, difficulty communicating with a mask);
- Limited social support, and ability to contact family and friends;
- Privacy issues and decreased awareness of surroundings (e.g., people entering the room);
- No awareness of hospitals activities communicated through announcements (e.g., emergency, or other warnings);
- Inability to communicate with medical and non-medical hospital staff (e.g., janitor, etc.); and
- Limited entertainment (e.g., no captioned television).

A qualitative study with 34 Deaf adults in Northern Italy explored the communication experience during hospital stay. Four themes emerged:¹⁴⁹

- **Experiencing a common vulnerability: the need for reciprocal understanding and sensitivity.** When communication strategies fail in their effectiveness during hospitalisation, Deaf patients perceive increased vulnerability;
- **Feeling discriminated against.** The use of oversimplistic manners, such as speaking very slowly or simplifying concepts, and maintaining communication with hearing caregivers to the exclusion of the patient, is perceived as a source of discrimination;
- **Perceived lack of consonance between care and needs.** When difficulties are experienced in expressing care needs, the consonance between patient needs and healthcare workers' interpretation and clinical judgments is poor. The essential needs of a Deaf patient, such as pain symptoms, may not be recognised by nurses, whilst needs that they do not feel are relevant or current may be cared for; and
- **Developing a sense of progressively disempowerment.** Communication barriers threaten decision-making participation and accessibility to health care. The process of reduced participation in decision-making may be voluntary (decided by the patient) or involuntary (decided by the healthcare provider). When healthcare providers lack competence regarding Deaf patients, they might fail to offer appropriate information, involvement in decision-making and in emotional and physical support. Limited accessibility and participation in the decision-making process contributes to the perception that independent self-management of their own health will not be achievable.

145. Davies & Channon, 2004

146. Sirch et al., 2017

147. Hoang et al., 2010

148. Disabled People's Association Singapore, 2017

149. Sirch et al., 2017

9.5. OUTCOMES

The following outlines the impact of communication barriers on patient satisfaction and outcomes, clinicians and health services.

Patient satisfaction and health outcomes

The quality of communication with healthcare providers is a major contributor to patient satisfaction and health care access. A 2002 study interviewed and surveyed 165 Deaf or hard of hearing women, finding that almost 50% of respondents said that they would be more likely to use health services if help and/or services for Deaf women were available.¹⁵⁰

Ineffective communication may result in patients experiencing fear, mistrust, frustration and embarrassment.^{151,152} As a result of dissatisfaction with their health care, Deaf patients may avoid and delay seeking health services or not seek care until they are very sick, then presenting when a condition is more advanced.^{153,154,155,156,157} Several studies have demonstrated that Deaf individuals may have decreased engagement in preventative health care when compared to the hearing population.¹⁵⁸ Patients with low English proficiency may demonstrate poorer understanding of chronic conditions and adoption of changes in lifestyle, reduced comprehension of diagnoses and treatment and poor adherence to medical advice, including crucial follow-up care.^{159,160,161,162}

'Patient satisfaction with the hospital experience is a complex and multifaceted phenomenon and may in turn influence further health service utilisation decision-making (e.g., refusing follow-up) and the level of patient compliance with prescribed treatments and recommendations'.¹⁶³

A 2011 case review from an ED in a Brisbane public hospital found that patients who speak a language other than English at home had: lower utilisation rates of ambulance services, longer length of ED stay and higher hospital admission rates.¹⁶⁴

A 2014 study by the Australian National University Medical School found adverse outcomes included physical harm, and delays in investigations and diagnosis, resulting from failure of interpreter use during consent for procedures, counselling of hospital discharge medications, and in obtaining proper medical history.¹⁶⁵ Documented experiences of patients with low English proficiency include diagnostic errors, medication complications, and discharge from hospital with poor understanding.¹⁶⁶

Communication barriers can lead to poorer personal empowerment, social inclusion, self-efficacy and autonomy and may also lead to low self-esteem, symptoms of anxiety, depression and greater mental health issues.¹⁶⁷

A 2006 study investigated factors impacting satisfaction with prenatal care and prenatal care disparities between Deaf and hearing women. Analysis of satisfaction measures for 23 Deaf and 32 hearing women found that: Deaf women were less satisfied overall with their prenatal care, less

150. Ubido et al., 2002
151. Lezzoni et al., 2004
152. Kuenburg et al., 2016
153. Chaveiro et al., 2009
154. Alexander et al., 2012
155. Yates, 2017
156. Dimitra et al., 2014
157. Witko et al., 2017
158. Orsi et al., 2007
159. O'Hearn, 2006
160. White et al., 2018
161. Emond et al., 2015
162. White et al., 2018
163. Sirch et al., 2017
164. Mahmoud et al., 2011
165. Rowse et al., 2014
166. White et al., 2018
167. Terry, Le & Nguyen, 2016

satisfied with physician concern and quality of communication, had fewer prenatal care appointments, and received less information from their physicians than did hearing women.¹⁶⁸

Intentional exclusion and/or a lack of access to communication supports restrict the rights of LEP people to express their opinions about what matters to them in hospital.¹⁶⁹ A 2019 study of 2,338 orthopaedic outpatients at Western Health found that the method employed to invite and inform patients of patient-reported outcome measures (PROMs) collection, and the environment in which it is undertaken, significantly alter the response rate. As PROM collection is clinically important for ongoing patient care, accessible forms of collection of outcomes from Deaf patients are required.¹⁷⁰

Impact on mental health

Ongoing communication barriers and the inability to communicate with one's peers and family contributes to feelings of inadequacy and low self-esteem and proportionally higher rates of mental illness in the Deaf population.¹⁷¹ Approximately 40% of the Deaf community may experience mental ill-health compared with 25% of the hearing population.¹⁷²

'Individuals with hearing loss have a higher prevalence of mental health disorders linked with a variety of psychosocial factors, including low socioeconomic status, social isolation and difficulties locating accessible mental health programs'.¹⁷³

Depression can be exacerbated through misdiagnosis, remaining undiagnosed, a lack of communication or understanding of symptoms, or the inability to ask questions or seek help.¹⁷⁴ Previous studies have found that existing screening methods for depression are inadequate for Deaf individuals. Additional challenges may include providers not typically screening for symptoms, and the perception that interpreters intrude on privacy. Such studies have recommended that appropriate patient assessment tools are developed in partnership with the community and that these are in plain, easily understood English, sign language accessible or pictorial format.¹⁷⁵

A 1998 United States study investigated knowledge, attitudes, and beliefs about mental illness and providers through interview of 54 Deaf adults. Recurrent themes included mistrust of providers, communication difficulty as a primary cause of mental health problems and profound concern regarding communication in therapy.¹⁷⁶

'Effective communication is a crucial element in mental health care, not only for history gathering and accurate diagnosis but also to ensure good treatment adherence and to obtain desired treatment goals and outcomes'.¹⁷⁷

A pilot program in the United States sought to provide 50 Deaf patients typical family medicine services and assist with their psychosocial and mental health needs. The study found that:¹⁷⁸

- The presence of clinicians who either were Deaf and/or worked closely with the Deaf community likely helped to improve patient comfort levels. The perceived culture-matching between mental healthcare providers and patients should not be underestimated; and
- The ability for Deaf patients to see their behavioural health specialist either in person or by videophone provided an effective solution for Deaf populations in remote locations.

168. O'Hearn, 2006
169. O'Halloran et al., 2019
170. Ho et al., 2019
171. Scheier, 2009
172. Richardson, 2014
173. Pertz et al., 2018
174. Richardson, 2014
175. Ibid
176. Steinberg et al., 1998
177. Pertz et al., 2018
178. Ibid

Clinician and health service outcomes

In addition to the significant impact on the quality of life for Deaf patients, a failure to ensure optimal communication exposes government agencies and their clients to significant social and economic risks. As highlighted in the department's *Cultural Diversity Plan 2015-19*, quality language services are an integral part of the service system.

'Hospitals must be able to deliver safe and high-quality care to the entire community, in all of its cultural and linguistic diversity'.¹⁷⁹

Standard 3 of the department's *Cultural Responsiveness Framework* states that a health service must provide an accredited interpreter for patients who need one.¹⁸⁰

'When people are unable to access interpreters in Victorian hospitals, effective communication is unlikely to take place, leading to an increased risk of harm through misdiagnosis, failure to establish informed consent, or failure to ensure the patient is sufficiently informed to manage their own care after discharge'.⁷²

Failure to do so creates safety and quality risks:

'The provision of language services is a quality and safety issue. For example, there are clear links between the health outcomes of patients and the communication between them and their health professional. Partnering with clients empowers them and encourages a positive experience of the health and community service sector. The delivery of safe high-quality care is requires effective communication between the client and the health care provider and is aligned with principles under the Australian Charter of Healthcare rights'.¹⁸¹

Communication barriers may result in Deaf patients feeling intimidated to ask questions or explain symptoms and the medical professional unable to discuss informed consent and treatment options, thus prohibiting the formation of the strong therapeutic relationship necessary for holistic care. Communication barriers may compromise several dimensions of health care quality, including patient centeredness, safety, effectiveness, timeliness, efficiency and equity.^{182,183}

Such impacts may include:^{184,185,186,187,188,189,190,191,192}

- Lower rates of preventative strategies being used compared with the general population;
- Increased risk of misdiagnosis;
- Increased rates of unnecessary diagnostic testing;
- Higher rates of complications, medication errors and incidents;
- Longer length of hospital stays, noting one study found Deaf inpatients are likely to remain in hospital twice as long as their hearing peers, due to several factors including a lack of appropriate community support and rehabilitation services;
- Higher rates of emergency department services and unplanned hospital readmissions; and
- Higher costs of treatment.

'The use of professional interpreters improves the quality of care for patients with (low English proficiency), resulting in higher patient satisfaction, fewer errors in communication, reduced disparities in utilization of services and improved clinical outcomes'.¹⁹³

179. Duckett et al., 2016

180. <https://www2.health.vic.gov.au/about/populations/cald-health>

181. <https://www.dhhs.vic.gov.au/publications/language-services-policy-and-guidelines>

182. Yates, 2017

183. Lezzoni et al., 2004

184. https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2017_044.pdf

185. https://www.health.qld.gov.au/_data/assets/pdf_file/0033/155994/guidelines_int.pdf

186. Queensland Government (2014) Language Services Policy Review.

187. <https://www.vic.gov.au/guidelines-using-interpreting-services/victorian-government-policy#victorian-government-policy>

188. Baines et al., 2010

189. Jacobs et al., 2007

190. White et al., 2018

191. Diamond et al., 2008

192. Chaveiro et al., 2009

193. Diamond & Jacobs, 2009

9.6. RECOMMENDATIONS

Improved access to health information and communication support has the potential to significantly enhance health care experiences and outcomes for the Deaf community. Literature on access to health care for Deaf people notes that optimal access requires consideration of communication, information, education and culture.¹⁹⁴ The following outlines key initiatives relating to enhancing:

- Health literacy;
- Cultural competence;
- Communication support; and
- Health service systems.

Health literacy

Key recommendations to enhance health literacy and empower self-management by Deaf patients include the provision of:^{195,196}

- Tailored health promotion initiatives to raise health knowledge in Deaf communities;
- Options for information channels, including conversation, hard copy publications and online resources;
- Access to culturally appropriate health information in sign language;
- Accessible published documents about health prevention, treatment, discharge and ongoing care; and
- Captioning of audio content on web-based videos.

Deaf-friendly approaches, such as skills-based learning, visual aids, interactive role playing, and visual metaphors, should be utilized.¹⁹⁷

Cultural competence training

'The high prevalence of un-interpreted encounters and the continued use of family members as interpreters may perpetuate health disparities and represent lost opportunities to improve care'.¹⁹⁸

Clinician preferences for using ad-hoc interpreters despite the availability of professional interpreters is evidence for the need for cultural competence training for clinicians.

'Educational strategies both at the undergraduate and advanced programmes for all health care professionals should be offered, aiming at developing cultural competence'.¹⁹⁹

Cultural competence training shows promise as a strategy for improving the knowledge, attitudes, and skills of health professionals. A 2005 systematic review of healthcare provider educational interventions to improve cultural competency found that both shorter and longer duration interventions appear effective, as do both methods using experiential learning and those not using experiential learning. Interventions teaching general cultural concepts, those teaching about specific cultures, and those that teach both are all associated with positive outcomes.²⁰⁰

'Understanding that the Deaf community is a linguistic and socio-cultural minority will help clinicians more effectively respond to issues of human diversity in the healthcare setting'.²⁰¹

194. Kuenburg et al., 2016

195. Ibid

196. Disabled People's Association Singapore, 2017

197. Landsberger & Diaz, 2010

198. Lee et al., 2018

199. Sirch et al., 2017

200. Beach et al., 2005

201. Hoang et al., 2010

Typically, cultural competence interventions refer to increasing participant understanding, skills and attitudes relating to: ^{202,203,204,205}

- Potential consequences of communication barriers;
- Legal issues surrounding communication barriers;
- Culturally sensitive care of patients with low English proficiency;
- Deaf culture; and
- Best practices for working with interpreters.

Such training relates to all health service staff, including clinical and non-clinical staff. In addition, the literature identifies the need to train both nursing and medical students in Deaf cultural competence. ²⁰⁶ In one study, the implementation of a 'Cross-Cultural Communication-Using an Interpreter' curricular intervention for third-year medical students was effective in increasing students' perceived efficacy in communicating with a patient with LEP, using untrained interpreters (i.e. those not NAATI trained) and accessing a hospital language line. ²⁰⁷

'Training medical students in Deaf cultural competency can significantly increase their capacity to care for community members and reduce the health disparities experienced by this community'. ²⁰⁸

A 2009 study provided recommendations relating to the curriculum for teaching clinicians how to overcome language barriers in health care. The study recommends that interventions include: ²⁰⁹

- The role of language barriers in health disparities;
- Means of overcoming language barriers;
- How to work with interpreters;
- Identifying and fixing problems in interpreted encounters; and
- Appropriate and safe use of one's own limited non-English language skills.

Recommended Curriculum Modules for Teaching Clinicians How to Overcome Language Barriers in Health Care ²¹⁰

MODULE	CONTENT	SUGGESTED TEACHING METHOD
Contributing role of language barriers in health disparities	<ul style="list-style-type: none"> ■ Review of literature of impact of language barriers on health and health care Description of salient cases ■ Review of laws regulating the provision of adequate interpreters 	<ul style="list-style-type: none"> ■ Didactic lecture ■ Reading and discussion of salient cases/first person accounts
Effective means of overcoming language barriers	<ul style="list-style-type: none"> ■ Review of issues that arise when ad hoc interpreters are used ■ Description of certified interpreter and what they bring to the role of professional interpreting 	<ul style="list-style-type: none"> ■ Didactic lecture ■ Video vignettes of problematic encounters in which ad hoc interpreters are used ■ Video vignettes of professionally interpreted encounters
How to work with interpreters	<ul style="list-style-type: none"> ■ Need for introduction and debriefing with interpreters ■ Positioning of interpreter ■ Use of jargon-free, easily translated information ■ Keeping eyes on the patient, not the interpreter ■ Asking the interpreter for help with cultural issues that arise ■ What to do if you have to use an ad hoc interpreter ■ Never use a child as an interpreter 	<ul style="list-style-type: none"> ■ Didactic lecture ■ Role-modelling in simulated encounter ■ Video vignettes of professionally interpreted encounters ■ Role-playing working with interpreters

202. Diamond & Jacobs, 2009

203. Reeves et al., 2002

204. Emond et al., 2015

205. Landsberger & Diaz, 2010

206. Kuenburg et al., 2016

207. McEvoy et al., 2009

208. Hoang et al., 2010

209. Diamond & Jacobs, 2009

210. Ibid

MODULE	CONTENT	SUGGESTED TEACHING METHOD
How to identify problems in interpreted encounters and what to do about them	<ul style="list-style-type: none"> Interpreted information does not match the patient's tone and/or demeanour More is said by the patient or clinician than appears to be interpreted encounters The interpreter takes control in the encounter How to politely guide the interpreter to use best interpreting practices 	<ul style="list-style-type: none"> Didactic lecture Video vignettes of problematic interpreted Role-modelling Role-playing
Should clinicians use their own limited language skills?	<ul style="list-style-type: none"> Description of how limited fluency inhibits accurate communication Review the literature documenting how limited language skills inhibit appropriate use of interpreters Encourage use of these limited language skills for rapport building 	<ul style="list-style-type: none"> Didactic lecture Discussion

Further research should also focus on the development of standard instruments to measure cultural competence.²¹¹

Communication support

'Clinical communication is a key component in the development of building positive therapeutic relationships and is one of the parameters of quality healthcare provision'.²¹²

Patient understanding, trust, and clinician-patient agreement can increase treatment adherence and support the development of better self-care skills and result in improved health and well-being.

Effective interpreter utilisation

'The presence of sign language interpreters during health consultations may impact on the development of meaningful and effective/therapeutic communicative exchanges between Deaf patients and health care professionals'.²¹³

A 2019 United Kingdom study explored the processes by which therapeutic alliance develops in mental health consultations with sign language interpreters through interviews with seven certified interpreters in the mental health system. Two key themes were generated:²¹⁴

- Nurturing the triangle of care, where the therapeutic process relied on collaboration, continuity, and trust; and
- Shared vision and knowledge, in which participants felt misunderstood and unsupported; there was a lack of Deaf awareness and clinicians appeared to feel deskilled.

The study recommends that interpreters are viewed as valued members of clinical teams and that clinicians can aim to be collaborative with interpreters and improve their awareness of mental health issues that are relevant to Deaf people.

'Interpreters cannot and should not be perceived as a passive and neutral conduit of emotional and highly sensitive information. Instead, interpreters should be equal partners in the triangle of care. This... builds trust, fosters collaboration and facilitates the development of a structure that can result in appropriate diagnosis and treatment'.²¹⁵

The study found that interpreters in the mental health setting need to be supported in their role and provided professional supervision to safeguard against interpreters become emotionally distressed and encourage them to remain working in mental health services.

211. Beach et al., 2005

212. Chatzidamianos et al., 2019

213. Ibid

214. Ibid

215. Ibid

The work of healthcare sign language interpreters is complex and multidimensional. A 2017 United States study described 44 task categories and 167 tasks relating to the work of healthcare ASL interpreters. Five task categories were among both the most important and the most frequent: demonstrating cultural adaptability, situation assessment, solving problems creatively, language and interpreting, and managing the discourse. The results of this study could be used in creating educational opportunities for healthcare workers to better understand the complexities and depth of the work of sign language healthcare interpreters and how to work with interpreters most effectively.²¹⁶

A 2012 New Zealand toolkit for interpreter use in general practice is designed from a clinician perspective to be a concise but nuanced, easily accessible resource that is based on the current evidence on interpreter use and aligns with Accreditation quality improvement requirements.²¹⁷ Refer to Appendix A1.

Other communication supports

In addition to access to Auslan interpreters across service types and hours of service delivery, other opportunities to strengthen communication include

- Implementing communication technologies (e.g., VRI); and
- Providing access to tailored clinical assessment tools (e.g., pain scales).

Health service systems

'Specific policies and measures are required to strengthen communication during hospitalisation to ensure delivery of safe and high-quality care'.²¹⁸

Recommendations to ensure equitable access to health care services include:^{219,220, 221,222}

- Embed organizational, professional norms around communication through policy leadership;
- Provide patient information leaflets and health advice in sign language, with captions on DVDs and websites;
- Implement cultural competence training for all health-care staff;
- Engage patients in discussion regarding available and preferred communication approaches;
- Educate physicians, nurses and patients about language services,
- Ensure communication support is accessible afterhours and in emergency situations, including access to professional interpreter services;
- Ensure medical records indicate preferred communication method;
- Schedule adequate consultation time;
- Enable reasonable adjustments including capacity to contact health-care staff, book appointments, receive test results and request repeat prescriptions by e-mail or text;
- Routinely monitor patient safety for low English proficiency patients. This requires use of systems and reporting to routinely monitor patient safety, including review of medical errors and near misses. Assess root causes and high-risk scenarios and develop strategies for improvement and error prevention;
- Seeking health indicator data and patient feedback, noting telephone surveys and written English surveys may be ineffective approaches; and

216. Olson & Swabey, 2017

217. Gray et al., 2012

218. Sirch et al., 2017

219. Smeijers et al., 2011

220. Alexander et al., 2012

221. Betancourt et al., 2012

222. Schenker et al., 2011

- Embed processes to identify areas that expose the hospital or its healthcare providers to liability. Exposures may include:
 - ▶ Inaccurate and incomplete medical history;
 - ▶ Improper preparation for tests and procedures;
 - ▶ Poor or inadequate informed consent;
 - ▶ Ineffective or improper use of medications or serious medication errors;
 - ▶ Use of interpreters who are not properly trained; and
 - ▶ Patient comprehension of their medical condition, treatment plan, discharge instructions, complications, and follow-up.

A summary from the literature is outlined in Table 9-3.

Table 9-3: Suggestions for Improving Communication²²³

FOCUS	ACTIVITY
Basic training & procedures	<ul style="list-style-type: none"> ■ Train all office staff, including clinicians, about the need to ensure effective communication; discuss professional, ethical, and legal obligations. ■ Specialized facilities, such as surgery units, recovery rooms, emergency departments, and radiology suites, should establish specific protocols for effective communication during all phases of care; review policies about removing and returning hearing aids. ■ Place prominently in medical record information about patient's desired communication strategy and other related personal preferences. ■ Prepare easy-to-read written instructions about what to do before clinician arrives (e.g., which clothes to remove and why). ■ Prepare easy-to-read written instructions about examining room or testing procedures. ■ Prepare pictures or diagrams depicting tests or procedures; have books with relevant pictures available for more detailed discussions (such as surgery).
Physical environment, resources & equipment	<ul style="list-style-type: none"> ■ Ensure that physical environment meets basic safety standards (such as light signal for fire emergency). ■ Use good lighting; clinician (and Auslan interpreter) well lit. ■ Minimize background noise. ■ Learn about local resources, especially Auslan interpreter services specifically trained for medical encounters and telephone relay services. ■ Acquire and learn how to use teletypewriter or telecommunications device for the equipment; if unavailable, ensure familiarity with telephone relay services. ■ Consider purchasing audio sound system for office communication with persons who are hard of hearing (especially in large practice with elderly patients). ■ Review automated telephone menu systems, considering alternatives for persons with hearing loss (e.g., e-mail or fax). ■ In radiology units, install coloured lights to signal when patient must take certain actions (e.g., holding breath and resuming normal breathing). ■ In waiting room, use vibrating pager or other nonvisual, nonauditory means to inform patients when clinician is ready for appointment.
Interactions with patients	<ul style="list-style-type: none"> ■ Ask patients about preferred communication approach. ■ Make appropriate effort to adhere to patients' preferred communication approach. ■ While communicating, always look and speak directly to patients. ■ For established patients, plan ahead to ensure required accommodation (e.g., the interpreter) is present for appointment; stay on schedule so interpreters do not leave before visit finishes. ■ Ensure that office staff communicates discreetly with patients in public setting. ■ Introduce all persons who enter room to patients. ■ Describe all planned physical manoeuvres and inform patients immediately before touching. ■ Periodically ask patients about effectiveness of communication; request suggestions to rectify unsatisfactory situations. ■ Periodically ask patients to summarize their understanding to identify miscommunications. ■ Provide brief, easy-to-read, written instructions about what to do after encounter.

223. Lezzoni et al., 2004

Summary

'Public health entities must work together with sign language users to address inequities in health information access'.²²⁴

Several recommendations to overcome communication barriers and reduce health care disparities for the Deaf community have been identified. These include enhancing health literacy, cultural competence, communication support and health service systems. Findings from a 10 year United States study are highlighted below. Whilst international study findings always need some qualifications as to its relevance in Australia, this study highlights relevant core issues in the availability of information and training.

Improving Access and Quality of Health Care for Deaf Populations A Collaborative Project of the Sinai Health System and Advocate Health Care²²⁵

- The research goal was to increase access to quality health and mental health care for Deaf and Hard of Hearing people. The strategies undertaken during the ten years included assessment, health education, provider training and research.
- Results of the project's interventions clearly demonstrated a need for "Deaf-friendly" health information and the effectiveness of that education when tailored to meet the needs of Deaf people.
- The **patient education intervention** covered the topics of depression management, cardiovascular disease prevention and management, and patient activation and self-efficacy. Each of these three curricula proved effective in increasing participant knowledge and intent to change behaviour. The group classes incorporated didactic presentations, participatory activities, take-home materials and interactive web-based activities across four consecutive modules, with content including: patient/provider communication, patient rights and responsibilities, informed consent, when to schedule a health care visit, preparing for the visit, communicating medical history, the risks and benefits of medication and other treatment options, making informed decisions about one's health, and understanding and managing chronic disease. Each of the participating organizations provided at least one staff person who received Train-the-Trainer training in the curriculum and then independently taught classes. Evaluation of the education sessions indicated participants were significantly more confident in their ability to interact with healthcare organizations and professionals.
- The provider and institutionally-focused interventions included two approaches:
 - ▶ An **educational training program**. The curriculum covered six content areas: information about the pre-lingually Deaf population and American Sign Language; regulatory requirements and risk management consequences; how to identify and use certified interpreters; the use of technology for more efficient and effective communication; how to establish "Deaf friendly" procedures and protocols; and resources for Deaf people seeking health care services. Emergency Department nurses, risk management staff and guest services staff were the target audience.
 - ▶ A **process improvement project** covering seven hospitals and seven outpatient clinics in which barriers to effective and efficient care for Deaf patients were identified, recommendations were made and process improvement plans were implemented to address those barriers. Two tools were used in conducting the assessment at each institution:
 - An assessment tool, covering the following topics: the existence of policy and procedure; staff knowledge of policy and procedure; staff education; actual practice; patient education; community outreach; and organizational support; and
 - An anonymous, self-administered survey of ten questions on similar topics which front-line staff were asked to complete.

Table 9-4 outlines an assessment tool created to support the study that may be adapted to facilitate process improvement in Victorian health services.

Table 9-4: Assessment tool: Improving Access to Care for Deaf Individuals²²⁶

COMPONENT	ACTION
Policy & Procedure	<ul style="list-style-type: none"> ■ Adopt policy to ensure that the request for & presence of an interpreter during a medical visit is documented in a standard manner. ■ Adopt a policy to ensure that there is a method to document a patient's refusal of an interpreter. ■ Have attendings who are not directly employed by the institution formally acknowledge their role in ensuring effective communication with Deaf patients. ■ Adopt policy to ensure standard and routine documentation of hearing loss and preferred mode of communication. ■ Adopt a policy for assessing the need for & use of auxiliary listening devices. ■ Adopt policy & guidelines to ensure availability of certified interpreters 24/7. ■ Adopt policy to ensure clear, easy method for staff to access policies.
Staff Education	<ul style="list-style-type: none"> ■ Add disability legislation and its requirements to new employee training. ■ Ensure that all employees receive training on Deaf culture and sign language as a language different than English and how to effectively communicate with Deaf persons. ■ Ensure that the request for & presence of an interpreter during a medical visit is routinely documented in a standard manner.

224. Barnett et al., 2011

225. Improving Access and Quality of Health Care for Deaf Populations A Collaborative Project of the Sinai Health System and Advocate Health Care – Final Report (2012)

226. Ibid

COMPONENT	ACTION
	<ul style="list-style-type: none"> Ensure that there is a method to document a patient's refusal of an interpreter. Adopt a standard method to document hearing loss and preferred mode of communication. Ensure that a Deaf patient is appropriately identified as needing an interpreter when referred for further testing or care. Develop annual competencies on ensuring access to quality care for Deaf patients.
Access to effective information	<ul style="list-style-type: none"> Install a VRI system and ensure access to all institutional departments. Adopt a picture book for communication on routine matters. Consider hiring staff interpreter if volume allows to ensure that interpreters are available as needed. Ensure that institution has assisted listening devices in good working order. Ensure that all TV's have closed-captioning and that staff know how to activate it. Install a videophone for patient use.
Patient education materials	<ul style="list-style-type: none"> Make available ASL patient education materials to Deaf patients either on the in-house system or with a link for the patient to access directly.
Organizational Support for Access for the Deaf Individual	<ul style="list-style-type: none"> Adopt a method to ensure that patient satisfaction data is collected from Deaf patients. Extend patient visit block time to allow for interpretation. Appoint one staff person to oversee services for Deaf patients.
Collaboration with the Deaf Community	<ul style="list-style-type: none"> Conduct outreach to Deaf community to let them know of the available services. Post a flyer informing patients of their right to an interpreter free of charge. Improve web site to be more useful to Deaf patients.

Key findings:

- Deaf individuals experience unique communication barriers in accessing healthcare.
- Health literacy is recognised as a fundamental skill required in maintaining health and accessing local healthcare. Patients with low English proficiency may demonstrate poorer understanding of chronic conditions and adoption of changes in lifestyle, reduced comprehension of diagnoses and treatment and poor adherence to medical advice. Many Deaf Australians lack access to preventative and ongoing health care information. This is due to a lack of available information in Auslan, together with limited opportunities to gather information through social networks and other informal pathways. As such, the capacity to self-manage health care is limited for these individuals.
- Due to an increasing complexity of the health system, help to navigate the system is becoming of greater importance for consumers, carers and health professionals.
- Communication is key to enabling patients to decide among different options of care, strengthening autonomy and capacity for self-management. Effective communication between patients and healthcare providers is essential to the provision of high quality, patient-centred health care. The quality of communication with healthcare providers is a major contributor to patient satisfaction and ongoing health care access.
- The use of terminology in health communication can be a complex issue. Misunderstandings may arise when patients do not fully understand the terms used by their healthcare practitioners.
- Healthcare providers and interpreters must explicitly clarify their mutual expectations before they start conducting a health care encounter.
- There is a significant body of research relating to the risks of ad-hoc interpreter use and misunderstandings of the role of the professional interpreter.
- The use of interpreters cannot be addressed by increasing interpreter availability alone. There are several factors influencing health care experiences across service types, including in primary care and emergency care, diagnostic services, and inpatient services. Increasing interpreter use requires interventions targeted at both individual physicians and the practice environment.
- Communication barriers can lead to poorer personal empowerment, social inclusion, self-efficacy and autonomy and may also lead to low self-esteem, symptoms of anxiety, depression and greater mental health issues.
- Ineffective communication may result in patients experiencing fear, mistrust, frustration and embarrassment. As a result of dissatisfaction with their health care, patients may avoid and delay seeking health services or not seek care until they are very sick, then presenting when a condition is more advanced.
- In addition to the significant impact on the quality of life for Deaf patients, a failure to ensure optimal communication exposes government agencies and their clients to significant social and economic risks.
- Improved access to health information and communication support has the potential to significantly enhance health care experiences and outcomes for the Deaf community. Recommendations to improve the quality and safety of care provided to hospitalized patients include initiatives to enhance health literacy, cultural competence of hospital staff, communication support and health service systems.
- Public health entities must work together with sign language users to address inequities in health information access.

10. Jurisdictional review

The following provides an overview of the operating model to facilitate equitable access to health services in other Australian and international jurisdictions.

10.1. AUSTRALIAN STATES AND TERRITORIES

Whilst each Australian State/Territory has in place a language service policy, the model for delivering Auslan interpreting and other communication supports varies. A summary is provided below.

Australian Capital Territory

The use of an accredited interpreter is required by ACT Government policy and legislation. The ACT Health Directorate and Canberra Health Services offers professional and accredited interpreting and translating services through the national Translating and Interpreting Service (TIS).²²⁷ TIS does not provide sign-language interpreters.

ACT Health Interpreter cards

ACT Health offers an **Interpreter Card** that lets healthcare providers know an interpreter is required. The card is available in 47 languages, excluding Auslan, which can be printed or saved on a smartphone or tablet. There is no sign-language specific card.

Figure 10-1: ACT Health Interpreter Card



24 Hour Emergency Interpreter Service

In the ACT, a 24 Hour **Emergency Interpreter Service** is operated by Deaf Society Interpreting and funded by the Department of Community Services Directorate. For emergency situations including interactions with police, hospitals or another emergency services, an Auslan interpreter can be arranged through a call or SMS to 0450 928 566. The Deaf Society staff will contact the emergency service provider to let them know that an interpreter is being organised and keep in touch with the Deaf client until an interpreter is confirmed.²²⁸

227. <https://www.health.act.gov.au/about-our-health-system/multicultural-health-act/need-interpreter>

228. <https://deafact.org.au/support/24eis/>

New South Wales

In any health care situation where communication is essential, health practitioners must engage professional healthcare interpreters for patients, families and carers who are Deaf. The policy *Interpreters - Standard Procedures for Working with Health Care Interpreters* must be adhered to by all staff across NSW Health. The Policy Directive describes when and how NSW Health staff must engage and work with healthcare interpreters.

NSW Health Care Interpreting Services (HCISs) provide access to professional interpreting services 24 hours a day, 7 days a week.²²⁹ Patients are not required to contact the HCISs to book an interpreter. The responsibility to book an interpreter lies with the health practitioner who is seeing a patient. Some HCISs also have an **emergency priority line** that is only available for targeted or critical facilities such as EDs, Birth Units and Intensive Care Units.

All health practitioners and relevant NSW Health administrative and support staff should be informed of the existence of the HCIS through **orientation programs**, **written procedures**, or **in-service training programs** as soon as possible after commencing employment. Each health organisation is to ensure that staff are aware of this Policy Directive, and that all staff are required to adhere to it and be proficient in its application. Training on working with healthcare interpreters by the HCIS should be provided to all staff who are in direct contact with patients.

Northern Territory

In the Northern Territory, the Interpreting and Translating Service NT works with government and businesses to help them communicate with Territorians who speak languages other than English. It is understood there is no Auslan specific language service provider and limited local access. As such, Auslan interpreting services are typically delivered via VRI with interstate interpreters.

In 2018, the Standing Committee on Health, Aged Care and Sport inquired the Hearing Health and Wellbeing of Australia. Several submissions highlighted the need for greater access to interpreters for medical services.²³⁰

Queensland

The *Queensland Language Services Policy*²³¹ aims to enhance access to interpreters and translated information to improve access to the full range of government and government-funded services for people requiring language support. The policy will be delivered through:

- Engagement of **certified interpreters** in circumstances where people experience difficulties communicating in English;
- Provision of **multilingual information**; and
- **Training of staff** in how to work with interpreters.

The Queensland Health Interpreter Service was established in 2007. Staff book interpreters on behalf of patients via the Interpreter Service Information System. Clients who require an interpreter are asked to inform staff before they arrive at a Queensland Health facility.

A Standing Offer Arrangement has been established for the provision of language services with a panel of six language service providers, including an Auslan specific LSP. This is a statewide whole-of-government arrangement available to all Queensland Government agencies and other eligible Queensland Government-funded service providers.

229. <https://www.health.nsw.gov.au/multicultural/Pages/health-care-interpreting-and-translating-services.aspx>

230. https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Sport/HearingHealth

231. <https://www.dlgma.qld.gov.au/resources/multicultural/policy-governance/lsp-policy.pdf>

In Queensland, each Hospital and Health Service is managed by its own Board and can implement additional policies to support patients. For example, in metro south, the Princess Alexandra Hospital has developed a hospital communication kit which is available for patients who are Deaf or Hard of Hearing. It contains *information and resources* to help overcome communication difficulties experienced during an admission or outpatient visit to hospital. The kit contains:²³²

- Auslan Ward Communication Tool – refer to Appendix A2;
- A visual pain scale to help healthcare workers comprehend the severity of symptoms reported in the absence of an interpreter; and
- Communication alert sign for staff to put on patient bedside chart and stickers to alert staff.

Figure 10-2: Communication alert stickers (Source: www.metrosouth.health.qld.gov.au)



South Australia

The *South Australian Interpreting and Translating Policy for Migrant and NonVerbal (Sign) Languages* policy ensures that South Australian Government agencies are aware of their commitment and responsibility to provide access to interpreting and translating services, based on fairness, equity and mutual respect. The policy provides guidance to South Australian Government agencies on the development of an interpreting and translating policy that will aid effective communication with all community members and enable their informed decision-making.

Multicultural Affairs in the Department of the Premier and Cabinet is responsible for maintaining this policy and the supporting templates that can be used for development of Government agency-specific policies, including:

- Using interpreting services – a guide for service providers;
- Deciding when to use an interpreting service;
- Can family and friends provide interpreting services;
- Using interpreting services: conflict of interest; and
- *Interpreting services: your rights and responsibilities* (See Appendix A3).

The Interpreting and Translating Centre (ITC) is a South Australian Government agency located within the Department of Human Services. ITC employs certified interpreters experienced in most of the community and commercial languages of South Australia, and works with Deaf Can:Do, The Royal South Australian Deaf Society, to provide Auslan interpreters, during and after business hours.

The major referral hospital, the Royal Adelaide Hospital, identifies two key processes in place to ensure delivery of interpreters and cultural support:²³³

- A referring doctor/GP should inform the hospital that an interpreter is required for a first visit; and
- If a patient or carer requires an interpreter at an appointment or during a hospital stay, a direct contact is provided or patients/carers may advise hospital staff.

232. <https://metrosouth.health.qld.gov.au/princess-alexandra-hospital/about-us/hospital-communication-kit>

233. <https://www.rah.sa.gov.au/patients-and-visitors/interpreters-and-cultural-support>

Tasmania

The *Multicultural Language Services Guidelines for Tasmanian Government Agencies* support Tasmanian Government agencies to take a systematic and consultative approach to meeting interpreting and multilingual information needs when delivering services to clients with a first language other than English. Guidelines include:

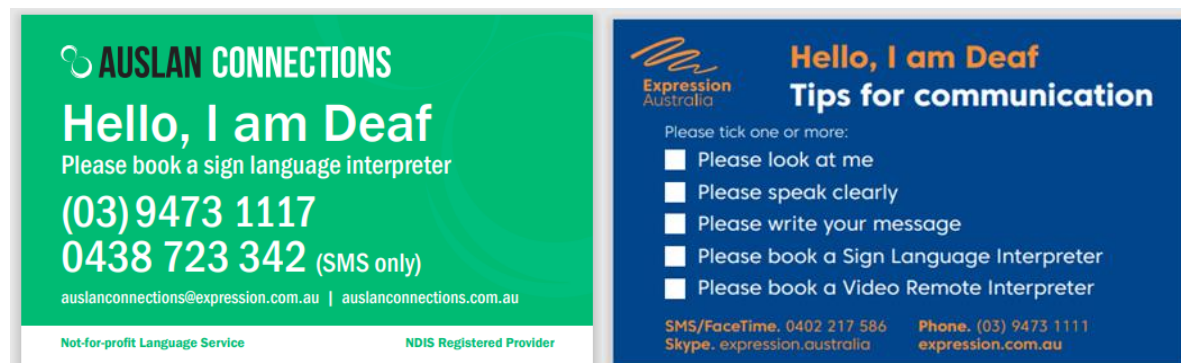
- **Establishing agency protocols for the use of interpreting and other language services:**
 - ▶ Acknowledging that providing interpreting and other language services is the responsibility of agencies;
 - ▶ Establishing guidelines for agency staff on when a credentialed interpreter must be used, taking into account the agency's obligations to its clients, the legislative requirements and risks that could impact on clients' health safety and/or human rights if an interpreter is not used;
 - ▶ Establishing protocols for engaging credentialed interpreters and protocols for when they are not available;
 - ▶ Ensuring that where the agency contracts with an external translating and interpreting service, that service establishes agreed protocols for the use of credentialed interpreters and protocols for when they are not available; and
 - ▶ Promoting public awareness of the availability of interpreter services.
- **Facilitating staff awareness, training and development:**
 - ▶ Ensuring that staff are aware of their respective agency's translating and interpreting policy and recognise that effective communication is integral to the delivery of all agency services;
 - ▶ Providing staff who may require an interpreter with guidelines to assist them in recognising when a client may require an interpreter and information on how to access and use translators and interpreters;
 - ▶ Ensuring that information regarding staff use of translating and interpreter services is available on the agency's intranet; and
 - ▶ Facilitating cross-cultural awareness training for relevant staff, including practical training on how to work with interpreters.

Two main communication services are available in Tasmania:²³⁴

- Expression Australia has a team of qualified Auslan interpreters who provide state-wide interpreting services for the Tasmanian community, including after-hours interpreting; and
- The NRS is a free, 24-hour national telephone service for people who are Deaf or hard of hearing to communicate with voice callers.

An 'I am Deaf' card is also available for use in Tasmania and Victoria.

Figure 10-3: I am Deaf Card (Tasmania and Victoria)



234. https://www.dhhs.tas.gov.au/publichealth/health_literacy/health_literacy_toolkit/communicating_with_people_who_are_deaf_of_rely_on_sign_language

Western Australia

The Western Australia *Health System Language Services Policy* aims to ensure that:

- All consumers and carers who need assistance with English or who are Deaf or hard of hearing are provided with access to appropriate interpreting and translating assistance;
- All health service provider staff who deal with consumers and carers have the **knowledge and skills** to assess the need for language assistance and to engage appropriate interpreting and translating services; and
- There are **suitable procedures and processes** in place to enable appropriate and timely engagement of interpreters and translators, particularly for health situations that have health, legal or other risks for consumers, providers or the health system.

The policy notes that staff must advise consumers, verbally and through display and use of resources:

- That they have the right to use interpreter services in order to understand and share necessary information (including multilingual information);
- That these services are free and confidential;
- When and how to ask for an interpreter; and
- How to give feedback regarding interpreter services.

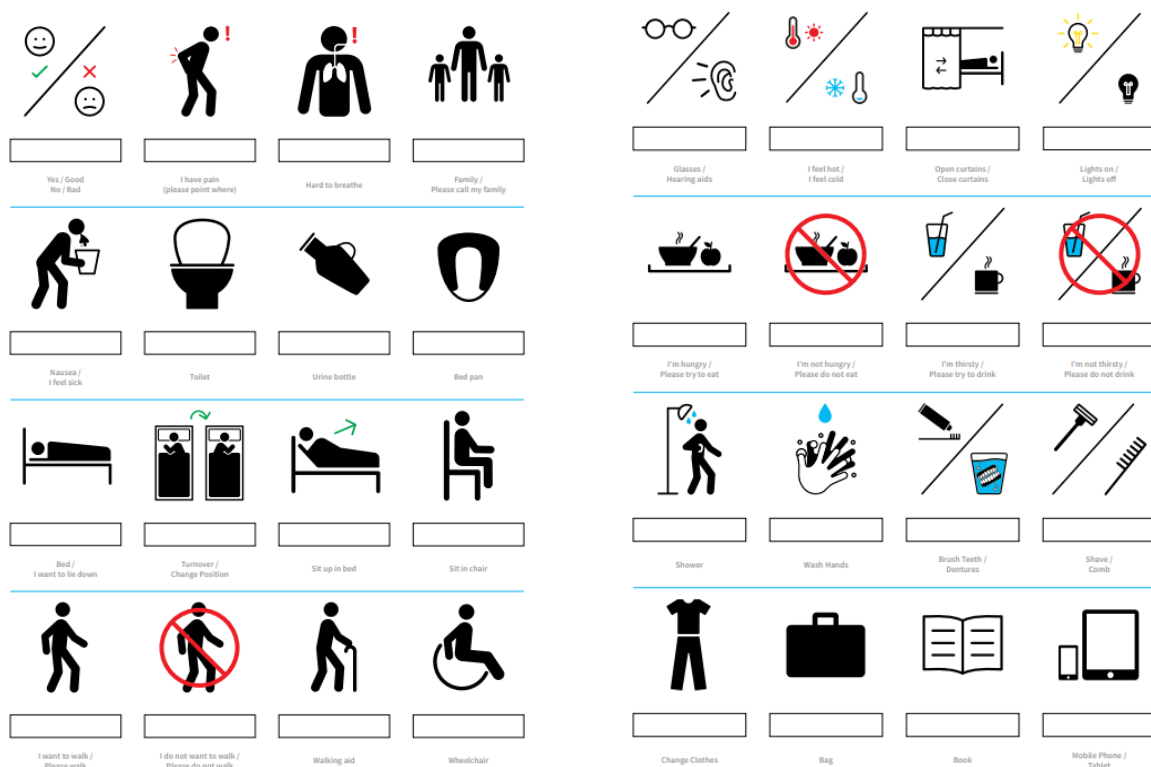
Language services are provided by qualified hospital-employed and agency provided interpreters. **Language service coordinator positions** are located in six of Perth's major metropolitan hospitals. The role of the language service coordinator is to manage and coordinate the booking of interpreting and translating services for their hospital and some of the smaller affiliated sites.

10.2. NEW ZEALAND

The *New Zealand Sign Language Act 2004* declared New Zealand Sign Language (NZSL) an official language of New Zealand. Interpreter services are available in most areas of New Zealand for hospital and primary care visits, with several District Health Boards funding local interpreter services for hospital and primary care visits. For example, the Auckland District Health Board provides:

- The Auckland DHB Interpreter Service for all Auckland DHB general practices and their patients;
- A 24-hour service is available through wards/departments for those patients who require it. Bookings are made through ward/department staff on behalf of the patient; and
- Communication cards for use in conjunction with interpreter services. Hospital staff can provide printed copies of the cards in the language spoken by the patient for use while they are receiving care in hospital. Cards should remain with the patient for use at their bedside during their stay.

Figure 10-4: Communication Card²³⁵ (Source: Auckland District Health Board)



10.3. UNITED KINGDOM

The United Kingdom National Health Service (NHS) *Guidance for Commissioners: Interpreting and Translation Services in Primary Care* aims to provide practical advice to commissioners including details of the legal position, principles for high quality interpreting and translation services, and commissioning and contracting considerations.²³⁶ The eight principles can be used by commissioners to help agree priorities and ambitions for improvements in local translation and interpreting services.

1. **Access to services.** Patients should be able to access primary care services in a way that ensures their language and communication requirements do not prevent them receiving the same quality of health care as others.
2. **Booking of Interpreters.** Staff working in primary care provider services should be aware of how to book interpreters across all languages, including British Sign Language (BSL), and book them when required.
3. **Timeliness of Access.** Patients requiring an interpreter should not be disadvantaged in terms of the timeliness of their access.
4. **Personalised Approach.** Patients should expect a personalised approach to their language and communication requirements recognising that “one size does not fit all”.
5. **Professionalism and Safeguarding.** High ethical standards, a duty of confidentiality and Safeguarding responsibilities are mandatory in primary care and this duty extends to interpreters.
6. **Compliments, Comments, Concerns and Complaints.** Patients and clinicians should be able to express their views about the quality of the interpreting service they have received, in their first or preferred language and formats (written, spoken, signed etc.).

235. <http://adhb.health.nz/assets/Uploads/Communication-cards-Blank3.pdf>

236. <https://www.england.nhs.uk/publication/guidance-for-commissioners-interpreting-and-translation-services-in-primary-care/>

7. **Translation of documents.** Documents which help professionals provide effective health care or that supports patients to manage their own health should be available in appropriate formats when needed.
8. **Quality Assurance and Continuous Improvement.** The interpreting service should be systematically monitored as part of commissioning and contract management procedures and users should be engaged to support quality assurance and continuous improvement and to ensure it remains high quality and relevant to local needs.

Key considerations include:

- Interpretation and translation should be provided free at the point of delivery, be of a high quality, accessible and responsive to a patient's linguistic needs;
- When an interpreter is required, additional time will be needed for the consultation;
- Language preferences and communication needs should be recorded in the patient's record and shared with other services when the patient is referred on (for example to secondary care services). A highly visible alert should be used to ensure staff are aware of the needs of the patient in time for them to book appropriate support;
- Where an interpreter is required the primary care provider is responsible for ensuring one is booked;
- It is good practice for the primary care provider to confirm to the patient, in advance of the appointment, the name and gender of the interpreter (if known) that has been booked;
- Interpreters must be registered with an appropriate regulator, and should be experienced and familiar with medical and health-related terminology; and
- All staff within primary care services should be offered training to raise awareness of the role of interpreting, the positive impact on patients and clinicians of high quality interpreting, and appropriate types of interpreting for specific situations. This training should include contact details of the organisation providing interpreting and translation services, how to book appointments and how to make complaints or provide feedback.

InterpreterNow App & NHS 111 BSL Service

In addition to an Interpretation and Translation Service within each NHS clinical commissioning group or region, the NHS provides additional web-based BSL services.

The InterpreterNow app can be used in a face to face situation with for example, a GP, nurse or dentist, by signing to the interpreter on screen.

In addition, the NHS 111 BSL service enables a patient who is Deaf or hard of hearing to use a computer and webcam, or the InterpreterNow app on a smartphone or tablet, to make a video call to a BSL interpreter and access an NHS 111 adviser. The interpreter telephones the adviser who will assess symptoms and give health care advice or direct the patient to the appropriate local service - where possible the NHS 111 team will book an appointment or transfer to the service.²³⁷

SignHealth (www.signhealth.org.uk)

SignHealth is a Deaf health charity that works to improve the health and wellbeing of Deaf people through promotion of easier access to healthcare and information and partnership with the NHS and other services to raise awareness and undertake research.²³⁸

The SignHealth BSL health video library covers topics from cancer and depression, to types of abuse and how to perform first aid.²³⁹

237. <https://interpreternow.co.uk/nhs111>

238. www.signhealth.org.uk

239. British Sign Language Health Video Library - SignHealth

Key findings:

Key service model components employed across relevant jurisdictions include:

- **Promotion** of patient rights relating to communication needs and interpreter access;
- An **Interpreter Card** that lets health care providers know an interpreter is required;
- **Patient information and resources**, including:
 - ▶ Communication tools (to compliment interpreters during for example, an inpatient ward admission);
 - ▶ A visual pain scale to help reporting of symptoms in the absence of an interpreter; and
 - ▶ Communication alert sign for staff to put on patient bedside chart and stickers to alert staff.
- Provision of **accessible information**, including videos where appropriate and sight translation of documents that support patients to manage their own health and make informed decisions;
- Clear hospital **policies, procedures and processes** relating to interpreter engagement and staff accountability for interpreter booking. Considerations include:
 - ▶ Scheduling longer medical appointments where interpreters required;
 - ▶ Communication needs should be recorded in the patient's record (with a visible alert); and
 - ▶ Communication needs should be shared with other services when the patient is referred on (for example to secondary care services);
- Hospital **staff orientation programs** and **in-service training** programs relating to assessing access needs, cultural awareness training for relevant staff, including practical training on how to book and work with interpreters;
- Use of **VRI and app-based technology** to enhance access, particularly in emergencies (e.g., EDs, birth units, intensive care units);
- Accessible **complaint and feedback** processes; and
- Routine **monitoring** of service access and quality.

11. Core service model components

The identified components of service model that may drive high quality, accessible health care for patients who are Deaf or hard of hearing are outlined in Figure 11-1.

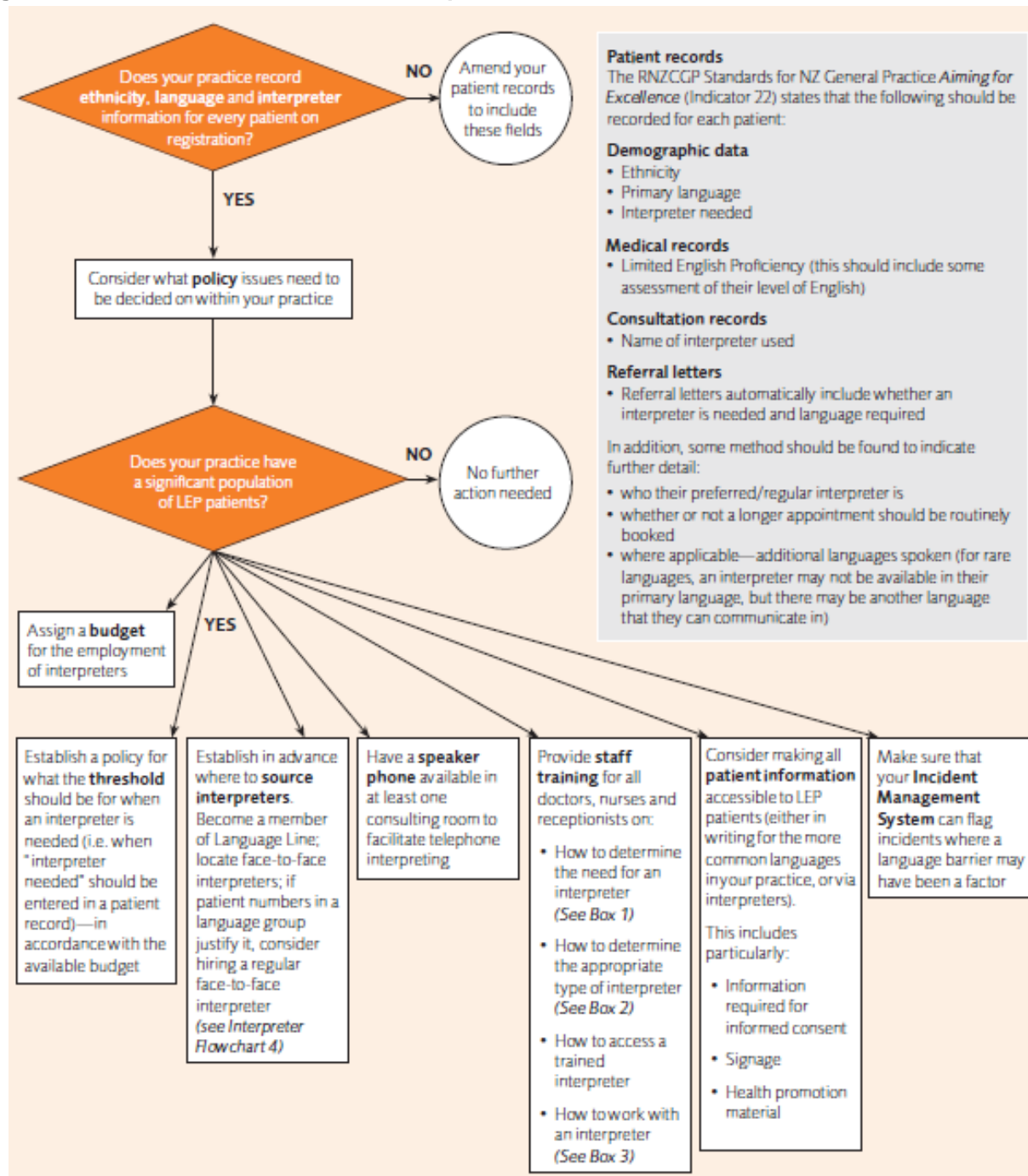
Figure 11-1: Service model components to strengthen health care access & outcomes



A1. Interpreter flow charts

The following flow charts were designed for use in primary care in New Zealand.²⁴⁰

Figure A1-1: Flow Chart 1: Practice Requirements



240. Gray et al., 2012

Figure A1-2: Flow Chart 2: Is an interpreter needed when a patient is from a non-English speaking background (NESB)?

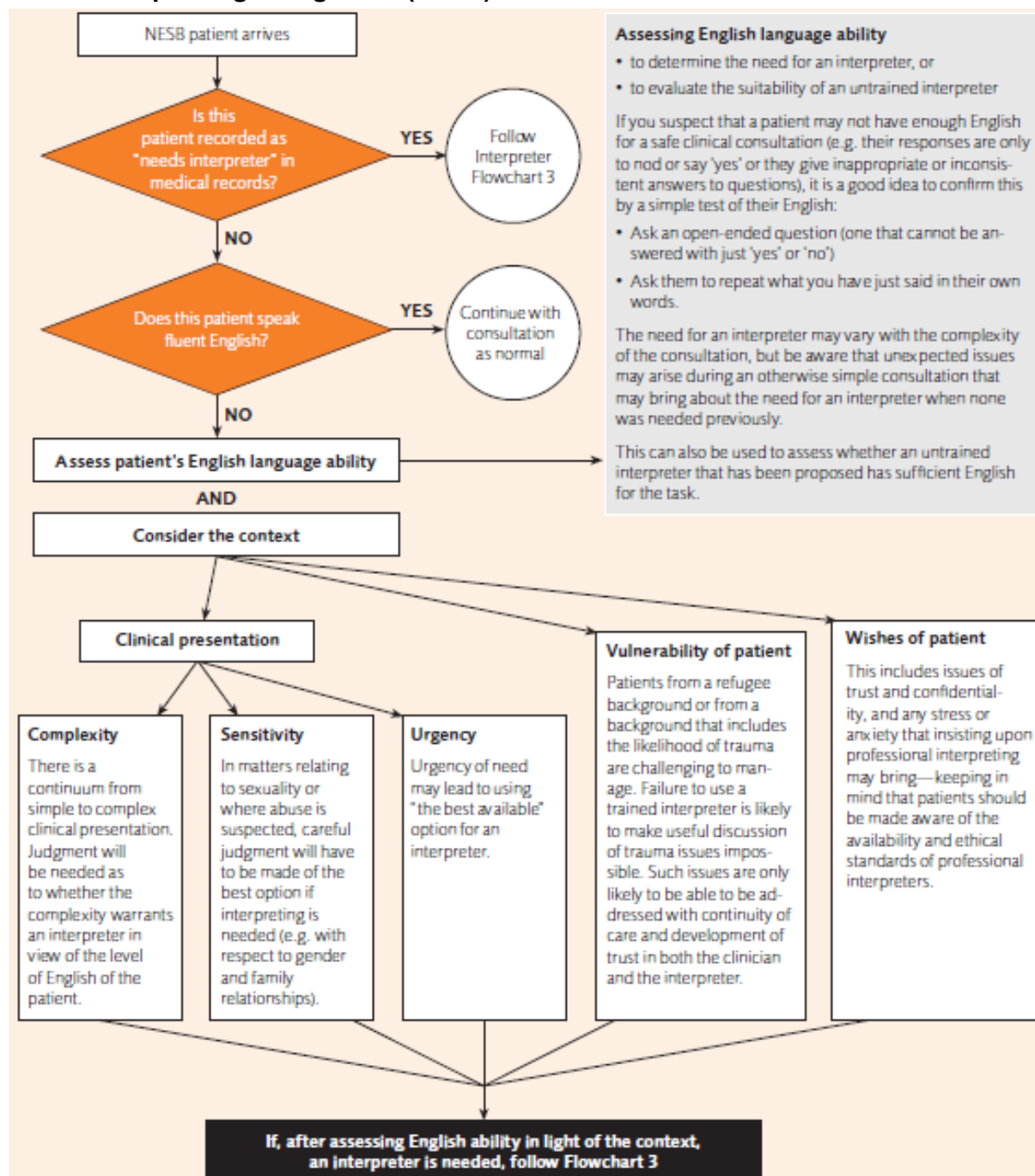
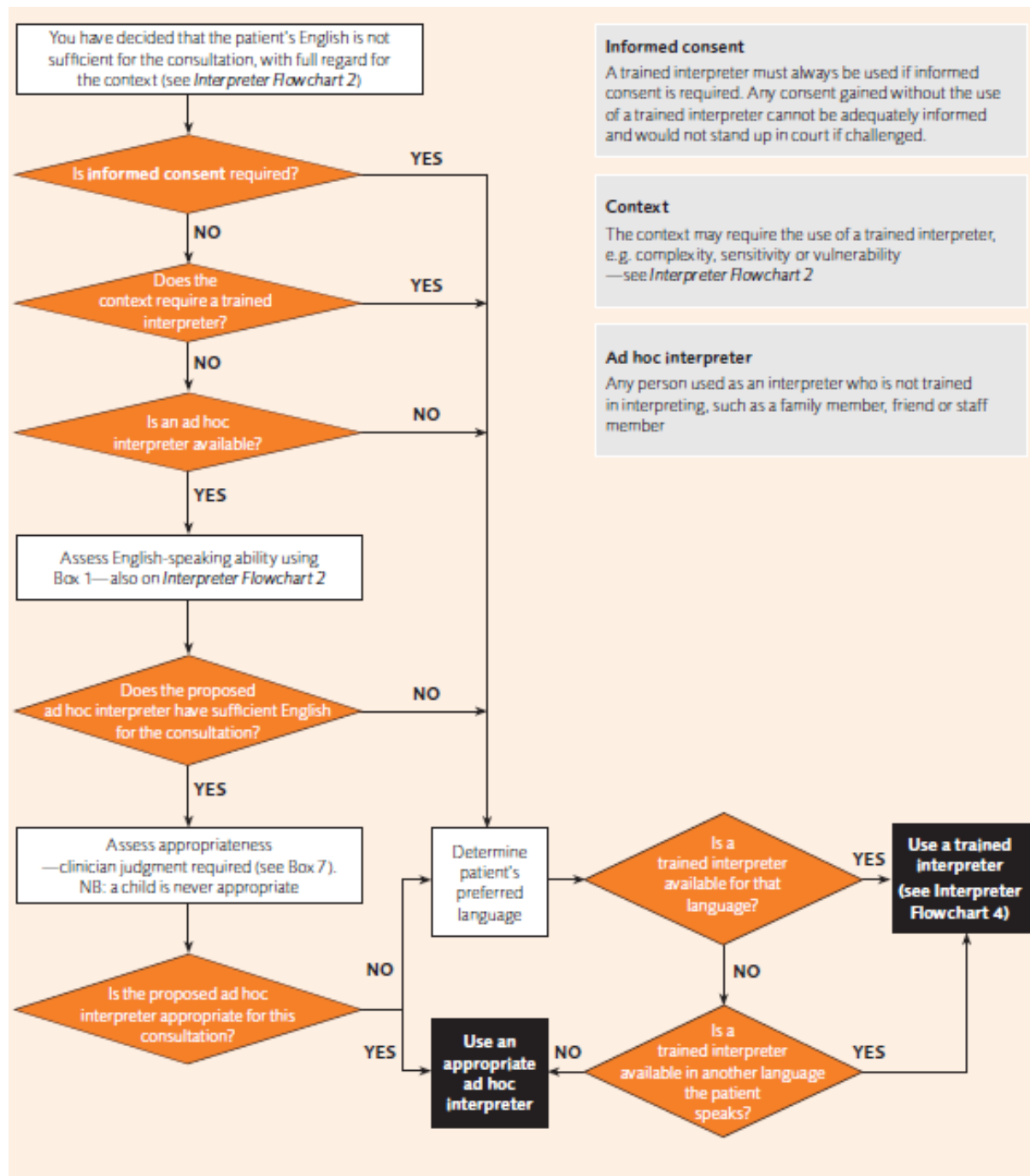


Figure A1-3: Flowchart 3: Trained or ad hoc? Choosing the best interpreter on a case-by-case basis



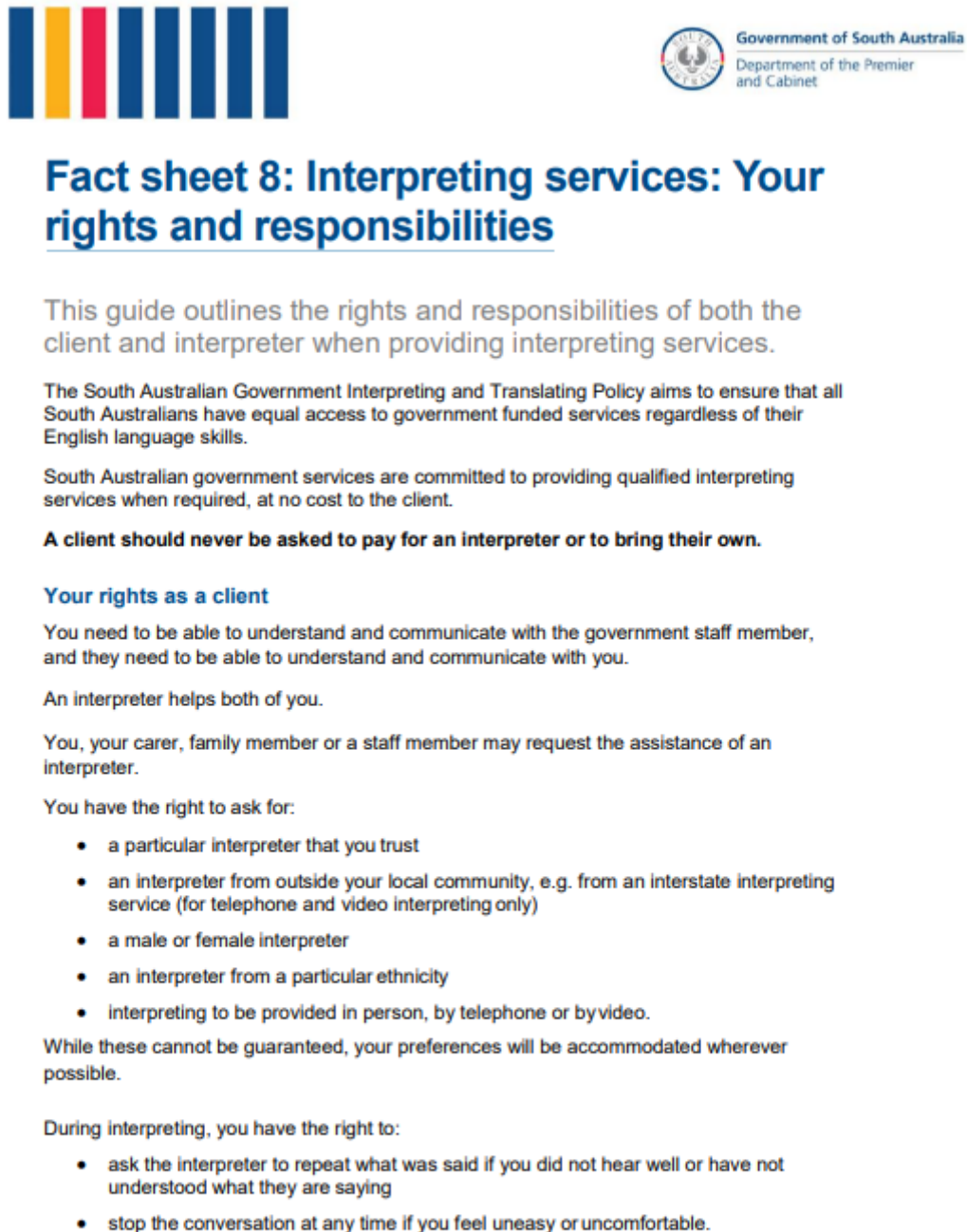
A2. Auslan Ward Communication Tool

Figure A2-1: Auslan Ward Communication Tool (Source: <https://www.health.qld.gov.au/multicultural>)



A3. Interpreting services Fact Sheet

Figure A3-1: Interpreting services: Your rights and responsibilities²⁴¹



The figure is a fact sheet titled "Fact sheet 8: Interpreting services: Your rights and responsibilities". It features a header with a logo of seven vertical bars in blue, yellow, and red, and the Government of South Australia logo. The text outlines the rights and responsibilities of clients and interpreters, including a list of rights such as the right to a particular interpreter, gender, ethnicity, and mode of service.

Fact sheet 8: Interpreting services: Your rights and responsibilities

This guide outlines the rights and responsibilities of both the client and interpreter when providing interpreting services.

The South Australian Government Interpreting and Translating Policy aims to ensure that all South Australians have equal access to government funded services regardless of their English language skills.

South Australian government services are committed to providing qualified interpreting services when required, at no cost to the client.

A client should never be asked to pay for an interpreter or to bring their own.

Your rights as a client

You need to be able to understand and communicate with the government staff member, and they need to be able to understand and communicate with you.

An interpreter helps both of you.

You, your carer, family member or a staff member may request the assistance of an interpreter.

You have the right to ask for:

- a particular interpreter that you trust
- an interpreter from outside your local community, e.g. from an interstate interpreting service (for telephone and video interpreting only)
- a male or female interpreter
- an interpreter from a particular ethnicity
- interpreting to be provided in person, by telephone or by video.

While these cannot be guaranteed, your preferences will be accommodated wherever possible.

During interpreting, you have the right to:

- ask the interpreter to repeat what was said if you did not hear well or have not understood what they are saying
- stop the conversation at any time if you feel uneasy or uncomfortable.

241. https://www.dpc.sa.gov.au/_data/assets/pdf_file/0013/140521/Fact-sheet-8-Interpreting-services-rights-responsibilities.pdf

Your responsibilities as a client

You should:

- give relevant and necessary information to the service provider to enable them to provide you the required services
- arrive on time when an appointment is booked
- show patience and respect when communicating through an interpreter by not talking for a long time or about many issues at the same time. The interpreter needs to remember what you are saying so that they will not forget any part of what you said
- complain to the service provider if you are unhappy with the interpreter or have concerns about their conduct, to avoid these concerns re-occurring.

Complaints can be lodged through the Australian Institute of Interpreters and Translators (AUSIT). You can call 1800 284 181 (free call) or email admin@ausit.org.

You should not:

- give a gift to the interpreter as they are bound by their professional Code of Ethics not to receive gifts
- ask the interpreter for a favour such as to transport you, even if both of you are going in the same direction.

The interpreter's role and responsibilities

The interpreter must:

- know your language
- speak English very well
- interpret exactly what the service provider says to you and what you say to the service provider without adding or omitting anything.

The interpreter must not:

- release any information about you to anyone in the community
- talk about your matter or business with anyone else without your permission
- give their advice or opinion about the issue being discussed
- talk with you separately from the service provider (e.g. the doctor, counsellor or police officer).

Your family member or friend should not interpret for you

You may bring a family member, friend or carer to any appointment to provide comfort or support.

However, you may notice that the service provider does not want your family member, friend or carer to interpret for you.

There have been instances where a family member or friend has interpreted for a client but:

- has accidentally miscommunicated an important message because they do not have the skills to interpret complex language or specialised terminology
- has not acted impartially
- feels they must 'protect' their relative or friend by not providing all the information
- has shared the client's personal information or private matters with other people.

The service provider has a responsibility to use a professional interpreting service, which will provide an interpreter who has interpreting qualifications and who must act impartially and confidentially.

For more on the risks of family or friends providing interpreting services, please refer to Fact Sheet 5 - Can family and friends provide interpreting services?

Supporting resources

This document is part of a series of resources available to other South Australian Government agencies when developing their interpreting and translating policies.

South Australian Interpreting and Translating Policy for Migrant and Non-Verbal (Sign) Languages

Fact sheets

Fact sheet 1: Using interpreting services – a guide for service providers

Fact sheet 2: Using translating services for written materials

Fact sheet 3: Language list by country and place

Fact sheet 4: Deciding when to use an interpreting service

Fact sheet 5: Can family and friends provide interpreting services?

Fact sheet 6: Role of bilingual staff in your organisation

Fact sheet 7: Using interpreting services: conflict of interest

Fact sheet 8: Interpreting services: your rights and responsibilities

You can access all of the interpreting and translating resources on the [Department of the Premier and Cabinet website](#).

For more information:

Multicultural Affairs

Department of the Premier and Cabinet

T (08) 8429 5961

E MulticulturalAffairs@sa.gov.au

W dpc.sa.gov.au/responsibilities/multicultural-affairs/

A4. Literature Review Reference List

- Alexander A, Ladd P & Powell S. *Deafness might damage your health*. Lancet (2012) 379.
- Australian Association of the Deaf (2004) *Access for Deaf people to health services - Comments to the HREOC Forum on Access to Health Services by Karen Lloyd, Manager Australian Association of the Deaf*.
- Baines D, Patterson N & Austen S. *An Investigation Into the Length of Hospital Stay for Deaf Mental Health Service Users*. Journal of Deaf Studies and Deaf Education (2010) 15:2.
- Barnett S, McKee M, Smith SR & Pearson TA. *Deaf sign language users, health inequities, and public health: opportunity for social justice*. Prev Chronic Dis (2011) 8:2.
- Beach MC, Price EG, Gary TL, Robinson KA, Gozu A, Palacio A, Smarth C, Jenckes MW, Feuerstein C, Bass EB, Powe NR & Cooper LA. *Cultural Competency: A Systematic Review of Health Care Provider Educational Interventions*. Med Care (2005) 43:4.
- Betancourt JR, Renfrew MR, Green AR, Lopez L & Wasserman M. *Improving patient safety systems for patients with limited English proficiency: a guide for hospitals*. (Prepared by the Disparities Solutions Center, Mongan Institute for Health Policy at Massachusetts General Hospital and Abt Associates, Cambridge, MA). Rockville, MD: Agency for Healthcare Research and Quality (2012).
- Bischoff A & Hudelson P. *Access to Healthcare Interpreter Services: Where Are We and Where Do We Need To Go?* International Journal of Environmental Research and Public Health (2010) 7.
- Blay N, Ioannou S, Seremetkoska M, Morris J, Holters G, Thomas V & Bronwyn E. *Healthcare interpreter utilisation: analysis of health administrative data*. BMC Health Services Research (2018) 18:348.
- Chatzidamianos G, Fletcher I, Wedlock L & Lever R. *Clinical communication and the 'triangle of care' in mental health and deafness: Sign language interpreters' perspectives*. Patient Education and Counseling (2019) 102.
- Chaveiro N, Porto CC & Barbosa MA. *The relation between Deaf Patients and the Doctor*. Braz J Otorhinolaryngol (2009) 75:1.
- Davies MC & Channon BT. *Deaf patients in the medical imaging department a qualitative study*. Journal of Diagnostic Radiography & Imagine (2004) 5:2.
- Deaf Australia. *Issues and challenge with Telehealth Service and Medical Services for Auslan users during Coronavirus (COVID-19)*. (2020) Available: <https://deafaustralia.org.au/wp-content/uploads/Telehealth-Deaf-Australia.pdf>
- Deaf Australia. *NDIA – Request for Services. Community of Practice: Deaf and Hard of Hearing – A Consumer's Report* (2019). Available: <https://deafaustralia.org.au/wp-content/uploads/Deaf-Australia-Community-in-Practice.pdf>
- Deaf Society. *Auslan Language Services and the NDIS: Ensuring Quality in an Environment of Workforce Shortage*. (2015) Available: https://deafsociety.org.au/documents/documentsNDIS_and_Interpreting_Paper.pdf
- Diamond LC & Jacobs EA. *Let's Not Contribute to Disparities: The Best Methods for Teaching Clinicians How to Overcome Language Barriers to Health Care*. J Gen Intern Med (2009) 25:2.
- Diamond LC, Schenker Y, Curry L, Bradley E & Fernandez A. *Getting By: Underuse of Interpreters by Resident Physicians*. J Gen Intern Med (2008) 24:2.
- Dimitra M, Christiana A & Evangelos F. *Deaf people's accessibility in health services*. Health Sciences Research (2014) 1:(4).
- Disabled People's Association Singapore. *Achieving Inclusion in Healthcare: Barriers and solutions to quality healthcare services for persons with disabilities* (2017) Available: <https://www.dpa.org.sg/wp-content/uploads/2017/09/Inclusion-in-Healthcare.pdf>
- Duckett S., Cuddihy M. & Newnham H. *Targeting zero: Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care*. State of Victoria (2016). Available: <https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/hospital-safety-and-quality-review>
- Emond A, Allsop L, Alexander A & Kyle J. *Access to primary care affects the health of Deaf people*. British Journal of General Practice (2015) 65:631.
- Flores G. *The Impact of Medical Interpreter Services on the Quality of Health Care: A Systematic Review*. Medical Care Research and Review (2005) 62:3.
- Gray B, Hilder J & Stubbe M. *How to use interpreters in general practice: the development of a New Zealand toolkit*. Journal Primary Health Care (2012) 4:1.
- Gray B, Stanley J, Stubbe M & Hilder J. *Communication difficulties with limited English proficiency patients: clinician perceptions of clinical risk and patterns of use of interpreters*. New Zealand Medical Journal (2011) 124:1342.
- Ha JF & Longnecker N. *Doctor-Patient Communication: A Review*. Ochsner Journal (2010) 10:38

Hill, S. (2014). *Report of the Victorian 2014 Consultation on Health Literacy*. Melbourne: Centre for Health Communication and Participation, La Trobe University. Available: <https://hic.org.au>

Ho A, Purdie C, Tirosh O & Tran P. *Improving the response rate of patient-reported outcome measures in an Australian tertiary metropolitan hospital*. Patient Related Outcome Measures (2019) 10.

Hoang L, LaHousse SF, Nakaji C & Sadler GR. *Assessing Deaf Cultural Competency of Physicians and Medical Students*. J Canc Educ (2010) 26.

How C. *A Review of Health Literacy: Problem, Tools and Interventions*. Proceedings of Singapore Healthcare (2011) 20:2.

Hsieh E. *Not Just "Getting by": Factors Influencing Providers' Choice of Interpreters*. J Gen Intern Med (2014) 30:1.

Hsieh E & Kramer EM. *Medical Interpreters as Tools: Dangers and Challenges in the Utilitarian Approach to Interpreters' Roles and Functions*, Patient Educ Couns (2012) 89:1.

Hsieh E, Pitaloka D & Johnson A. *Bilingual Health Communication: Distinctive Needs of Providers from Five Specialties*. Health Commun (2013) 28:6.

Jacobs EA, Sadowski L & Rathouz PJ. *The Impact of an Enhanced Interpreter Service Intervention on Hospital Costs and Patient Satisfaction*. J Gen Intern Med (2007) 22:2.

Johnston T & Napier J. *Medical Signbank: Bringing Deaf People and Linguists Together in the Process of Language Development*. Sign Language Studies (2010) 10:2.

Jones EG, Renger R & Firestone R. *Deaf Community Analysis for Health Education Priorities*. Public Health Nursing (2005) 22:1.

Karliner LS, Jacobs ES, Chen AH & Mutha S. *Do Professional Interpreters Improve Clinical Care for Patients with Limited English Proficiency? A Systematic Review of the Literature*. Health Services Research (2007) 42:2.

Kuenburg A, Fellingner P & Fellingner J. *Health Care Access Among Deaf People*. Journal of Deaf Studies and Deaf Education (2016) 21:1.

Kushalnagar P, Naturelle J, Paludneviciene R, Smith SR, Werfel E, Doolittle R, Jacobs S & DeCaro J. *Health Websites: Accessibility and Usability for American Sign Language Users*. Health Communication (2014) 30:8.

Kushalnagar P, Ryan C, Smith S & Kushalnagar R. *Critical health literacy in American Deaf college students*. Health Promotion International (2018) 33.

Lee JS, Nápoles A, Mutha A, Pérez-Stable EJ, Gregorich SE, Livaudais-Toman J & Karliner LS. *Hospital discharge preparedness for patients with limited English proficiency: A mixed methods study of bedside interpreter-phones*. Patient Education and Counselling (2018) 101.

Lee JS, Pérez-Stable EJ, Gregorich SE, Crawford MH, Green A, Livaudais-Toman J & Karliner LS. *Increased Access to Professional Interpreters in the Hospital Improves Informed Consent for Patients with Limited English Proficiency*. J Gen Intern Med (2017) 32:8.

Lezzoni LI, O'Day BL, Killeen M & Harker H. *Communicating about Health Care: Observations from Persons Who Are Deaf or Hard of Hearing*. Ann Intern Med (2004) 140.

Mahmoud I, Hou XY, Chu K & Clark M. *Is language a barrier for quality care in hospitals? A case series from an Emergency Department of a teaching hospital in Brisbane*. Australasian Epidemiologist (2011) 18.

Major G, Napier J, Ferrara L & Johnston T. *Exploring lexical gaps in Australian Sign Language for the purposes of health communication*. Communication & Medicine (2012) 9:1.

Massa J, Withers K, Leggett N, Dirago R & Yoon S. *Health Needs Analysis (HNA) of the Victorian Deaf Community reveals 'poor access to Auslan interpreters within hospitals a national concern'* Available: <http://dx.doi.org/10.1016/j.physio.2015.03.046>

McKee MM, Winters PC, Sen A, Zazove P & Fiscella K. *Emergency Department utilization among Deaf American Sign Language users*. Disability and Health Journal (2015) 8.

McEvoy M, Santos MT, Marzan M, Green EH & Milan FB. *Teaching Medical Students How to Use Interpreters: A Three Year Experience*. Medical Education Online (2009) 14:1.

Meador HE & Zazove P. *Health Care Interactions with Deaf Culture*. Journal of the American Board of Family Medicine (2005) 18(3).

Napier J & Kidd MR. *English literacy as a barrier to health care information for Deaf people who use Auslan*. Australian Family Physician (2013) 42:12.

Naseribooriabi T, Sadoughi F & Sheikhtaheri A. *Barriers and Facilitators of Health Literacy among D/deaf Individuals: A Review Article*, Iran J Public Health (2017) 46:11.

O'Halloran R, Douglas J, Cruice M, Davidson B, McKinley K & Bigby C. *Representation and reporting of communicatively vulnerable patients in patient experience research*. International Journal of Speech-Language Pathology (2019) 21:5.

- O'Hearn A. *Deaf Women's experiences and satisfaction with prenatal care: A comparative study*. Family Medicine (2006) 38:10.
- Olson AM & Swabey L. *Communication Access for Deaf People in Healthcare Settings: Understanding the Work of American Sign Language Interpreters*. Journal for Healthcare Quality (2017) 39:4.
- Orima Research. *Supply and Demand for Auslan Interpreters across Australia* (2004). Available: <https://www.dss.gov.au/our-responsibilities/disability-and-carers/publications-articles/policy-research/report-on-supply-and-demand-for-auslan-interpreters?HTML>
- Orsi JM, Margellos-Anast H, Perlman TS, Giloth BE & Whitman S. *Cancer screening knowledge, attitudes, and behaviors among culturally Deaf adults: Implications for informed decision making*, Cancer Detection and Prevention (2007) 31.
- Pertz L, Plegue M, Diehl K, Zazove P & McKee M. *Addressing Mental Health Needs for Deaf Patients Through an Integrated Health Care Model*, Journal of Deaf Studies and Deaf Education (2018) 23:3.
- Power MR & Power D. *Everyone Here Speaks TXT: Deaf People Using SMS in Australia and the Rest of the World*. Journal of Deaf Studies and Deaf Education (2004) 9:3.
- Reeves D, Kokoruwe B, Dobbins J & Newton V. *Access to Primary Care and Accident & Emergency Services for Deaf People in the North West. A report for the NHS Executive North West Research and Development Directorate* (2002). Available: <https://www.researchgate.net/publication/265058383>
- Richardson KJ. *Deaf Culture: Competencies and best practice*. The Nurse Practitioner (2014) 39:5.
- Richler M, Vaillancourt R, Celetti SJ, Besançon L, Arun HP & Sebastien F. *The use of pictograms to convey health information regarding side effects and/or indications of medications*, Journal of Communication in Healthcare (2012) 5:4.
- Rowse J, Anderson K, Phillips C, Chan. *Critical case analysis of adverse events associated with failure to use interpreters for non-English speaking patients*. Australian National University Medical School. (2014). Available: <https://ausit.org/wp-content/uploads/2020/02/ANU-Critical-Case-Analysis.pdf>
- Scheier DB. *Barriers to health care for people with hearing loss: A review of the literature*. Journal of the New York State Nurses Association (2009).
- Schenker Y, Pérez-Stable EJ, Nickleach D & Karliner LS. *Patterns of Interpreter Use for Hospitalized Patients with Limited English Proficiency*. J Gen Intern Med (2011) 26:7.
- Schenker Y, Wang F, Selig SJ, Ng R & Fernandez A. *The Impact of Language Barriers on Documentation of Informed Consent at a Hospital with On-Site Interpreter Services*. J Gen Intern Med (2007) 22:2.
- Sirch L, Salvador L & Palese A. *Communication difficulties experienced by Deaf male patients during their in-hospital stay: findings from a qualitative descriptive study*. Scand J Caring Sci (2017) 31.
- Sleptsova M, Hofer G, Morina N & Langewitz W. *The Role of the Health Care Interpreter in a Clinical Setting: A Narrative Review*. Journal of Community Health Nursing (2014) 31:3.
- Smeijers AS, Ens-Dokkum MH, van den Bogaerde B, & Oudesluys-Murphy AM. *Clinical practice: The approach to the Deaf or hard-of-hearing paediatric patient*. Eur J Pediatr (2011) 170.
- Smith CE, Massey-Stokes M & Lieberth A. *Health information needs of d/Deaf adolescent females: A call to action*. American Annals of the Deaf (2012) 157(1)
- Steinberg AG, Sullivan VJ & Loew RC. *Cultural and Linguistic Barriers to Mental Health Service Access: The Deaf Consumer's Perspective*. Am J Psychiatry (1998) 155
- Steinberg AG, Wiggins EA, Barmada CH & Sullivan VJ. *Deaf Women: Experiences and Perceptions of Healthcare System Access*. Journal of Women's Health (2004) 11:8.
- Terry DR, Le Q & Nguyen HB. *Moving forward with dignity: Exploring health awareness in an isolated Deaf community of Australia*. Disability and Health Journal (2016) 9.
- White J, Plompen T, Osadnik C, Tao L, Micallef E & Haines T. *The experience of interpreter access and language discordant clinical encounters in Australian health care: a mixed methods exploration*. International Journal for Equity in Health (2018) 17:151.
- Ubido J, Huntington J & Warburton D. *Inequalities in access to healthcare faced by women who are Deaf*. Health and Social Care in the Community (2002) 10:4.
- Witko J, Boyles P, Smiler K & McKee R. *Deaf New Zealand Sign Language users' access to healthcare*. New Zealand Medical Journal (2017), 130:1466.
- Yates J. *Deaf Access to Health Care* (2017). Available: <https://digitalcommons.liberty.edu/honors/674/>