Te Poari Tautoko I Nga Rohe Ki Te Raki

Northern DHB Support Agency Ltd

Working with District Health Boards towards
excellence in health and disability support services

Asian Mental Health Interpreter Workforce Development Project

Project Report

Curricula & Guidelines Development

for

Asian Interpreters & Mental Health Practitioners to work effectively together

"to achieve health gain for the Asian community in New Zealand"

Report prepared by
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Auckland, New Zealand
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AUCKLAND DISTRICT HEALTH BOARD

COUNTIES MANUKAU DISTRICT HEALTH BOARD
A Community Partnership

Waitemata District Health Board
Te Wai Awhina

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- Respondents to the public consultation
- Participants of the pilot training programmes

A photo of the project steering and working group members. (Seated): Bonnie Yi, Hien Mack, Janet Chen, Patrick Hinchey (Back Row): Victoria Camplin-Welch, Eileen Swan, Dr Ratana Walker, Shelley Sha, Patrick Au, Dr Sanu Pal, Paula Nes, Sue Lim, Bram Kukler. (Insert): Dr Rajendra Pavagada, Ineke Crezee (Absent:) Dr Sai Wong, Stephanie Doe, Ana Sokratov.

A photo of the pilot training workshop participants at a combined Mental Health Practitioner & Interpreter training session.

Executive Summary

Current New Zealand experience and research tell us that Asian migrants and refugees have difficulties accessing New Zealand mental health services because of the lack of trained interpreters and because the mainstream services are not culturally appropriate. Language problems, cultural differences, the use of untrained interpreters and the lack of culturally appropriate services all have a negative impact on equitable access to appropriate and quality care for Asian immigrants with limited English proficiency.

Aim

The specific aim of the project was to develop and propose a "package" of curricula and guidelines for training both Asian interpreters and mental health practitioners providing secondary mental health services in the Auckland region. The training package focuses on cultural competency and the skills required for practitioners and interpreters *to work together effectively*.

Method

An international and national literature review was conducted to look at issues affecting the effectiveness of interpreting in mental health. Best practice curriculum development models, training programmes and guidelines for practitioners and interpreters to work together effectively were also reviewed. A working group was formed to focus on developing the package.

Key stakeholders including mental health staff, Asian interpreters, Asian and non-Asian consumers were consulted. Pilot training was conducted to test the package with selected participants. Evaluation was undertaken before and after the pilot training and at the end of each training session. This feedback was incorporated into the final package. To ensure robust implementation, the working group was given the opportunity to provide feedback about the overall implementation process.

Key Literature Findings

To improve the quality of interpreting in mental health:

1. Interpreter's role should be defined
2. Interpreter's competencies should be developed
3. Practitioners and interpreters should be culturally responsive and competent
4. Guidelines should be developed
5. A systems-change approach should be considered
6. Quality evaluation should be considered
7. Organisation support and commitment is needed
8. Evaluation process is essential for evaluating the effectiveness of the programme

Conclusion and Key Recommendations

Evidence suggests that delivering culturally competent mental health care can achieve mutually agreed outcomes for culturally and linguistically diverse clients. It reduces misdiagnoses, enhances effectiveness and reduces health inequalities. Ongoing efforts need to be made to increase the cultural competency of both workforce and providers, and to train interpreters and practitioners to work together effectively to better meet the needs of Asian mental health service users and their families.

This is the first time that specialised training curricula and guidelines have been developed as a combined package for mental health practitioners and interpreters, and for widespread implementation across the Auckland region in order to ensure best and most consistent practice.

Key Recommendations

It is recommended that the Northern Regional Mental Health Directorate and the three Auckland-Metro District Health Boards (DHBs) consider:

1. A further phase to this project to implement the training of Asian interpreters and mental health practitioners across the Auckland region using the proposed "package":
    - Training Curriculum for Asian Mental Health Interpreters
    - Training Curriculum for Mental Health Practitioners to work effectively with Asian clients and interpreters
    - Guidelines for mental health practitioners and interpreters to work together effectively
2. Development of the guidelines and their incorporation into local policy, as well as into induction programme for interpreters and mental health practitioners.
3. Further research to evaluate the effectiveness of the training in terms of:
    - Improved working relationships between interpreters and practitioners
    - Improved Asian consumer experiences with interpreter-assisted interventions
    - Impact on access to services by Asians with mental health problems
4. Exploring ways to provide ongoing training/supervision/support for interpreters
5. Recording the training programmes on DVD/CD-Rom for dissemination to groups for training/revision or to participants where training is not easily accessible, and evaluation of this process
6. Future development in order to extend the "package" to include the perspectives and training of:
    - Non-Asian ethnic interpreter workforce
    - Practitioners from primary health and non-government organisations (NGO) workforce

Conclusion

The project has developed, piloted and evaluated a package for training interpreters and practitioners, resulting in the key recommendations above. Implementation of these recommendations would improve the skills and competencies of practitioners and interpreters.

Ensuring the two occupational groupings are equipped to provide culturally competent care will be a major step forward in providing a high-quality mental health service. The ultimate goal is for mental health services in Auckland to become more accessible and more effective for Asian mental health service users and their families.

This project did not consider the perspectives and training needs of non-Asian interpreters, sign language interpreters, primary health services and non-government organisations.

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1. Introduction

1.1 Background

The migration influx of Asian[1] people into New Zealand began in the late 1980's, peaked in 1995 and continued to lead the net migration figures with an average of over 15,000 people per year over 1996 to 2002, making Asian people the fastest growing population in New Zealand. Asians make up 12.5% (146,000) of the Auckland population (Statistics, NZ, 2001), the second largest population after Europeans. The increasing numbers and issues of ethnic differences, cultural diversity and people with limited English proficiency (LEP) pose a significant challenge to mental health services and the mental health workforce in the Auckland region in relation to addressing the language and culture gap.

Current experience and research conducted in New Zealand show that Asian migrants and refugees are encountering difficulties in accessing New Zealand mental health services because of the lack of trained interpreters and because mainstream services are not culturally appropriate. Language and cultural barriers have a significant impact on equitable access to appropriate and quality care, (Walker et al., 1998; Ngai et al., 2001 Ho, et al., 2003; Ministry of Health, 2003).

There has been ample research into language barriers impacting on initial access and communication barriers affecting diagnosis and treatment. The first barrier affects clients in relation to presenting for assessment and care, while the second barrier has an impact on the quality of care obtained. Generally speaking, non-English speaking clients seem to prefer interacting with a health professional who can speak their first language, (Bowen, 2001; Holt et al., 2001). In the mental health field, the preferred approach for health providers is to match a qualified professional to the client's first language where possible, to ensure the delivery of adequate diagnosis and treatment, (Craig, 1999). Employing more Asian mental health professionals would improve access to services; however it is not feasible to have adequate professionals fluent in all the Asian cultures, languages and dialects of their clients. There are currently 30 different spoken languages/dialects requiring language support by interpreters in Auckland, (Interpreter Service Data Source, 2005).

The second best approach is to use skilled professional interpreters to address the communication barrier, (Bulwada, 2004). However the use of interpreters who have not been specifically trained to work in mental health can be problematic and can hinder the communication process. This increases the risk of misinterpretation, non-diagnosis or misdiagnosis of the client's illness, and may lead to treatment errors and/or non-compliance. It may have a negative impact on treatment compliance or result in termination of prescribed treatment, and/or reluctance to seek further or early medical intervention, leading to more serious or prolonged illness and unnecessary cost, (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988; Hattar-Pollara et al., 1995; Craig, 1999; Lin et al., 1999; Kleinman, 2004; Tse, 2004; Nguyen, 2005).

This situation may be further compounded by cultural issues. Culture can have a considerable impact on the clients' presentation of symptoms or problems, the way clients experience depression, clients' help seeking patterns, as well as client-practitioner communication and relationship, and professional practice, (Craig, 1999; Kleinman, 2004).

[1] **Asian** refers to immigrants from Asia including people coming from West Asia including countries like Afghanistan, Nepal, to South Asia, covering the Indian sub-continent, East Asia covering China, North and South Korea, Taiwan, Hong Kong, Japan and South East Asia, consisting of countries like Singapore, Malaysia, Philippines, Vietnam, Thailand, Myanmar, Laos, and Kampuchea, (Statistics NZ 1995, 1999, 2003)

There is a need for interpreters to be trained to work in mental health and for these interpreters to have an adequate awareness and understanding of the cultural backgrounds and mental health situation in their communities, (Ho et al., 2003; Ministry of Health, 2003). The literature shows that relying solely on interpreters to bridge the communication and cultural gaps for services that may be culturally unresponsive or uninformed will not provide equitable access to services, (Doyle et al, 1987; Stevens, 1993a; James 1998). Efforts need to be made to increase the cultural competency of both workforce and providers, and efforts need to focus on training practitioners to work with interpreters, (Cappon & Watson, 1999; Tse et al., 2005).

In November 2004, the Northern Regional Mental Health Directorate at the Northern DHB Support Agency (NDSA) and the three Auckland-Metro DHBs considered the development of a regional Asian mental health interpreter workforce, as well as training for mental health practitioners to work with interpreters, as a first and an immediate step for the region to address the language and culture gap, in order to improve equitable access and appropriate care for Asian mental health service users accessing secondary mental health services in the Auckland region.

The decision to go ahead with the project was made by all three Auckland-Metro DHBs jointly. A project manager was appointed and a project to support the necessary processes was commissioned by the NDSA in January 2005.

1.2 Purpose and Scope of the Project

The specific aim of the project was to develop and propose a "package" with curricula and guidelines for training Asian interpreters and mental health practitioners who provide secondary mental health services for the diverse Asian immigrant population in the Auckland region, focussing on cultural competency and appropriate skills *to work together effectively*. The deliverables included:

1) Training Curriculum for Asian Mental Health Interpreters
2) Training Curriculum for Mental Health Practitioners
3) Guidelines for Mental Health Practitioners and Interpreters *to work together effectively*

It was not within the scope of this project to explore the training needs of other non-Asian and sign language interpreters; training needs for practitioners working with mental health clients in primary health and non-government organisations. In addition, the focus of the project is not on specific interpreting methods and skills. An additional limitation of this project was that it did not include research into the effectiveness of the training curricula and guidelines in terms of the improvement these might mean for the relationship between practitioners and interpreters, consumer experience in interpreter-assisted interventions, or access to mental health services by Asian people with limited English speaking ability.

1.3 Project Methodology

1.3.1 Project Structure and Membership

The project was established based on a formal project management structure. Project sponsors were Derek Wright (NDSA Regional Director) and Dr Dwayne Crombie (WDHB CEO).

Project Team: The appointed project manager was Sue Lim. The project team was further comprised of Dr Ratana Walker (Research advisor), and Hien Mack (project member). With the assistance of the team members, the Project Manager provided management and coordination support for the overall project processes – this included secretarial support, consultation and evaluation tasks, and compilation of the project report.

Project Steering Group: The steering group was established in February of 2005 with membership representing stakeholders (ADHB, WDHB, CMDHB, Asian and non-Asian mental health practitioners, ARPHS, AUT, RAS, interpreters, and consumers). See Appendix 1 for Terms of Reference.

Members were Bram Kukler (Chair); Eileen Swan, Dr Sai Wong, Dr Sanu Pal, Patrick Au, Dr Mina Bobdey, Patrick Hinchey, Stephanie Doe, Paula Nes, Dr Rajendra Pavagada; Janet Chen, Adem Bedasso, Ana Sokratov, Anne Ho, Hien Mack, Shelley Sha, Ineke Crezee, Nyunt Naing, Victoria Camplin-Welch, Sue Lim (Project Manager).

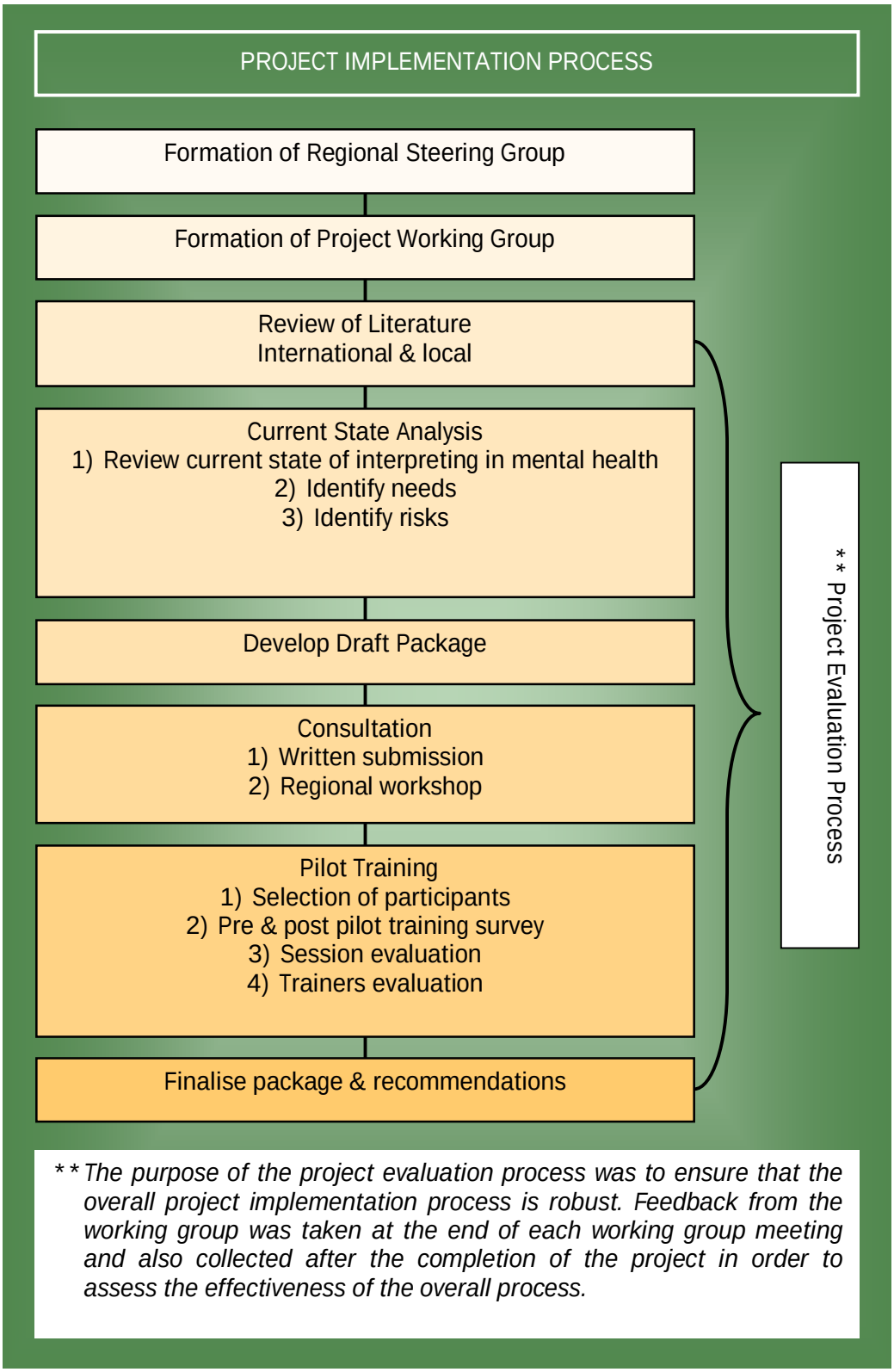
Project Working Group: A sub-group consisting of members of the steering group was formed as a panel of experts in February 2005, in order to focus on the development of the package. The working group was required to provide advice, and to participate actively in discussions and debates/workshops in order to form recommendations for the steering group to sign off on. Membership included representation from ADHB, WDHB, CMDHB, Asian and non-Asian practitioners, ARPHS, AUT, RAS, interpreters, consumer and interpreter services. See Appendix 2 for Terms of Reference.

The project working group was chaired by Dr Ratana Walker (Project Research Advisor). Members included:

- Dr Sai Wong (psychiatrist representing ADHB, CMDHB, WDHB)
- Dr Sanu Pal (psychiatrist representing ADHB)
- Dr Rajendra Pavagada (psychiatrist representing CMDHB)
- Patrick Au (Mental Health Nurse representing ADHB)
- Patrick Hinchey (practitioner and Team Leader representing WDHB)
- Victoria Camplin-Welch (Clinical Manager and psychologist representing Refugees as Survivors
- Janet Chen (Asian Public Health Coordinator representing ARPHS)
- Ineke Crezee (lecturer and the Interpreter Course Coordinator representing AUT)
- Anne Ho (Asian consumer)
- Hien Mack (Project Team Member and interpreter)
- Shelley Sha (interpreter and Community Mental Health Support Worker AMHS)
- Bonnie Yi (Interpreter Service Coordinator representing the APHIS Interpreter Service).
- Sue Lim (Project Manager, Service Manager representing WDHB Asian Health and Interpreter Services)

Key Stakeholders: Mental health clinical directors, practitioners, team leaders, managers, consumers, interpreter services, and interpreters were identified as key stakeholders in the consultation process.

1.3.2 Project Implementation Process



1.4 Structure of the Report

The **next section** provides an overview of the issues affecting the effectiveness of interpreting in mental health and a review of national and international literature confirming best practice and models for the development of the package. **Section 3** provides a brief overview of the current state of mental health interpreting services, a summary of issues; identified needs and risks. **Section 4** then goes on to briefly describe the package development process. **Section 5** is the focus of the report, as it outlines the proposed package. Finally **Section 6** contains the Conclusion, which highlights and proposes key recommendations for the NDSA and the three Auckland-Metro DHBs to consider.

A set of companion documents is available providing detailed documentation supporting the development of the package. These include:

- Consultation Report
- Evaluation Report
- Agendas and minutes/notes of meetings and workshops

2. Literature Review

The purpose of the review is to examine issues affecting the effectiveness of interpreting in mental health, how to improve the quality of interpreting in mental health interpreting and to confirm best practice and models for the development of training programmes and guidelines for mental health practitioners and interpreters to work together effectively to deliver culturally competent, safe, effective, quality and appropriate care to culturally and linguistically diverse immigrant populations.

The literature review addresses the following questions:

1. Issues affecting the effectiveness of interpreting in mental health
2. How to improve the quality of interpreting in mental health
3. Curriculum development methods
4. Cultural Competency Training
5. Training programme for mental health interpreters

2.1 Issues affecting the effectiveness of interpreting in mental health

Use of untrained interpreters

The fact that interpreter functions may take many forms has been well-researched. The person performing the interpretation function may be an untrained interpreter such as a family member, a young person/child, a community volunteer, a bilingual staff member or practitioner or a trained professional interpreter.

Untrained interpreters' level of proficiency in both English and the client's language may vary, as may his or her knowledge of the subject area for which interpreting is needed. Volunteers, friends or family members who have limited to non-existent clinical vocabulary, interpreting skills and knowledge of professional ethics should be avoided, (Aye, 2002; Groman et al., 2004, Tse, 2004). The need to maintain confidentiality and objectivity, emphasized in professional ethical codes of conduct in health interpreting is seldom recognised by informal interpreters, (Bowen, 2001).

Bilingual children are quite often seen as a convenient provider of interpretation for those recently arrived communities, especially refugee families. Child interpreters are both inappropriate and ineffective especially for sensitive health and personal information, because they do not have sufficient language or the emotional maturity to interpret accurately, (Green et al., 2004).

Not every bilingual can be an interpreter without formal training, (Bulwada, 2004). There is consensus among experts in the field that untrained interpreters pose many risks to both the patient and the practitioners – risks which can be greater than having no interpreter, (Bowen, 2001).

> *"…The error rate of untrained interpreters (including family and friends) is sufficiently high as to make their use more dangerous in some circumstances than no interpreter at all. This is because it lends a false sense of security to both provider and client that accurate communication is actually taking place." (An excerpt from a report of the US Office of Minority Health, 1999)*

Use of interpreters not trained to work in mental health

Technical language used for *diagnosis* (such as schizophrenia, bipolar disorder); for *symptoms* (such as delusions, hallucinations, psychosis); for *treatment* (such as counselling, case management, electro-convulsive therapy, psychosocial rehabilitation, supported accommodation), and for *names* (such as Community Mental Health Centre (CMHC), Crisis Assessment Treatment Team (CATT)) can be confusing for interpreters who have not been trained to work in mental health and this can impede the treatment and assessment process, (Craig, 1999; Bowen, 2001; Minas et al., 2001; Nguyen, 2005).

Misinformation, misinterpretation, or lack of training on mental illness could also result in inappropriate behaviour of interpreters (Minas et al., 2001). Accurate interpreting by well trained interpreters is necessary, (Tucker et al., 2003, Bulwada, 2004; Nguyen, 2005).

Interpreters performing a variety of roles

Interpreters may be expected to provide anything from straightforward language interpreting to cultural interpretation, advocacy or health educator functions, (Putsch, 1985).

The interpretation process is highly complex, especially when the roles expected by providers, clients and interpreters are not congruent. In addition, sometimes assumptions within the Western model of healthcare may prevent equity of care. Interpreters are sometimes asked to help arbitrate the cultural expectations of both client and provider and provide support to the patient, (Hemlin et al., 1996; Kaufert et al., 1998). Sometimes they are asked to provide emotional support, not only to clients, but also to providers, (Stevens, 1993b), or expected to function as health service workers (Hwa-Froelich et al., 2003), which may lead to interpreters getting over-involved and feeling responsible for failings in diagnosis and care, (Hemlin et al., 1996; Kaufert et al., 1998).

Ineffectiveness of the interpreting process can also be caused by the inherent "power imbalance" that exists within the practitioner/client relationship. Ineffectiveness may also be due to miscommunication because of different assumptions related to roles, health, and appropriate communication, (Putsch, 1985; Stevens, 1993b; Jackson, 1998).

Impact of culture

"Culture" refers to the integrated pattern of human behaviour that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious or social group, (Cross et al., 1989). Each of these characteristics is shared by the group through symbols, communication, language and social patterns, (Family Resource Coalition, 1996).

Culture influences health beliefs and practices, (Flowers, 2004), and is a direct determinant of disease and illness, (Campinha-Bacote, 1994b). As mentioned, culture has considerable impact on the diagnosis process, clients' presentation of symptoms or problems, clients' experience of depression, their help seeking patterns, the client-practitioner communication, relationship and professional practice (Kleinman, 2004).

Campinha Bacote said that values and beliefs can make each of us diverse even within our own culture, (Campinha-Bacote, 1994b). An interpreter who is not (culturally responsive) cultural sensitive or aware, has little or no knowledge of how cultural difference and cultural similarities can impose their own cultural values on a client. This can impact negatively on the interpretation process. Some interpreters have considerable knowledge of a particular culture in terms of religious, cultural practices or historical or political events, while others may have limited knowledge of a community and not be able to comment broadly, especially when the interpreter does not originate from the same country as the client, (Minas et al., 2001).

Similarly where practitioners are not culturally responsive and do not know how to respect or acknowledge the cultural difference or work carefully with clients and/or interpreters from other cultures, this may lead to potential cultural imposition and therefore poor outcomes, (Craig, 1999). The variation between practitioners in both their understanding and awareness of the different cultural perspectives of their clients; and their level of skills in working with interpreters affects the effectiveness of the interpretation process, (Nguyen, 2005).

There is sufficient evidence to conclude that a lack of cultural understanding can lead to misinterpretation, non-diagnosis or misdiagnosis of client's illness, treatment errors, non-compliance or early termination of treatment, reluctance to seek further intervention, all of which may lead to more serious or prolonged illness and unnecessary cost, (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988; Craig, 1999; Lin et al., 1999; Aye, 2002; Kleinman, 2004; Tse, 2004; Nguyen, 2005).

Social Stigma in Mental Illness

Stigma refers to a negative outcome or unwanted effect that results from any physical attribute, character or behaviour which deviates from the norm and is perceived to be undesirable, (Bakshi, 1999). Mental illness is highly stigmatised in all communities, (Minas et al., 2001). Asians dislike talking about mental health because of stigmatisation of mental illness as a supernatural punishment for wrong-doing in many Asian cultures, (Ho et al., 2003). Where there is a high degree of stigma, clients with limited English proficiency may not want to involve interpreters for fear that their mental illness be disclosed to their communities. This is especially common in smaller communities and may result in reluctance by clients to have a professional interpreter present even though they have limited English language skills, (Minas et al., 2001; Aye 2002).

Interpreters may also be affected by stigma. In the case of interpreting for trauma or abuse clients, some interpreters from refugee communities may have difficulties with agonizing and conflictive communication, which may affect them personally, when they have had experiences similar to those of the clients for whom they are interpreting, (Tribe, 1999; Loutan et al., 1999; Bowen, 1999).

Confidentiality

Many of the service users are not aware that interpreters are bound by the Interpreters' Code of Ethics to maintain confidentiality in their work and are concerned with disclosing information in the presence of an interpreter. This may also lead to clients' refusal of an interpreter, (Minas et al., 2001).

Continuity

Credibility and trustworthiness of both practitioner and interpreter are vital to the continuity of treatment. It is not easy to build trust and rapport with clients especially when interpreters are involved, (Nguyen, 2005), and this is even more difficult when different interpreters are involved in providing interpreting for one client. Clients' attitudes to and comfort with a particular interpreter take time to establish and having to rebuild a rapport with each new interpreter can be time-consuming and ineffective, (Minas et al., 2001).

Lack of ability to interpret simultaneously

Clients experiencing a manic episode may talk without stopping and interpreters who are not able to change the mode of interpreting from consecutive to simultaneous interpreting may affect the effectiveness of the interpretation, (Minas et al., 2001).

Clients with partial hearing impairment or low levels of literacy

Interpreters not being aware of the clients' hearing and understanding ability can impact on the outcome of the treatment process. Clients with partial hearing impairment or low literacy levels require interpreters to understand and make appropriate adjustment to the volume, tone of voice, or speed of conversation, (Lam et al., 2004).

Accuracy of information

Interpreters may omit information, or substitute their own interpretations on both the questions and the answers, or sometimes may change the direction of the questions or

normalise the client's answers because of a lack of mental health or psychiatric knowledge or to minimise the presenting psychopathology. This can have a significant or negative impact on the treatment and assessment process, (Flaskerud, 1990; Craig 1999).

Different educational and social standings of client and interpreter
Different educational and social standings of client and interpreter can affect the communication styles and understanding of the interpreter. These hidden influences may distort the information conveyed to the clinician by the interpreter, (Marcos 1979; Kim, 1995; Craig, 1999).

Professional partnerships
There is a general lack of understanding on how to work in partnership with interpreters. Interpreters will not be able to work effectively with practitioners who do not respect them. Also interpreters prefer to be "worked with" rather than "used", (Minas et al., 2001).

2.2 How to improve the quality of interpreting in mental health

Defining the roles of mental health interpreter is essential
Mental health interpreting is highly specialised, and involves accurate and effective interpretation of information from one language to another, (Minas et al., 2001; California Healthcare Interpreters Association Standards & Certification Committee, 2002).

While the principal responsibility of an interpreter is to bridge the language barrier between individuals speaking different languages in order that they may communicate freely with each other, (Downing, 1995) there is no consensus on the best way to define the interpreter's role. An interpreter may be viewed as a bilingual community worker, where interpretation is only one part of a larger role, including advocacy or cultural mediation. One result of the lack of consensus is often conflicting expectations of the interpreter's role, (Kaufert & Koolage, 1984).

Descriptive research has documented the range of roles, functions and programme models that have been developed in North America. For example, the expanded role of the community cultural mediator (which combines the functions of language interpretation, cultural mediation and community-oriented cultural advocacy) has been documented in the Cultural Mediator Handbook, developed in the Harborview Medical Centre programme, (Jackson-Caroll et al., 1998). The California Healthcare Interpreters Association Standards & Certification Committee has also presented a model that incorporates the cultural clarifier and patient advocate roles. Putsch (1985) drew on descriptive case studies of several models of interpreter-mediated communication in his description of alternative models of interpretation. Kaufert et al. (1984) used case examples to draw observations on the work of Aboriginal interpreter advocates in working as translators, advocates, cultural informants and brokers. In South Africa, interpreters act as "language specialists", as "culture specialists", as "patient advocates", and as "institutional therapists", (Drennan & Swartz, 1999).

There are concerns with the expanded role for language interpreters to function as advocates or cultural mediators or support workers. Professionals who want direct communication with the client are often uneasy with any role other than exact transmission of messages. They are concerned with distortions, censoring and influencing by interpreters carrying out support, advocacy, mediation roles, (Marcos, 1979, Downing 1997).

In spite of the lack of consensus on what the interpreter's role should be, it is generally

accepted that effective interpretation must involve more than just interpreting "words". Interpretation must also involve interpreting meanings, and clarifying misunderstandings that may arise due to differences between the cultures of the two participants in the health exchange, (Dias & O'Neill, 1998). This recognises that the culture of the patient includes more than his ethnicity. Individual values, beliefs, and previous experiences may or may not be similar to others in the client's ethnic community. There is also a need to explain the culture of the medical system, the technical language, the assumptions and practices, and the rights and expectations of patients, (Jackson, 1998).

Competencies needed for mental health interpreter to be effective

Interpreters need to be trained with cultural competency skills and the knowledge required to work in mental health, (Bowen, 2001; Tucker et al., 2003; Bulwada, 2004; Nguyen, 2005). Interpreters working in mental health should:

- *Be fluent in two languages, one of them English. The interpreter should be able to speak, understand, and write in both languages*
- *Be culturally competent in all cultures in which he or she interprets* - Interpreters must know not only the meaning of words in another culture but must understand the meaning of concepts in both cultures in order to provide literal, as well conceptual and semantic equivalence of the original, (Dunckley et al., 2003; Hunt & Bhopal, 2004).
- *Understand the medical and ethical dilemmas in mental health services*
- *Be able to apply the ethics and professional rules to the mental health interpreting situation:* maintain confidentiality at all times, interpret accurately, refrain from providing advice or giving own opinions.
- *Be skilled in facilitating between patient and provider without becoming a barrier to building a treatment relationship*
- *Be assertive when needed to prevent communication breakdown:* interpreters need to be assertive when they need to ask for communication to pause, so as to give him/her time to explain the cultural concept.
- *Be familiar with mental health settings and the mental health system*: be familiar with the titles and roles of different mental health providers such as psychologists, social workers, therapists, nurses etc, be familiar with organisations such as community mental health centres, private hospitals, etc, and also with different processes and practices in the mental health system, such as treatment, assessment, admission etc.
- *Be familiar with the vocabulary specific to mental health services:* be familiar with mental health terminology and jargon.
- *Be familiar with the terminology of interpretation:* be familiar with interpreting jargon, techniques and underlying theories, such as 'consecutive interpreting', 'simultaneous interpreting', 'relay interpreting'
- *Be skilled in sight translation:* competent with translating a document from written to spoken language.
- *Must have extensive general knowledge*

(Bulwada, 2004).

Importance of Cultural competency

Culturally competent health care can reduce misdiagnosis, inappropriate treatment and enhance effectiveness. It can also reduce health inequalities in ethnic minorities, (Groman, Ginsburg, & American College of Physicians, 2004). This requires the health workforce to be culturally capable to acknowledge and respect cultural differences and work with clients from diverse ethnic cultural and language backgrounds, so as to avoid cultural imposition, (Craig, 1999). The lack of formal professional cultural sensitivity and awareness can predispose health care providers to discriminatory practices, even without intent of racial bias or calculated cultural insensitivity, (Majumdar et al., 2004).

Cultural competency is defined as a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations, (Cross et al., 1989). The word ***"competence"*** implies having the capacity to function effectively. A culturally competent system of care acknowledges and incorporates at all levels the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs, (Cross et al., 1989).

Cultural competency is an ongoing developmental process towards which agencies strive. Individuals and organisations gradually learn the skills and knowledge to advance along the cultural competency continuum, (Cross et al., 1989).

Basic cultural competency is characterised by acceptance and respect for cultural differences and a continuing self-assessment against policies and practices. Advanced cultural competency is characterised by an organisation operating at a level at which cultural knowledge is high and policies and practices are in place that have produced positive results and satisfaction from the culturally diverse client, (Cross et al., 1989)

In order to ensure that interpreters are capable to perform the roles of cultural clarifier, cultural advisor or broker, and are culturally responsive and effective, interpreters should participate in cultural competency training. They need to be culturally competent and capable to respond appropriately to clients who may have different values and beliefs. They need to be culturally sensitive (aware of their own cultural assumptions and able to understand people from other cultures without imposing their own cultural values on them) and culturally responsive (have the knowledge to become aware of the needs of a culturally diverse population), (California Healthcare Interpreters Association Standards & Certification Committee, 2002).

One important thing to note is that relying solely on interpreters to bridge the communication and cultural gaps for practitioners or service providers that may be culturally unresponsive or uninformed will not provide equitable access, (Stevens, 1993a; James 1998; Doyle & Visano, 1987). Efforts need to be made to increase the responsiveness of health services and cultural competency of providers. This may involve training for practitioners to work with interpreters. Cultural competency training is essential for both mental health interpreters and practitioners, (Cappon & Watson, 1999; Tse et al., 2005; Nguyen, 2005).

Understanding the differences between Non-Western/Traditional and Western Societies

Mental health interventions are encouraged to include the exploration of the client's interpretation of events, rather than just applying professional understandings, (Craig, 1999). For example, many other cultures do not place the same value on personal autonomy as European cultures. For some cultures identity exists in the relationship with others more than in the person's relationship with the self. Introspection is not encouraged and decisions and problems are dealt with in a collective or communal way, (Rothenburger, 1990; Wright, 1991). Understanding the differences between Western and non-Western/traditional cultures would help in the exploration process of Asian clients' interpretation of their mental health problems. Below is a list of the main features of Eastern/traditional culture:

- Social integration is emphasised more than autonomy, that is, the family, not the individual, is the unit of society
- Dependence is more natural and infirmity (illness) is less alien
- When affiliation is more important than achievement, shame, rather than guilt becomes a driving force of how one appears to others
- The collectivity of the community is valued, rather than the individuality of its members

- Decisions are not made at an individual level but on a familial, tribal or communal level, in the best perceived collective interest
- Family structure is characterised by affiliated behaviour at the expense of differentiating behaviour
- Rearing is oriented towards accommodation, conformity, independence, affection versus individuation, intellectualisation, independence and compartmentalization
- Religion plays an important role in symptom formation, attributions (God's will) and management. Psychological symptoms are attributed to weakness of personality, lack of faith, lack of conformity, laziness, etc.,

And the main features of Western culture:

- Individual-oriented
- Nuclear family
- Status achieved by own efforts
- Relationship to kin: determined by individual choice
- Choice of marital partner, determined by interpersonal relationship
- Knowledge of relatives - restricted only to close relatives
- Decision making - autonomy of the individual
- Locus of control internal
- Doubt in doctor-patient relationship
- Suing for malpractice - common
- Deference is self-determined
- Doctor-patient relationship – mistrust
- Individual is irreplaceable, self-pride
- Community care for the mental patient
- Health and disease: attribution of illness and recovery is self-determined
- Informed consent – individual decision
- Confidentiality- porous
- Involuntary admission – individual decision

(Okasha, 2002)

Guidelines for practitioners and interpreters to work together effectively

Working with an interpreter in the clinical relationship requires specialised training of both the clinician and the interpreter, (Nguyen, 2005). Harry Minas and his team developed "Working with Interpreters: Guidelines for mental health professionals" for the Victorian Transcultural Psychiatry Unit in 2001. Their aim was to guide practitioners with suggestions on how to work with interpreters in order to achieve better results from the assessment and treatment process. They encourage a professional partnership approach between clinician and interpreter and promote the need to "work with" interpreters instead of "using" interpreters in order to achieve effectiveness, (Minas et al., 2001). The Cultural Awareness Tool "Understanding Cultural Diversity in Mental Health" also offers a good example of guidelines developed for practitioners to work with interpreters, (Sean, 2002).

A study led by the Massachusetts Medical Interpreters Association (MMIA) and conducted by Dr Maria Paz Avery for the Educational Development Centre Inc. in 1996 also developed standards of practice to serve as guidelines for the development of educational and training programmes for interpreters. The aim was for these to serve as an evaluation tool to rate the performance of the students and working interpreters, to form the basis for educating and preparing providers to work with interpreters, and to create a foundation for the certification examinations of health interpreters, (MMIA 1996).

Assigning same interpreter to a client

This is a recommended option in the "Working with Interpreters: Guidelines for mental health professionals", in order to ensure continuity and effectiveness of the interpretation process, (Minas et al., 2001).

Adopting a systems-change approach towards culturally competent organizations
The New York Office of Mental Health, with support from the Substance Abuse and Mental Health Services Administration Centre for Mental Health Services, has developed tools to assist organizations to define and measure progress towards cultural competency. Harvard Pilgrim Health Care in Boston systematically analyses all its organizational units for improvement relative to culturally and linguistic competence. Harvard Pilgrim Health Care started with interpreter training, went on to services implementation, and continued to introduce more advanced cross-cultural training for all staff, in addition to making the development of a diverse workforce a strategic priority. It also tracks the evolution and measures the effectiveness of the programme through patient satisfaction surveys of minority populations, (Cross et al., 2001).

Quality evaluation to assess effectiveness
Another suggestion for ensuring effectiveness is an ongoing assessment of the skills and performance of interpreters and practitioners. There has been limited research into the quality of interpreter services. One approach is to survey users, however most health service evaluations do not include a component on satisfaction with language access services. Additional research is needed to obtain feedback from service users themselves, (Garber & Maufette-Leenders, 1995). These strategies must recognise the difficulties in adapting and translating survey instruments. There is also an additional challenge in terms of the risk clients' reliance on a particular interpreter. In addition, uncertainty about the implications of negative feedback may bias survey results, (Bowen, 2001).

Organisational support and commitment
Organisations that are serious about achieving cultural competency engage in an ongoing review of policies and practices and enable their workforce to engage in training at regular intervals, (Cross et al., 1989). Support and commitment for the following will increase workforce capability and its capacity to meet the needs of culturally and linguistically diverse populations.

- Policy development to mandate cultural competency training and ongoing professional development for practitioners and interpreters
- Responsiveness to cultural diversity mandating the appropriate use of interpreter services
- Development of an interpreter accreditation process
- Budgetary provisions for staff training
- Budgetary provisions for interpreter services

(Bowen, 2001; Minas et al., 2001; Thapliyal et al., 2005)

The absence of standards and policies requiring interpreters to be trained professionally results in a low demand for trained interpreters. Many interpreter training programmes therefore do not have enough students, as students are unlikely to pay for courses when employment is uncertain. A lack of trained interpreters contributes to a situation where there is continuing reliance on untrained interpreters. A national response to promote implementation of policies regarding health interpreter use, training and standards is required, (Bowen, 2001).

2.3 Curriculum Development Methods

In California, many organisations sought a reputable programme that was pre-designed to eliminate the duplicative efforts of developing curricula. The Cross Cultural Health Care Program's (CCHCP) "Bridging the Gap" is used in many health care institutions in California. The course is taught "as is" with limited adaptations, (Roat, 2003). The California Endowment filled this gap by providing tailor-made programmes such as "Connecting Worlds".

A competency-based method was used to develop the translation and interpretation

programme of the Katrivk School Board for Inuit Interpreters in Nunavik, (Raymond, 2001). A role-based method called "DACUM" (Developing a Curriculum) was used to develop the training programme for training interpreters as part of a study led by Massachusetts Medical Interpreters Association (MMIA), conducted by Dr Maria Paz Avery for the Educational Development Centre Inc. in 1996. This development process involved a panel of experts with experience in the field to describe and define the tasks (that make up the jobs) of the interpreter, identify the needed competencies, skills and attitudes required to perform the tasks appropriately. The MMIA study selected 12 interpreters from a wide range of experience, representing six language groups to participate in a workshop directed by an experienced facilitator. The tasks identified were organised into three basic dimensions: 1) interpretation, 2) cultural interface; and 3) ethnical behaviour.

2.4 Cultural Competency Training

Several cultural competency training models are offered to address the challenge faced by the workforce to address the gap in cultural proficiencies, (Tse et al., 2005)

- Nursing Council of New Zealand
- Queensland Transcultural Mental Health Centre
- Purnell's Model of Cultural competency
- Developing culturally competent workforce (National Institute of Mental Health)
- Research Centre for Transcultural Studies in Health
- Cultural competency Model of Care

Since there is no specific consensus to the content, style or delivery of such training, the framework developed by Campinha-Bacote and Munoz (1994a) could be developed for cultural competency training for practitioners and interpreters.

1. Cultural awareness – is the process where participants examine and explore their own biases and prejudices toward other cultures
2. Cultural knowledge – is the process for participants to obtain information based on different cultural and ethnic groups, as well as understanding their world views, in order to understand how they interpret their illness
3. Cultural skills – is the process for participants to learn how to perform cultural assessments accurately.
4. Cultural encounter – is the process that encourages participants to engage directly in cross-cultural interactions with patients from culturally diverse backgrounds.
5. Cultural desire – is the process that motivates participants to engage in cultural encounters

Understanding the impact or influence of culture on mental health is a component of the Cultural Awareness Tool "Understanding Cultural Diversity in Mental Health", which was developed by the Queensland Health Department. It provides practitioners with general guidance on how to manage culturally and linguistically diverse clients with mental illness (how to elicit their client's understanding of the presenting problem, whilst conducting an assessment) in a more culturally-sensitive manner. The tool can be used for training purposes, (Sean, 2002).

Cultural competency training could adopt all or some of the following topics: an introduction to cultural competency in health; building appropriate partnerships; building organisational systems; language services; cross-cultural conflict resolution; cross cultural communication; supervising and hiring a multicultural workforce; and working effectively with diverse teams, (Cross et al., 1989).

Cultural Competency Performance Measurement Tools

Developing cultural competency is a developmental process that starts with an introspective look at oneself. To be culturally responsive, interpreters should

continually participate in cultural competency training, (California Healthcare Interpreters Association Standards & Certification Committee, 2002). The following is a set of cultural responsiveness performance measurement tools offered by the California Healthcare Interpreters Association Standards & Certification Committee, 2002, that could be used by interpreters for self assessment.

- Identify personal biases and assumptions
- Recognise personal values and cultural beliefs
- Prevent personal reactions and feelings that can interfere with the accuracy of the message
- Appropriately move to a cultural clarifier role when clinical staff and the patient indicate a lack of understanding of health beliefs and practices
- Continually update knowledge of the dynamic cultures of patients, clinical staff and the culture of the healthcare system (in our case: of New Zealand)

The Cultural Awareness Tool "Understanding Cultural Diversity in Mental Health" describes the features of a culturally competent health practitioner (Sean, 2002) that could be used as a checklist to measure practitioners' cultural competency levels.

2.5 Training Programme for Mental Health Interpreters

Training programmes have been developed in many countries, (Roat, 1995; Bischoff et al, 1998; Weiss et al, 1998). Determining which model of training for interpreters is most effective is not clear-cut. The model of service provision and training cannot be isolated easily from the definition of the interpreter role. The objectives of a particular training programme, as to whether to provide core interpreting functions or alternative roles in cultural arbitration will require the definition of the interpreter's role or competencies, (Bowen, 2001; Bulwada 2001).

Duration and contents of the training

The duration and the contents of the training are important criteria for any training course. The "Connecting Worlds" healthcare interpreter training offered by Healthy House (a California Health Collaborative) has ninety minutes of community health beliefs and practices as part of a total of forty hours of instruction in a small class size of 25. The weakness of that training is the lack of practicum, which is essential for mental health interpreting. The Medical Interpreting programme offered by Merced College filled this gap by providing 40 hours of practicum, and includes cultural concepts, folk medicine and medical vocabulary. However, the college only targets Spanish speakers.

The Healthcare Interpreters Certification Program offered by Reedley College is designed to enhance the provision of healthcare to ethnic populations, and the programme includes cultural interpreting, health issues in different ethnic communities, interpreting in different health care service areas, and field placement. The programme has 300 hours of instruction. The "Bridging the Gap" programme, offered by the Refugee Health Program, Sacramento County, Department of Health & Human Services, includes eight hours on culture and its impact on interpreting. A similar programme is also offered by the Cross Cultural Health Care Program of Santa Rosa.

Forty hours is the most common length of training. Community-based programmes offer more in-depth cover of cultural interpreting and relationship-related issues such as conflicts, ethical difficulties and conflicting expectations from the community and clinical staff. Practicum is a part of longer, university and college-based programmes in California for supervised practice, (Roat, 2003).

While the above mentioned training programmes are not exclusively designed for mental health care interpreting, there is one specific training programme designed by the Asian Counselling and Referral Services, Seattle, USA for interpreters of Southeast Asian Languages working in mental health, (Lochnicht, 1995). Topics include

understanding interpretation; Southeast Asian perceptions of mental illness; Euro-American mental health; Diagnosis, Assessment and Interpreter Services; and Mental Health Treatment Services.

All trainings should include a broad and inclusive definition of cultural and population diversity including consideration of race, ethnicity, class, age, gender, sexual orientation, disability, language, religion and other indices of difference, (Roat, 2003).

Training efforts should be developmental. Diverse patients, community representatives, and advocates should participate as resources in the design, implementation and evaluation of cultural competency curricula, (Roat, 2003).

Training Delivery

Training can be delivered as follows:

- Short informal training such as conferences and workshops
- Longer and more formal training through community colleges
- Formal training through universities, e.g. using professional school curricula

(Roat, 2003)

Trainers

The instructor's skills needed are as follows:

- Bilingualism
- Experience in living, researching or working within cultural communities (e.g. Public Health graduates)
- Experience in interpreting
- Completion of a particular "training of trainers" course, such as training in cultural competency
- Experience in teaching
- Experience in Mental Health Care
- Interpersonal skills, organisational skills, innovativeness and flexibility
- Knowledge of the practical issues health care organizations face in meeting the service delivery needs of diverse populations
- Seeing cultural competency training and learning as a developmental process, and having organised their training programmes to reflect this perspective
- Having developed an extensive amount of resource materials, tools and methods to support their training, and
- Understanding organisational cultural competency as well as individual cultural competency in health care.

(Roat, 2003)

Evaluation

Evaluation should be a part of the training in order to measure the impact of the programme on communication in mental health care, (Roat, 2003).

Accreditation

Closely related to issues of training are those of accreditation. Accreditation generally involves a skills test that is external to any course taken, and as such is a mechanism for ensuring standards achieved. It is important for standards to be set at national level and for the process to incorporate both the complexity and the scope of the interpreter's role, (Bowen, 2001).

2.6 Literature Findings

There is clear evidence that delivering culturally competent health care can reduce misdiagnosis, inappropriate treatment as well as enhance effectiveness and reduce health inequalities for ethnic minorities. It requires the interpreter and mental health workforce to be culturally competent and able to work together effectively to deliver quality and appropriate care to culturally and linguistically diverse clients.

The findings from the literature suggest that:

a) To improve the quality of interpreting in mental health
   - The interpreter's role should be defined and should include that of cultural advisor and clarifier
   - Interpreter's competencies should be developed and should include cultural competency and a working knowledge of mental health system and settings, and familiarity with their own culture
   - Practitioners and interpreters should be culturally responsive and competent to provide quality, safe and culturally appropriate care to culturally and linguistically diverse clients
   - Guidelines should be developed for practitioners and interpreters to work together effectively and should include the need to assign the same interpreter to the same client where possible
   - A systems-change approach should be considered to support the development of culturally competent organisations
   - Quality evaluation should be considered to assess the effectiveness of interpreter and practitioner workforce performance as an ongoing process
   - Organisational support and commitment is needed

b) Methods for developing a training curriculum could be based on existing reputable training programmes to avoid duplicative efforts; or could be either role-based or competency-based.

c) Cultural competency training
   - The framework offered by Campinha-Bacote could be used for training interpreters and practitioners in cultural competency
   - Achieving cultural competency is a developmental process
   - Cultural responsiveness performance assessment or checklist tools could be used to measure individual cultural competency

d) Training programme for mental health interpreters:
   - In addition to cultural competency training, topics could include understanding the roles of interpreter; the main difference between Eastern/traditional and Western cultures; understanding perceptions of mental illness; impact of culture on mental health; mental health treatment services; diagnosis, assessment and interpreting.
   - There is no specific consensus in terms of content, training delivery, duration and trainers
   - Efforts for training should be developmental
   - An evaluation process is essential for evaluating the effectiveness of the programme
   - Accreditation of participants could be considered as a mechanism to ensure the standards have been achieved. It is important for standards to be set at a national level.

3. Interpreting and Mental Health Services

3.1 Current State and Issues

3.1.1 Legislative framework

The Health and Disability Commissioner Act 1995 and the Health and Disability Code of Rights 1996 give mental health and addiction consumers the right to be provided with services that take into account the needs, values and beliefs or different cultural, religious, social and ethnic groups. The Code also gives mental health consumers the right to freedom from discrimination, coercion, harassment and exploitation. Right 5 makes services responsible for providing an interpreter.

The Mental Health (Compulsory Assessment and Treatment) Act 1992 and the 1999 amendments promote a culturally sensitive approach. Section 5 provides that the powers to enforce the Act must be made "with proper respect for the person's cultural and ethnic identity, language, and religious or ethical beliefs". Section 6 states that the court, tribunal or person must ensure that the services of an interpreter are provided for the mental health consumer.

The New Zealand Public Health and Disability Act 2000 provides for the public funding and provision of personal health services, public health services, and disability support services in order to pursue a number of objectives which include independence of people with disabilities, the best care or support for those in need of services, and reducing health disparities by improving the health outcomes of Maori and other population groups.

The Human Rights Act 1993 requires providers of mental health and addiction services to ensure that their policies and practices do not unlawfully discriminate on the grounds of, for example, sex (including pregnancy, and childbirth), religious belief, race, colour, ethnic or national origins, disability or age.

The Health Professional Competency Assurance Act (2003) incorporates the basic principles of ongoing competence and the separation of the registration and the disciplinary process.

3.1.2 Relevant policy and guidelines

The Northern Region Mental Health & Addictions Services Strategic Direction 2005-2010 proposed the following vision for refugees and recent Asian migrants

- Equal opportunity to access quality services delivered in a culturally appropriate manner for refugee and recent Asian migrant clients and their families
- Access to professionally trained and qualified interpreting services to meet the needs of migrants and refugees with experience of mental illness and their families

The Mental Health Commission's Recovery Competencies or Mental Health Workers (2001) – These guidelines are intended to provide cultural safety. Competency 7.5 of the 2001 Mental Health Commission's Recovery Competencies for Mental Health Workers, states that every mental health and addiction service worker should demonstrate:

- Knowledge of diversity within Asian cultures
- Knowledge of Asian culture for example importance of family, religious traditions, duty, respect for authority, honour, shame and harmony
- The ability to articulate Asian views on health
- Knowledge of traditional Asian treatments, and
- The ability to involve Asian families, communities and service users in services

The Blueprint for Mental Health Service in New Zealand (1998) provides a benchmark for access and quality of service provision.

The Draft Second Mental Health Plan (2005) provides a future strategic framework for the responsiveness of mental health and addiction services for people from diverse cultures and ethnic groups. It states that by 2007 the Ministry of Health (MoH) will have developed resources on cultural capability to assist health service providers to address the needs of people from diverse cultural backgrounds. It also states that the DHB planning and funding is responsible for developing services and cultural responses that reflect the cultural mix and diverse needs of the DHB. The Plan also aligns with the Southeast Asian models of holistic health and recommends that "people with mental illness and addiction are most likely to recover through holistic approaches that incorporates an understanding of people within their social cultural and social context".

3.1.3 Interpreter Services in Auckland Region

The three Auckland-Metro DHBs currently contract interpreters hired/contracted on a casual basis or employed on full or part-time contracts by

- Auckland Public Health Interpreting Service (APHIS) to provide services to ADHB mainstream health services
- Counties Manukau Interpreting Service providing services to CMDHB
- Waitemata Auckland Translation and Interpreting Service (WATIS) providing services to WDHB

Many of the interpreters work across the three Auckland DHBs.

3.1.4 Assessment and Accreditation of Interpreters

The assessment of language proficiency and the accreditation of interpreters working in health settings in New Zealand is currently undertaken by:

- The National Accreditation Authority for Translators and Interpreters (NAATI)
- Auckland University of Technology (AUT)
- Christchurch Polytechnic Institute of Technology (CPIT)

They offer the following certification courses to prepare interpreters to work in general health settings:

<u>Australian Interpreting Certificate Courses</u>

- National Accreditation Authority for Translators and Interpreters (NAATI) Level 3 Interpreting Test
- National Accreditation Authority for Translators and Interpreters (NAATI) Level 2 course

<u>New Zealand Interpreting Certificates</u>

- Auckland University of Technology (AUT) Certificate Course in Advanced Interpreting in Health (assessments comparable to (NAATI) Level 3 testing, with emphasis on health)
- AUT Certificate in Liaison Interpreting and Certificate Course in Healthcare Terminology (comparable to (NAATI) Level 2, with emphasis on health)

Some interpreters have attained accreditation from courses from New Zealand that are no longer offered:

- Manukau Institute of Technology (MIT) Certificate Course in Healthcare Interpreting
- Auckland Technical Institute (ATI) / Auckland Institute of Technology (AIT) Certificate Course in Healthcare Interpreting

Due to shortages of interpreters in some Asian ethnic minority groups, some interpreters are contracted without formal interpreting accreditation and are contracted based on their overseas medical qualifications or interpreting experience.

All basic interpreter training courses offered in New Zealand and Australia are certification courses. All of the courses provide theory and practice on interpreting. The

AUT Certificate in Liaison Interpreting Course covers a range of topics in its curriculum, including cross-cultural communication. These courses train interpreters to be competent with linguistic and communication skills in at least two languages (English and one other), to abide by the Interpreters' Code of Ethics and to be familiar with community settings in New Zealand, including the New Zealand health system and basic health terminology. The AUT Certificate in Advanced Interpreting Health includes a number of sessions on mental health interpreting topics.

There were two local initiatives developing curricula for training interpreters to work in mental health informally. The ADHB team (Eileen Swan, Dr Sai Wong and Patrick Au) had drafted a course outline for their project. Refugees as Survivors (RAS) a non-government organisation providing mental health services to refugees, had developed a specialised curriculum to train refugee community support workers as interpreters to work with specialists at the RAS centre. Apart from these, there is no specialised formal training programme available in NZ for training interpreters in secondary mental health settings.

3.1.5 Training for Mental Health Practitioners to work with interpreters

The proposed educational programme developed for the Mental Health Workforce Development Programme (MHWDP) "Asian Mental Health Workforce Development Feasibility Project" includes topics for training practitioners to improve their awareness of issues and skills in relation to working with Asian mental health clients and working with interpreters, (Tse, et al., 2005).

Since 2001, the Asian Health Support Service in Waitemata DHB has worked on developing an organisational policy and guidelines for practitioners on how to work with interpreters effectively and has been running bi-monthly training sessions for practitioners on Cultural Perspectives in Asian Patient Care and Guidelines on how to work effectively with interpreters. These training sessions are not specifically aimed at mental health practitioners only.

3.1.6 Challenges faced by interpreters working in mental health services

Interpreters are generally expected to act as a conduits, cultural clarifiers and advisors. However, they are also asked to provide emotional support, liaison support and crisis contact roles by practitioners or clients if they are willing. The different roles and expectations from clients and practitioners, varying levels of competencies and experiences between interpreters; and lack of available training or consistent standards of practice are key issues faced by interpreters working in mental health in the Auckland region.

Below is a summary of issues/challenges identified by the working group and workshop with interpreters; and consultation respondents and pilot training participants:

- Lack of recognized professional status
- De-valued by working with professionals who do not understand the role of the interpreter or who do not have experience working with interpreters
- Neutrality can be difficult when a client is misrepresenting or distorting the ideology and practice of the interpreter's own culture or political affiliation
- Responsibility – the interpreter often has to make important judgments when a client is communicating through them, some of which may require the astute combination of clinical insight and experience that comes with psychological and psychiatric training
- Vicarious traumatization and indirect therapy – experiences can be re-activated when interpreting in therapeutic contexts.
- Lack of pre-briefing and de-briefing
- Conflict of interest and breach of the international interpreters' code of ethics when asked to act as a support/liaison person while interpreting for the client

- § Lack of knowledge about mental illness, mental health practices and different mental health services
- § Lack of understanding of how culture impacts on mental health
- § Difficulty translating client's concepts of thinking and certain mental health terminology
- § Lack of common norms for their cultures
- § Practitioners' lack of understanding of the clients' culture and background
- § No ongoing training or specific training on mental health
- § No consistent standards of practice and management of interpreters
- § Lack of mechanism for feedback or complaints
- § No peer support/supervision

3.1.7 Challenges faced by mental health practitioners working with interpreters

Below is a summary of issues/challenges identified by the working group during its meetings, at the workshop with interpreters, and in the course of consulting respondents and pilot training participants.

- Being observed
- Loss of control of the interview and thereby feeling greater detachment from the client
- Threatened in their own role – feel like a solution giver and the interpreter becomes the primary connection
- Extended time factor in sessions and thereby feeling less effective
- Conflict may arise if interpreter has to broker two sets of irreconcilable viewpoints or positions (e.g. medical versus spiritual intervention)
- Tension if working with interpreters of a different gender
- Language is the main tool of psychiatry and psychology and there may be lack of trust on the clinician's part in the interpreter's ability to render an accurate translation of the client's story as there no are means to check this directly
- Difficult or sensitive material for the interpreter can affect the translation and the rapport between therapist and client
- Nuances in language which are a vital tool are lost. The dialogue becomes more simplified, often directive and even generalized. This is influenced to a certain degree by the fluency and competency of the interpreter
- The full range of therapeutic and personal styles, as well as particular types of reflective intervention approaches are limited
- Assessment and treatment time is limited –communication takes virtually double the time
- The therapeutic relationship is affected by the presence of the interpreter
- The triadic relationship affects the process of treatment (transference and counter-transference issues)
- Intervention tends to become simplified and more concrete
- Sometimes interpreters are affected by emotional content of session and need de-briefing, which means another intervention is required for the practitioner
- Potential misdiagnoses

- § Interpreters have inadequate mental health vocabulary or lack understanding as to how to interpret the clients' symptoms and problems
- § Interpreters not aware of the framework which is being used in the process of therapy
- § Omission or message not conveyed in the manner it was delivered in: interpreter does not directly translate everything that the client says, or fails to provide literal translation, or cannot find the exact language equivalent
- § Interpreters became over-involved with the client; counter-transference issues in the translation process
- § Interpreters not understanding the person's dialect
- § Interpreters acting as a broker for other services

- Interpreters have own conversations with clients; sometimes offering advice or clarifying answers posed to them (the client) by mental health practitioners before conveying the client's response.
- Interpreters answering cellphone calls during consultation/review process
- Interpreter does not separate own opinions/clients' opinions properly
- Client declining the use of interpreter, because of shame and stigmatism.

3.2 Identified Needs

The initial process to develop the draft package involved setting up a working group of experts to focus on the development of the package based on the tasks (roles) required to be performed by mental health interpreters. Defining the role of a mental health interpreter was the first step followed by the process of identifying the needed competencies, skills and attitudes required by interpreters to perform the tasks appropriately. This was followed by identification of competencies needed by practitioners to work effectively with interpreters. These role-based and competency-based curriculum development methods were adopted to ensure the variable of the competencies required by both teams were controlled and the training curricula were designed to meet the appropriate learning needs and targeted competencies of interpreters and practitioners.

The development process identified the following needs.

Roles of the interpreter working in mental health

There was consensus from the working group and eight Asian interpreters in the initial workshop that interpreters should only perform the following tasks (roles) when working in mental health:

- ***Conduit*** – interpret literally with no omissions, additions or editing, or clarify as required (interpreter need to alert practitioners when interpreting literally)
- ***Clarifier*** – interpret the underlying and metaphorical meanings within the cultural context
- ***Cultural Advisor*** – provide a necessary cultural framework for the message being interpreted (required to inform either party about relevant cultural practices and expectations, ethics and etiquette when there is either apparent or potential misunderstanding, and to assist in maintaining a good therapeutic relationship through mutual cultural respect and understanding).

Competencies required for mental health interpreters

Interpreters working in the health sector are diverse in terms of their understanding of cultural issues in mental health, educational background, and interpreting experience in mental health. Some have little to no knowledge. Some are well-educated and experienced. In order to ensure that interpreters taking up this specialised training are competent with at least the theory and practice on interpreting, the working group decided that interpreters must have at least one of the following certifications to gain entry into the specialised training programme:

- National Accreditation Authority for Translators and Interpreters (NAATI) Level 2 and Certificate in Healthcare Terminology; OR
- AUT Certificate in Liaison Interpreting and Certificate in Healthcare Terminology (comparable to NAATI 2), OR
- Equivalent

This minimum course entry criterion was determined after examining the qualifications of interpreters working in Auckland[2]. Unfortunately not all interpreters would be eligible to enrol into the course based on this threshold. The working group did not have

[2] Qualifications data provided by Waitemata Auckland Translation & Interpreting Service; Auckland Public Health Interpreting Service and Counties Manukau DHB Interpreting Service, June 2005

time to address the need for pre-entry assessments or courses for those who did not meet the course entry criteria.

There is a wealth of evidence in the literature supporting the decision of the working group that the following core competencies are needed for interpreters to perform effectively within the above roles.

- Understanding the roles of mental health interpreter
- Familiarity with mental health system, services, and practice
- Understanding the impact of culture on mental health
- Understanding how to work effectively with practitioners

Competencies required for practitioners to work effectively with interpreters
There is strong evidence from the literature and a consensus from the working group that the following will form the basic competencies required to enhance the skills and knowledge of practitioners to work effectively with interpreters:

- Understanding the impact of culture on mental health
- Understanding the role of the mental health interpreter
- Understanding how to work effectively with interpreters

Organisational Support and Commitment
Findings from the literature and feedback from consultation have also highlighted the need for:

- Organisations (in this instance, the three Auckland-Metro DHBs) to:
  - support and encourage a culturally competent workforce
  - provide staff with guidelines and training on how to work with interpreters
  - support culturally responsive strategies by providing interpreter services in a timely manner and promoting the use of interpreters appropriately
  - budget provision for the training of the workforce
  - budget provision for interpreter services
- Interpreter services to:
  - Provide guidelines to interpreters as part of policy and as an induction for interpreters
  - Establish mechanisms to check the competency of interpreters with dialects
  - Provide feedback mechanisms for interpreters
  - Monitor the quality of interpreter service and performance of interpreters
  - Provide peer support/supervision
  - Provide ongoing training
- A national professional body to be established to provide accreditation for the health interpreter workforce, regulate standards and practices and provide ongoing professional development as well as a mechanism for feedback
- A website for interpreters to access information on professional development

3.3 Identified Risks

The high level risks identified at the onset of the project include:

RISKS AND RISK MANAGEMENT			
HIGH LEVEL RISKS	**Probability** (low, med, high)	**Impact** (low, med, high)	**Risk management strategy**
Lack of support and commitment from NDSA and the Auckland-metro DHB's for the implementation of the recommendations.	Medium	High	Representation from NDSA and three Auckland-metro DHBs and interpreter services at governance and / or working group levels
Lack of buy-in from clinicians, interpreters, consumers, secondary mental health services	Medium	High	Extensive consultation with key stakeholders including clinicians, interpreters, management, consumers across the region
Non-align with regional direction	Low	Low	Ensure linkages with regional Asian mental health steering group

Other risks identified during the development process include:

RISKS AND RISK MANAGEMENT			
OTHER RISKS	**Probability** (low, med, high)	**Impact** (low, med, high)	**Risk management strategy**
Interpreters playing dual roles for clients in clinical intervention process as emotional support or advocate, which is a breach of the international interpreters' code of ethics.	Medium	High	Escalate the issue of the lack of bi-lingual Asian community mental support workforce to support the diverse LEP Asian immigrant population to the regional steering group.
Interpreters playing liaison support role to monitor the health status of LEP clients for practitioners and act as crisis contact person for clients, which creates unwarranted clients' and service providers' expectations that interpreters were there to provide unpaid support for clients, as well as the risk of interpreters being overloaded, and over-involved in the clients' case.	Medium	High	Escalate the issue of the lack of bi-lingual Asian community mental support workforce to support the diverse LEP Asian immigrant population and the need to explore ways to improve access for LEP Asian clients and family members to access the mental health crisis team during and after office hours.
Uptake of the training programme by practitioners	Low	High	DHB representatives of steering group to assist with promoting the programme
Uptake of the training programme by interpreters (cost of training; lack of interest, not meeting the minimum course entry criterion).	Medium	High	(1) Funders to consider funding the training of interpreters; (2) Interpreter services to promote the benefits; (3) Further project to look at training those who don't meet course entry criteria

4. Package Development Process

4.1 Project Working Group

The structure of the training curriculum and guidelines for interpreters and practitioners were designed by the project working group. The working group is an expert panel in cross-cultural psychiatry, mental health, has experience working with interpreters, working as professional interpreters, experience in teaching, facilitation and research. The group is also from diverse cultural backgrounds which includes Pakeha, Chinese from Hongkong, China, and Malaysia, Indian, Vietnamese, Dutch, and South African. The panel provided significant input into the development of the package.

Twelve workshops were held from 24/2 to 30/11 for the working group. The workshops involved examining overseas and local mental health interpreting service and training models, reviewing written materials, papers, and local interpreter and practitioner training courses, current state of mental health interpreting services and gaps to determine the roles of mental health interpreters, identify the needed competencies, skills and attitude required by interpreters to perform the tasks, and the skills and knowledge required by practitioners to work effectively with interpreters. Eight Asian interpreters were invited to participate in the initial workshop to determine the roles of interpreter.

A draft package was developed for consultation and pilot training.

4.2 Consultation

Consultation packs were disseminated widely by mail and email to invite stakeholders across the region to provide feedback to the working group. Two methods for submission of feedback were provided to stakeholders.

Written Submissions:

- 15 written submissions were received by email or mail
- 6 submissions were from Asian interpreters (identified as Chinese, Korean, or Indian culture)
- 9 submissions were from mental health staff made up of psychiatrist, community mental health nurses, professional leaders and manager
- Respondents were from ADHB; WDHB, CMDHB, and RAS

Verbal Feedback: Regional Consultation Workshop 1/9/05

- 32 participants attended the regional consultation workshop held in Penrose
- 16 participants were Asian interpreters (identified as Chinese, Sikh, Vietnamese, Thai, Burmese, Indian, Japanese, or Korean)
- 16 other participants comprise of consumer, professional leader; community support workers, mental health nurses, psychotherapists, nurse educator, social worker, psychiatrist, and managers/coordinators/team leaders
- Participants were from ADHB, WDHB, CMDHB, RAS and AUT

Consultation Outcomes

All feedback received through the consultation processes was collated and circulated for the trainers to respond to and make revisions to the draft training package before the pilot training. All suggestions from respondents were incorporated in the pilot and final training packages except for the following suggestions which were considered beyond the scope of this project.

Feedback relating to Session 3: MH Practice

- Separate session on how to work with young people affected by mental disorders
- Provide list of existing support groups and programmes available for Asian clients
- Provide a list of resources (names and clinics of Chinese counsellors)

- Provide a list of standard internationally recognized terminology in common Asian languages on terms, jargon and diagnosis in mental health setting

Feedback relating to professional development of interpreters

- Provide pathways, mechanisms for feedback or complaints, as to the quality of interpreters' performance and services
- Provide information on website for interpreters
- Provide ongoing training, group meetings; regular peer supervision, knowledge sharing for interpreters
- AUT to provide certification of interpreters' dialect competency
- Set up brainstorming sessions for ethnic groups to determine the common norms of their cultures
- System to cross-check the competency of interpreters
- Provide interpreters with an insight of current interpreting services, existing deficiencies, and required improvements.

Feedback relating to Interpreter Services

- Match interpreters and clients by gender, age, dialects
- Encourage management, booking and call centre staff to join this training
- Interpreter services' awareness of differences of dialects and cultures
- Set up a consistent structure of managing the interpreter service
- Mechanism to monitor the consistency and quality of interpreter services

A full consultation report is available on request.

4.3 Pilot training

Purpose
The purpose of the pilot training was to test the training package with a selected group of Asian interpreters and mental health practitioners.

Objective
To evaluate the effectiveness of the package from participants' feedback in terms of content, presentation, relevancy/usefulness, training materials and facility.

4.3.1 Selection of Participants

Interpreters

- Registration of interest flyers and forms were sent to all interpreters working in Auckland region on 25/7 by mail.
- 44 applications were received, reviewed and considered.
- Selection was based on meeting minimum course entry criteria, a mix of the top Asian languages and equal representation from the three Auckland-Metro DHBs (9 from ADHB, 9 from CMDHB and 9 from WDHB)
- 27 interpreters were selected representing 13 Asian languages, 10 culture/ethnic groups. The culture groups represented include Chinese, Indian, Korean, Japanese, Vietnamese, Thai, Burmese, Sri Lankan, Laos, and Cambodian. Languages of participants include Mandarin, Cantonese, Shanghainese, Hindi, Gujerati, Korean, Japanese, Vietnamese, Burmese, Tamil, Laos and Cambodian.

Mental Health Practitioners

- § Registration of interest flyers and forms were sent to all practitioners working in secondary mental health services in the Auckland-metro DHBs on 25/7 by email.
- § A total of 24 practitioners enrolled (9 from CMDHB, 7 ADHB, 6 WDHB and 2 from RAS)
- § Participants comprised of psychiatrists, psychologists, counsellors, clinical nurse educators, community mental health social workers/occupational therapist, nurses, crisis team staff, acute inpatient team staff , psychotherapist, care coordinator, managers, and team leaders
- § Out of 24 participants, 7 were Asians

4.3.2 Trainers/facilitators

The following were trainers/facilitators selected to deliver the pilot training. All the trainers were also members of working group and are expert in cross-cultural psychiatry, mental health or interpreting, and have experience in teaching/facilitation.

- § Dr Sai Wong
- § Dr Sanu Pal
- § Mr Patrick Au
- § Victoria Camplin-Welch
- § Ineke Crezee
- § Hien Mack

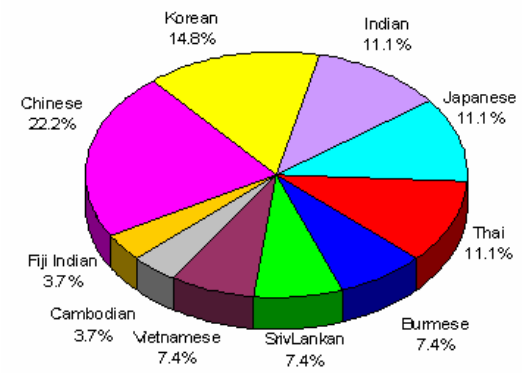
4.3.3 Pilot Training Sessions

- § 6 training sessions were held for Asian interpreters (participants) over 5 days on 22/9, 29/9, 6/10, 13/10 and 27/10/05
- § 3 training sessions were held for mental health practitioners over 1 day on 27/10/05

4.3.4 Pre and Post Pilot Training Survey Results

For Interpreters

- 27 Interpreters were selected to participate in the 5-Day Pilot training Course.
- 85% of them were female.

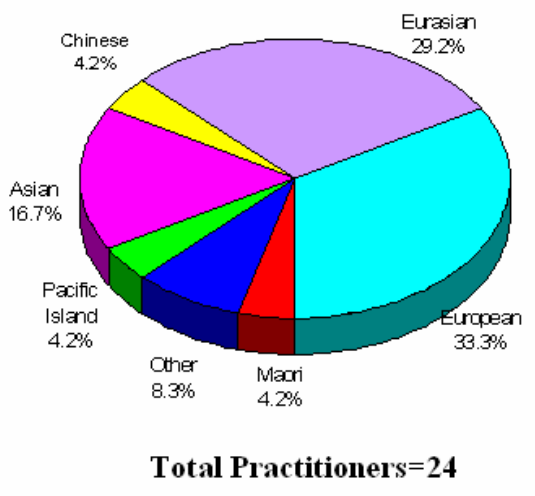


Total Interpreters=27

- 52% of interpreters had lived in NZ for more than 10 years and only 4% for less than 5 years.
- § Prior to the training, 85% of interpreters reported having excellent or good relationships with mental health staff. 76% of them felt well-respected.
- § 26 interpreters rated the training as excellent/good with 1 did not respond

For Practitioners

- § 24 Practitioners participated in a one-day course.
- § 79% of them were female.



- § 54% of them were mental health nurses, 17% were social workers, 8% psychiatrists.
- § Prior to the training, only 50% of practitioners reported having excellent or good relationship with interpreters. 77% of them felt well-respected.
- § 19 practitioners rated the training as excellent or good except for 3 who did not respond.

4.3.5 Pilot Training Session Evaluation Results

All feedback and ratings received from the session and post training evaluation were collated and circulated to the trainers and working group to review and make revisions to the final package. Suggestions from participants were considered and incorporated in the final package.

The following tables provide a summary of the ratings from participants of the sessions in terms of achievement of session objectives, content, presentation, relevancy/ usefulness, training materials, facility/venue as well as satisfaction rating of the overall training programme.

Table 1: Ratings of the Five-Day Training Sessions for Asian mental health Interpreters

	SESSIONS					
	1	**2**	**3**	**4**	**5**	**6**
	The percentages below are ratings of excellent/good					
No of Participants	27	27	27	27	27	27
No of Respondents	27	27	27	27	27	26
Achievement of Session Objectives	92.3%	91.3%	96.2%	74.1%	96%	93.8%
Content	92.3%	95.7%	100%	96.3%	96%	100%
Presentation	100%	91.3%	100%	85.2%	100%	100%
Relevancy/Usefulness	96.2%	91.3%	100%	92.6%	100%	100%
Training Materials	96.2%	91.3%	96.2%	96.3%	96%	93.7%
Facility/Venue	88.5%	81.6%	88.5%	92.6%	92%	93.7%
POST-TRAINING SURVEY Level of satisfaction with overall training programme =	100% (26 respondents) rated their level of satisfaction with the overall training as excellent /good § 77% rated as excellent overall § 23% rated as good overall					

Table 2: Ratings of the One-Day Training Sessions for Mental Health Practitioners

	SESSIONS		
	1	**2**	**3**
	The percentages below are ratings of excellent/good		
No of Participants	24	24	24
No of Respondents	18	15	11
Achievement of Session Objectives	94.4%	93.3%	100%
Content	100%	93.3%	90.9%
Presentation	100%	86.7%	100%
Relevancy/Usefulness	88.9%	93.3%	100%
Training Materials	96.3%	93.3%	90.1%
Facility/Venue	77.8%	73.3%	72.8%
POST-TRAINING SURVEY Level of satisfaction with overall training programme =	100% (22 respondents) rated their level of satisfaction with the overall training as excellent /good § 54% rated as excellent overall § 46% rated as good overall		

Interpreter Session 4 (Cross-Cultural Communication), which received a relatively low score of 74.1% for achievement of session objectives, was reviewed to make sure the title and the learning objectives were revised to match the topics covered. Otherwise the average score for all areas was very high, at 90%+.

Ratings from the post-training survey of practitioners and interpreters for the overall training programme were highly satisfactory with 100% of the respondents rating the programme as excellent or good. Trainers made every effort to review and consider feedback from earlier sessions and made necessary adjustments to the presentation style/teaching methods to suit participants. This has seen a significant improvement in the ratings for presentation in latter sessions.

4.3.6 Pilot Training: Trainers' Evaluation Results

Trainers were given an opportunity to provide feedback to the project from a trainer's perspective about the training programme they were involved in, in terms of content, delivery, support and their views about the overall training programme. Five out of six trainers provided written feedback by email.

Trainers provided a lot of feedback in terms of content, overall structure of the course, delivery of the training, support provided and suggestions for improvement. Suggestions include the need to review the duration, delivery format and re-sequence some of the Interpreter Sessions 2, 3, 4 and 5; and the need to review the duration, delivery format of all the practitioner sessions. Feedback was considered and incorporated in the final package.

All respondents were very pleased with the overall training programme, the good team work amongst the trainers, good planning, and coordination for the development of the package to the delivery of training and commended on the excellent support they received from the curriculum design phase to the training delivery phase.

4.4 Project Process Evaluation

Working group members were given the opportunity to provide feedback about the project process at the end of each working group meeting to enable formative improvement of the process. Feedback was documented as part of the meeting notes, (all minutes/meeting notes are available on request).

At the end of the project, the working group was given a questionnaire to provide feedback to the project team. The questions asked of them were:

- Clarity in relation to the project objective
- Clarity in relation to their role and responsibilities
- Were you happy with the overall project process?
- What did you like about the process?
- What did you dislike about the process?
- Any suggestions to improve the process?
- Overall comments

The purpose of the process evaluation was to ensure that the project process was robust and ensured that the working group members were happy with the overall project.

Seven members of the working group (50%) submitted their feedback by mail or email. Respondents were particularly impressed with the overall project in terms of commitment from the working group, the chairing of the meetings, project management, detailed workshop notes, clarity of information provided to enable discussions, and the environment provided to enable an active and inclusive engagement/discussion process. There were suggestions to improve the mix of working group membership to have a more balanced representation of clinicians, interpreters, management, and researchers. Other suggestions include establishing criteria, and improving management support for clinicians in terms of providing time-off to participate in the project.

NB: An evaluation report is available as a companion document to this report which provides more detailed results from pre and post pilot training survey, session evaluation, trainers' evaluation and project process evaluation.

5. Proposed Package

The following proposed package is based on the working group review of the consultation and pilot training evaluation findings and adjustments made to the final training curricula and guidelines. The proposed package was considered essential and relevant for interpreters and practitioners to gain the necessary knowledge, attitudes and skills to work together effectively, in order to deliver better and culturally appropriate services to Asian mental health clients with LEP.

- Training Curriculum for Asian mental health interpreters
- Training Curriculum for mental health practitioners: to work effectively with interpreters and Asian mental health clients
- Guidelines for Practitioners and Interpreters to work together effectively

Structure of the training curriculum

The content of the curricula has incorporated both theory and practical aspects. Feedback from the pilot training participants indicated a strong preference towards more practical content than theory, and the preference for handouts and references for trainees to gather in-depth analysis and references post training.

***Session aims*:** to provide an introduction and outline for each session for trainers to review before teaching the material in each session.

***Duration*:** time provided for trainers to work within to complete the training and for information to participants at the start of each session.

***Learning objectives*:** information for trainers to provide to participants at the start of each session and for trainers to achieve

***Session topics*:** guide the training delivery

***Training and learning process*:** the delivery of the training depends on the preferred style of the trainers/facilitators. It includes exercises to introduce participants, introduce session contents, learning objectives, previous sessions, lecture presentations, interactive exercises, role plays, group works and video presentations. The lecture style of delivery will generally correspond to a technical subject matter. Feedback from pilot trainees showed a preference for more group work, role plays and interactive exercises for practical learning. An alternative teaching methodology would be considered for implementation.

***Handouts*:** provided to participants at various stages of the training for as reference material, depending on the trainers' preference.

References: provided to participants for further reading, for in-depth analysis of the practical content or for research.

Terminology*:* for the purpose of these training curricula (see Section 8).

Participants' Evaluation

Feedback and evaluation of the training curriculum will be gathered at the end of each session. The evaluation will be based on the overall objectives of the training programme and learning objectives for each session. Participants will be asked to assess, rate or comment on:

- What they had learnt as compared against session objectives
- Overall training in terms of content, presentation, relevance/usefulness, training materials, facility/venue.

5.1 Training Curriculum for Asian Mental Health Interpreters

This training curriculum is designed to target the learning needs of bi-lingual qualified Asian interpreters who may have little or no knowledge about mental illness or mental health problems, and who are interested in interpreting in mental health settings or who are frequently asked to interpret in mental health settings and required to perform the roles of a *Conduit*, *Clarifier* and *Cultural Advisor*.

The training curriculum is for Asian interpreters who wish to gain more knowledge and understanding of to work effectively with practitioners in mental health settings.

The overall goal of the training is to enhance Asian interpreters' cultural capability, mental health knowledge and ability to work effectively with mental health practitioners working in secondary mental health services to provide quality and appropriate care for LEP Asian clients.

Targeted competencies: To achieve the overall goal, the training was designed to correspond with the four complementary themes:

- Understanding the roles of mental health interpreter
- Familiarity with mental health system, services, and practice
- Being culturally competent
- Understanding how to work effectively with practitioners

Minimum course entry criteria: Asian interpreters interested in this course must be:

- A qualified interpreter: i.e. have either completed the AUT Certificate in Liaison Interpreting, or National Accreditation Authority for Translators and Interpreters (NAATI) Level 2 or equivalent and must
- Be competent to carry out sight translation, simultaneous interpreting, consecutive interpreting, contextual and semantic interpreting in at least one Asian language
- Have extensive knowledge of their own culture/community

Overall structure of the curriculum

The following sessions make up the full Asian interpreter mental health training curriculum. The overall training would take 32.5 hours to complete over the course of 6 days, with Session 3 run over two and a half days. The time allocated below does not take into consideration time set aside for meals or breaks. The curriculum is divided into five sessions.

- Session 1:Roles of Mental Health Interpreter (4 hrs)
- Session 2: Introduction to NZ Mental Health System and Services (6 hrs)
- Session 3: Mental Health Practice: "An Introduction to Psychiatric "Lingo" for mental health interpreters" with emphasis on an Asian perspective (2 x 5 hour half day sessions)
- Session 4: The Impact of Culture on Mental Health "the Chinese Example" (7 hrs)
- Session 5: Guidelines for interpreters on how to work effectively with practitioners in mental health settings (5.5 hrs)

A sequential logic was built into the ordering of the sessions. For example interpreters need to attend Session 1 before Session 2 and each session begins with a recap of the overall training goal, previous session learning objectives and topics.

5.1.1 Interpreter Session 1: Roles of Mental Health Interpreter

Session aim: Assist participants in gaining an understanding of the roles of mental health interpreter, the responsibilities and rights, the importance of pre-briefing, structuring and post-briefing sessions, and self care.

Duration: 4 hours

Learning objectives: at the end of this session, participants will be able to:

- Describe the preferred roles of the Mental Health Interpreter
- Demonstrate familiarity with the interpreters' Code of Ethics, rationale and application in ethical dilemmas
- Demonstrate familiarity with the rights and responsibilities of interpreters in Mental Health settings
- Outline the importance of briefing and debriefing, and be able to outline what questions the interpreter should ask of the health professional in order to achieve the best outcome
- Describe the structure of mental health interpreter assisted client-professional interviews
- Describe the importance of interpreter self-care and ways of achieving this
- Demonstrate familiarity with possible challenges from a therapist's and client's perspective
- Explain when, why and how a mental health interpreter should/could refuse interpreting assignments

Session topics:

- Roles of mental health interpreter
- Expected Competencies
- Responsibilities: Adherence to Code of Ethics for interpreters; understand roles, common errors
- Rights
- Pre-session briefing
- Structuring sessions
- Debriefing after session
- Coping strategies (self-care)

Handouts:

- Roles of mental health interpreter
- Rights and Responsibilities
- Pre-briefing, structuring and post-briefing
- Self-care

References:

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5.1.2 Interpreter Session 2: Introduction to NZ Mental Health System and Services

Session aim: Assist participants to become familiar with an overview of NZ mental health system and services, the various roles of mental health professionals and how to interpret in different mental health settings

Duration: 6 hours

Learning objectives: at the end of this session, participants will be able to:

- Provide a definition of Mental Health
- Explain the role of the various Mental Health Professionals
- Explain the concepts of Psychiatry and Psychology
- Understand inpatient settings in Mental Health
- Understand outpatient settings in Mental Health
- Understand crisis situations settings in Mental Health and know what is expected of the interpreter in these situations (same for forensic mental health setting)
- Understand the special demands of working with children and family in Mental Health settings
- Understand the special demands of working with older people in Mental Health settings
- Understand the special demands of working in the mental health respite settings

Session topics:

- An example of the mental health system in NZ (Auckland as an example)
- Glossary
  - Mental Illness
  - Mental Disorder
  - Insanity
  - Mental Health
  - Mental Sub-normality
  - Mental Disability
- Professionals working in the mental health system
- Specialist roles within mental health system
- Legislation used in the mental health system
- Mental Health related services
- Principles of Recovery
- Types of treatment settings
- Interpreter's roles – from the practitioner's perspective
  - Interpreters working in general mental heath settings
  - Interpreters working in specialist mental heath settings
- Case discussion

Handouts:

- Powerpoint presentation
- Mental Health Services in Auckland – an overview of Child & Adolescent Mental Health Services and Adult Mental Health Services
- List and description of professionals working in the mental health services

References:

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2. Section 23, Criminal Justice Act 1985
3. World Health Organisation: Definition of Mental Health, p1. 2001.
4. Edwards. Definition of Mental Health. Definition of Mental Health. 1999.
5. The Criminal Procedures (Mentally Impaired Persons) Act. A legal term used in for mental disability. 2003.
6. Mental Health Act. 1992.
7. Protection of Personal and Property Rights Act. 1988
8. Drug and Alcohol Drug Addiction Act. 1966.

5.1.3 Interpreter Session 3: Mental Health Practice

"An Introduction to Psychiatric "Lingo" for mental health interpreters" with emphasis on the Asian perspective

Session aim: Introduce participants to various aspects of mental health practice to familiarise them with mental health symptoms, vocabulary, jargon, DSM-IV, ICD10, major disorders, medications, general process of mental health examinations, risk assessment, rights of patients, roles of health practitioners in Compulsory Treatment Orders (CTOs), informed consent, treatment and planning options.

Duration: 2 half day sessions (5 hours per session)

Learning objectives: at the end of this session, participants will be able to:

- Describe the symptomatology of mental health problems, including both commonly used vocabulary and jargon
- Describe the DSM-IV, ICD10 and their uses in Mental Health settings
- Give a description of the major disorders (thought, mood, personality, anxiety), their symptoms and commonly used treatment modalities
- Demonstrate familiarity with commonly used psychiatric medications, their uses and side-effects
- Describe the purpose and general process of mental health examinations, including risk assessment
- Describe the rights of patients under the NZ Mental Health Act
- Describe the roles of health practitioners involved in CTOs, reasons for obtaining CTOs, patient rights
- Give a definition of Informed Consent, its role and purpose
- Demonstrate familiarity with treatment and planning options

Session topics:

- What is psychiatry?
- What makes the psychiatrist tick: integration between knowledge /skills
  - Practice
  - Effect of culture on symptoms
  - Impact of culture on mental status examination (MSE)
  - How to apply assessment techniques
  - Determining where to treat
  - Risk assessment
  - What are the warning signals?
  - Risk management
- Guide to working with Chinese clients with a mental health history
- Case vignette

Handouts

- Overall concept of symptom-based diagnosis, relationship to cause/treatment
- Schizophrenia – voice and thought
- An introduction to the medications commonly used in psychiatry
- Global assessment of functioning
- Intelligence: dementia, mental retardation
- Essential symptoms of clinical disorders
- DSM-IV/ICD-10 Diagnostic/Billing Codes for M.I.N.I. Diagnoses
- Major Depressive Disorder Scale
- Mental Health Practice
- The management of mental disorders: Volume 2 Handbook for the Schizophrenic disorders
- Complications: Management II
- Coping with difficult behaviour
- A cognitive view of delusions and voices
- A case scenario – a referral to the community mental health centre

5.1.4 Interpreter Session 4: Impact of Culture on Mental Health *"the Chinese Example"*

Session aim: introduce participants as to how culture impacts on mental health, raise awareness of different cultures, and strategies on how to communicate with people from other cultures.

Duration: 7 hours

Learning objectives: at the end of this session, participants will be able to:

- Explain in their own words what culture entails and be able to list the many different components of culture as they apply to life in general and (mental) health in particular
- Develop self-awareness of own cultural biases, especially the issues of counter-transference
- Demonstrate familiarity with the major differences between western and eastern cultures
- Understand the correlations between culture, religion and healing
- Understand the various modalities for treatment of [mental] health problems, including traditional approaches to treatment
- Understand the implications of cultural modalities for [client] behaviour in treatment settings
- To increase the awareness of different cultures and how to communicate with people from other cultures

Session topics

- Introduction
  - Culture technician vs culture profession
  - Clinical quality for cross-cultural work
- A framework to understand Chinese culture /health practices
  - What is culture and its mental health implications
  - Definition of culture
  - Function of culture
  - How culture perform its functions: key cultural components
  - Cultural diversity / universality
  - Practical implications
  - Cultural orientation/mental health
  - Determining individual cultural orientation
  - Culturally endorsed adaptive strategies
- Skills in Management: Managing cross-cultural clients from theory to practice
  - The principles or skills of assessment/management
  - Framework for assessment: the formulation
  - Managing Chinese clients: culturally appropriate management
  - Guidelines on how to work with interpreters
- Case vignette

Handouts:

- ACMA Newsletter: How to tell you're Chinese
- Exercises in Cross Cultural Readiness
- Framework for Cultural Assessment
- Depression Inventory
- Chinese Translated Patient Information
- Cultural diversity/universality

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5.1.5 Interpreter Session 5: Guidelines on how to work effectively with practitioners in mental health settings

Session aim: assist participants to become familiar with commonly used treatment options in psychotherapy and counselling; and guidelines on how to work with mental health practitioners .

Duration: 5.5 hours

Learning objectives: at the end of this session, participants will be able to:

- Demonstrate familiarity with commonly used treatment options in psychotherapy and counselling, their objectives and uses
- Understand how mental health professionals and mental health interpreters can work together in practice
- Demonstrate the ability to work effectively with mental health professionals together in practice

Session topics:

- Factors that influence the working relationship
- The Therapeutic Triad
- Boundaries
- Transference
- Counter-transference
- Video /role plays (in small groups)

Handouts:

- Challenges from 3 perspectives
- How to work together effectively
- Factors that affect the working relationship: the therapeutic triad; boundaries; transference and counter-transference

Reference:

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5.2 Training Curriculum for Mental Health Practitioners: *How to work with Asian clients and interpreters*

This training curriculum is designed to target the learning needs of mental health practitioners working in secondary mental health services from a mixed background in terms of years of experience in working in mental health, or working with Asian clients from diverse cultural and language backgrounds and/or learning how to work with interpreters.

The training curriculum is for those who wish to gain more understanding of how to work effectively with interpreters and with Asian mental health clients from diverse culture and language backgrounds. This training would also be useful for members of management teams who are involved in the development and selection of modules for professional development of mental health teams.

The overall goal of the training for practitioners is to enhance practitioners' cultural capability and ability to work effectively with interpreters and Asian clients.

Targeted competencies: To achieve the overall goal, the training is designed to correspond with the three complementary themes

- Understand the impact of culture on mental health
- Understand the roles of the mental health interpreter
- Understand how to work effectively with interpreters

Overall structure of the training curriculum
The following sessions make up the full training curriculum for mental health practitioners. The full training would take 13.5 hours to complete over 2 days. This does not take into consideration time set aside for meals or breaks.

- Session 1: The Impact of Culture on Mental Health "the Chinese Example" (7 hrs) – Day 1
- Session 2: Role of Mental Health Interpreter (1 hr) – Day 2
- Session 3: Guidelines for practitioners on how to work effectively with interpreters mental health settings (5.5 hrs) – Day 2

A sequential logic was built into the ordering of the sessions. For example practitioners need to attend Session 1 before Session 2 and each session begins with a recap of the previous session(s), overall training objective and learning objectives.

5.2.1 Practitioner Session 1: The Impact of Culture on Mental Health Practice *"The Chinese Example"*

Session aim: introduce participants as to how culture impacts on mental health, raise awareness of different cultures and how to communicate with people from other cultures

Duration: 7 hours

Learning objectives: at the end of this session, participants will be able to:

- Explain in their own words what culture entails and be able to list the many different components of culture as they apply to life in general and (mental) health in particular
- Develop self awareness of own cultural biases, especially the issues of counter-transference
- Demonstrate familiarity with the major differences between western and eastern cultures
- Understand the correlations between culture, religion and healing
- Understand the various modalities for treatment of [mental] health problems, including traditional approaches to treatment
- Understand the implications of cultural modalities for [client] behaviour in treatment settings
- To increase the awareness of different cultures and how to communicate with people from other cultures

Session topics:

- Introduction
  - Culture technician vs culture profession
  - Clinical quality for cross cultural work
- A framework to understand Chinese culture /health practices
  - What is culture and its mental health implications
  - Definition of culture
  - Function of culture
  - How culture perform its functions: Key cultural components
  - Cultural diversity / universality
  - Practical implications
  - Cultural orientation/mental health
  - Determining individual cultural orientation
  - Culturally endorsed adaptive strategies
- Skills in Management: Managing Chinese clients from theory to practice
  - The principles or skills of assessment/management
  - Framework for assessment: the formulation
  - Managing Chinese clients: culturally appropriate management
  - Putting into practice (specific skills)
  - Culturally appropriate service delivery
  - Presentations (Symptoms)
  - Help seeking
  - Cultural impact on MSE
  - Culture effect on symptoms (Chinese examples)
  - How to apply assessment techniques
- Hindu culture

Handouts: (same as Interpreter Session 4 handouts)
References: (same as Interpreter Session 4 references)

5.2.2 Practitioner Session 2: Roles of the Mental Health Interpreter

Session aim: Assist participants to gain an understanding of the roles of mental health interpreter, their responsibilities, and rights.

Duration: 1 hour (Day 2)

Learning objectives: at the end of this session, participants will be able to:

- Describe the preferred roles of the Mental Health Interpreter
- Demonstrate familiarity with the interpreters' Code of Ethics, rationale and application in ethical dilemmas
- Demonstrate familiarity with the rights and responsibilities of interpreters in Mental Health settings
- Outline the importance of briefing and debriefing, and be able to outline what questions the interpreter should ask of the health professional in order to achieve the best outcome
- Describe the structure of mental health interpreter assisted client-professional interviews

Session topics

- Roles of mental health interpreter
- Expected Competencies
- Responsibilities
  - Knowledge of and adherence to the Code of Ethics for interpreters
  - Understanding roles
  - Being aware of common errors

Handouts:

- Role of the mental health interpreter
- Rights and Responsibilities
- Pre-briefing, structuring and post-briefing

References: (same as for Interpreter Session 1 references)

5.2.3 Practitioner Session 3: Guidelines for practitioners on how to work effectively with interpreters

Session aim: assist participants to familiarise with commonly used treatment options in psychotherapy and counselling; and guidelines on how to work with interpreters effectively

Duration: 5.5 hours

Learning objectives: at the end of this session, participants will be able to:

- Demonstrate familiarity with commonly used treatment options in psychotherapy and counselling, their objectives and uses
- Understand how mental health professionals and mental health interpreters can work together in practice
- Demonstrate the ability to work effectively with mental health professionals together in practice

Session topics:

- Factors that influence the working relationship
- The Therapeutic Triad
- Boundaries
- Transference
- Counter-transference
- Video /role plays (in small groups)

Handouts:

- Challenges from 3 perspectives
- How to work together effectively
- Factors that affect the working relationship: the therapeutic triad, boundaries, transference and counter-transference

Reference: (refer to Interpreter Session 5)

5.3. Guidelines for Mental Health Practitioners and Interpreters to work together effectively

These guidelines provide an overview of how both mental health practitioners and interpreters could work effectively to best serve people from culturally and linguistically diverse backgrounds accessing mental health services.

This component is incorporated as part of the mental health interpreters and practitioners training programme to ensure that the same set of training and information is provided to both teams to achieve effectiveness and consistency.

In order to implement and achieve best and most consistent practice across the three Auckland-metro DHBs and interpreter services widely, it is recommended that the guidelines be implemented, incorporated or developed into local policy and be included as part of an induction programme for interpreters and mental health practitioners.

The intention of the guidelines is to provide practical suggestions and options for practitioners to work effectively with interpreters and vice versa. This may vary according to the tasks required in different clinical or mental health settings

5.3.1 Guidelines for practitioners to work effectively with interpreters

A Clients rights to access interpreter services

- Right 5 of the Code of Health and Disability Services Consumers' Rights gives clients the right to effective communication, which includes the right to a competent interpreter when a client has limited ability to understand and speak English
- Section 6 of the Mental Health (Compulsory Assessment and Treatment) Amendment Act 1999 requires the provision of interpreters to mental health consumers if they require one.

B Clients' rights to refuse interpreter services

Clients and family members have the right to refuse interpreting services. Refusal could be due to anxiety about being identified as having a mental health problem or receiving a mental health service. It could also be due to concerns about confidentiality being maintained. The practitioner should try to find out from the client the reason for the reluctance to have an interpreter. If it is because of confidentiality, then a useful solution might consist in explaining to the client the Code of Ethics which interpreters and practitioners are bound by.

C Understanding interpreters' roles, rights and responsibilities

Interpreting involves accurate and effective translation and the role of interpreter is to act as a

- **Conduit** – to interpret literally with no omissions, additions or editing, or clarify as required; it requires the interpreter alerting practitioners when interpreting literally.
- **Clarifier** – to interpret the underlying and metaphorical meanings within the cultural context
- **Cultural Advisor** – to provide a cultural framework for the message being interpreted. The interpreter is required to inform either party about relevant cultural practices and expectations, ethics and etiquette, when there is either apparent or potential misunderstanding, and to assist in maintaining a good therapeutic relationship through mutual cultural respect and understanding.

Interpreting in mental health requires a specialised skill. Not all interpreters working in the health sector will be trained to work in mental health. This may mean that there may not be an adequate pool of mental health trained interpreters available to meet the

needs. Bearing this in mind, practitioners should establish the interpreter's skills before the interview session.

Responsibilities: Interpreters are expected to adhere to the Code of Ethics which includes:

- Accuracy
- Confidentiality
- Impartiality
- Conflict of interest
- Professional courtesy
- Declining work
- Contractual obligations
- Self education
- Standard of conduct

Rights of Interpreters: Interpreters have the right to

- professional recognition and regard
- briefing
- debriefing
- breaks
- privacy
- refuse assignments

D Assess the need for an interpreter

- When a client is unable to communicate (express in oral and written form) or comprehend English proficiently to enable effective assessment or effective communication process
- When a client/family member/caregiver requests an interpreter
- When a person prefers to speak and is more fluent in a language other than English

E Selecting and booking a suitable interpreter

- Where possible it is a good practice to request or book the same interpreter, especially for continuity when trust/rapport/relationship have been developed between the client/family and the interpreter.
- Where possible, request/book an interpreter with experience or who has been trained to work in mental health
- If necessary find out from clients/families how comfortable they feel with a particular interpreter by advising the interpreter service to telephone the client/family prior to confirming an interpreter
- Ascertain appropriate language/dialect (e.g. a person born in China may speak Cantonese, Mandarin, Shanghainese, Hokkien, Teo Chew or one of many other dialects)
- Assess the client's/family member's preferences regarding gender, dialect, country, ethnicity, age of interpreter, etc. where possible. Be aware of differences of dialects and cultures
- Consider the use of on-site or face to face interpreters when a significant amount of information needs to be discussed, conveyed or collected
- In crisis situations where there is a delay in obtaining a trained interpreter, and if it is absolutely unavoidable, a family member may be used as an interpreter, but a suitable interpreter should still be engaged as soon as possible to clarify and confirm information. In such instances, a telephone interpreter could be considered to assist with the intervention until the arrival of an on-site interpreter or until an on-site interpreter can be arranged.
- Allocate adequate time for interpreter-assisted sessions

Points to note:

- Do not use the telephone interpreting service for clinical consultations
- Only use the telephone interpreting service for obtaining basic information

- Avoid using children or relatives as interpreters, as they may censor or distort what was said, for cultural reasons, to protect the client, or because they are not familiar with the terminology.

F Pre-briefing session

- Check with interpreter about his or her interpreting skills, training or experience working in mental health
- Brief the interpreter about the case
- Clarify objectives/purpose for the session
- Obtain cultural background information from the interpreter if necessary e.g. relevant cultural etiquette and expectations
- Establish mode of interpreting i.e. consecutive or simultaneous interpreting
- Clarify whether to interpret every word or the gist of the sentence
- Maintain confidentiality including not discussing client or any information that will not be translated back to client (especially in front of the client)
- Ensure seating arrangements are prepared appropriately i.e. seating dependent on the mode of interpreting and the situation e.g. for simultaneous interpreting and for hearing impaired client, interpreter may sit closer to the client; for consecutive interpreting, triangle seating is recommended (with some exceptions) and for a larger group sessions, all parties should be seated in the form of a circle.

G During the session (structuring)

- Introduce yourself and the interpreter (for first interviews)
- Arrange seating as appropriate, introduce the interpreter and explain interpreter role and confidentiality.
- Explain who you are and your role
- Very important to explain that interpreters are bound by the Code of Ethics and that confidentiality will be maintained (it takes time for the client to trust and build a good rapport with an interpreter)
- Establish the ground rules to speak ***through*** the interpreter (i.e. not ***to the interpreter***)
- Maintain eye contact with the client /family member at all times
- Speak to the client directly, using the first person "I" and "you" instead of "ask/tell him or her" throughout the sessions
- Keep sentences brief and concise
- Pause at the end of each sentence to allow the interpreter time to interpret
- Explain to the client the need for practitioners to pause in between sentences for interpreters to interpret accurately
- Explain the need for interpreters to clarify statement with the client/family or practitioner
- Maintain the direction of the interview and intervene if necessary when the interpreter and the client seem to be having a private conversation or when the session is getting disorderly due to the behaviour of the client
- Avoid jargon or colloquial language which may be difficult for interpreters to translate and explain
- Explain the meaning of technical terms, where necessary

Points to note:

- Avoid having lengthy discussions with the interpreter, as this will make the client feel excluded. If this is unavoidable, explain to the client prior to engaging in lengthy discussion (should try to clarify information during debriefing session)
- Avoid using children or family members to interpret (other than obtaining basic client information if the need arises)
- Be aware of the body language and non-verbal cues between both the client and the interpreter
- If you need to leave the interview abruptly, or answer the phone, explain your actions prior to doing so
- Avoid leaving the interpreter alone with a client during a session

- Try to arrange the same interpreter for subsequent sessions if the client is comfortable with the interpreter

H De-briefing after the session

- Summarise the session and whether objectives were met
- Check with the interpreter whether there was anything you might have missed (e.g. non-verbal communication, culture-bound statements by the client).
- Clarify any cultural issues, interpretation of words or concepts
- Seek further clarification or information if necessary
- Assess whether interpreter was affected by any aspect of the session that they may have found confusing or distressing, and address misunderstandings if necessary
- Plan follow-up procedure/appointments as appropriate

If any of the following issues/behaviours occurred during the interview session:

  - Interpreter did not interpret everything that was said
  - Interpreter carried on 'asides' with the client or the client's family, without interpreting any of this to you.
  - Interpreter was speaking on behalf of the client/carer/guardian.
  - Interpreter answered mobile phone call during interview
  - Interpreter behaved towards the client in a demeaning manner, either verbally or non-verbally.

- Discuss with the interpreter and reason why it was unacceptable (assuming, in the first instance, that the interpreter was not aware of the problem). For some language groups (especially newly arrived communities) trained interpreters are not available so the person interpreting may not be familiar with some aspects of interpreting.
- If the interpreter refuses to acknowledge the problem or if it is repeated, bring this to the attention of the person responsible for the interpreter service who can take the issue up with the interpreter concerned. Ask that this interpreter not be sent again.

5.3.2 Guidelines for interpreters to work effectively with mental health practitioners

A Understanding roles, rights, and responsibilities of interpreters

§ See 5.3.1.(A)

B When accepting an interpreting assignment

Interpreters should:

- Only accept assignments that can be fulfilled and completed, i.e. they should not overbook assignments
- Inform the service if running late for the appointment
- Dress to a professional standard, and wear official identification card.
- Be punctual for appointments
- Ask the person who assigns the appointment for information about the assignment, to prepare for any terminology that might come up during the interview.

C Prior to the session

- Clarify interpreting skills, and experience working in mental health
- Obtain information about the case and purpose of the interview
- Discuss seating arrangement and agree on the mode of interpreting
- Provide cultural information to assist the practitioner

D During the session (structuring)

- Clarify statements with the client/family or practitioner if necessary
- Don't give any information or interpret anything if uncertain, tell the practitioner if he/she does not know how to interpret

E Unacceptable practices

- Not interpreting everything
- Having a separate conversation with client/family member or practitioner during the session and excluding the other party
- Speaking on behalf of the client/family member
- Answering the phone during an interview
- Humiliating or behaving badly towards the client
- Giving private telephone number or home address to clients. Tell them to contact the interpreter service or mental health service for any further interpreting needs
- Accepting money, gifts or food from clients,
- Lending money or buying gifts for clients
- Asking clients for personal information not directed by the staff
- Giving health advice to clients or family after interpreting sessions

6. Conclusion and Recommendations

There is sufficient evidence to suggest that delivering cultural competent mental health care can achieve mutually agreed outcomes for culturally and linguistically diverse clients, reduce misdiagnosis, enhance effectiveness and reduce health inequalities. Ongoing efforts need to be made to increase the cultural competency of workforce and providers, and to train interpreters and practitioners to work together effectively to provide culturally appropriate services to improve the needs of Asian mental health service users.

This is the first time that specialised training curricula and guidelines have been developed as a combined package, not only for training both mental health practitioners and interpreters, but also for widespread implementation across the Auckland region to ensure best and most consistent practice.

Key Recommendations
The project recommends that the Northern Regional Mental Health Directorate and the three Auckland-Metro DHBs consider:

1 A further phase to this project to implement the training of Asian interpreters and mental health practitioners across the Auckland region using the proposed "package"
   - Training Curriculum for Asian Mental Health Interpreters
   - Training Curriculum for Mental Health Practitioners to work effectively with Asian clients and interpreters
   - Guidelines for mental health practitioners and interpreters to work together effectively

2 In order to implement and achieve best and most consistent practice across the three Auckland-Metro DHBs and interpreter services widely, it is recommended that the guidelines be incorporated or developed into local policy and be included as part of induction programmes for interpreters and mental health practitioners.

3 Further research to evaluate the effectiveness of the training in terms of
   - improved working relationships between interpreters and practitioners
   - improved LEP Asian consumer experience in interpreter-assisted interventions
   - effect on access to services by Asians with mental health problems

4 Exploring ways to provide ongoing training/supervision/support for interpreters

5 Recording the training programmes on DVD/CD-Rom using visual material for dissemination to groups for training/revision or to participants who are in areas where training is not easily accessible, and to evaluate the effectiveness of the same

6. Future development to extend the "package" to include perspectives and training of
   - non-Asian ethnic interpreter workforce
   - practitioners from primary health and non-government organisation (NGO) workforces

Conclusion
The project has developed, consulted, piloted and evaluated the package for training interpreters and practitioners and has made recommendations about the same. Implementation of these recommendations will be what many of those consulted want and believe is necessary to improve the skills and competencies of practitioners and interpreters.

Ensuring that interpreters and practitioners have the necessary competencies to provide culturally competent care is a major step forward in providing a high-quality mental health service. The ultimate goal is for mental health services in Auckland to become more accessible and more effective to Asian mental health service users and their families.

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8. Glossary of Terms and Acronyms

Asian refers to immigrants from Asia, including people coming from West Asia including countries like Afghanistan, Nepal, to South Asia, covering the Indian sub-continent, East Asia covering China, North and South Korea, Taiwan, Hong Kong, Japan and South East Asia, consisting of countries like Singapore, Malaysia, Phillipines, Vietnam, Thailand, Myanmar, Laos, and Kampuchea, (Statistics NZ 1995, 1999, 2003).

An **immigrant** (also referred to as "**migrant**" in this report) is a person born overseas who entered New Zealand under an immigration programme (www.immigration.govt.nz website). Immigration programmes comprise of Skilled/Business, Family Sponsored and International/Humanitarian streams. Asian migration usually refers to the movement of Asian peoples to New Zealand from other countries rather than internal migration within New Zealand.

A **Refugee** is defined as "any person who, owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his/her nationality and is unable, or owing to such fear, is unwilling to avail himself / herself of the protection of that country" (United Nations Convention 1951, and the 1967 Protocol Relating to the Status of Refugees). In 1967 the protocol relating to the status of refugees extended this definition to include displaced people who are seeking temporary refuge to escape political and social disruptions.

Ethnicity is the ethnic group or groups that people identify with or feel they belong to. It is self-determined and perceived. People can belong to more than one ethnic group. Ethnicity is a cultural affiliation, as opposed to race, ancestry, nationality or citizenship. The definition of Asian used in this report is based on the categories used in the census.

Interpreter is a person who facilitates communication between two or more parties who do not have a common language, or have limitations in communicating. Health interpreters are generally trained with consecutive and /or simultaneous interpreting skills and are fluent in English and one or more ethnic languages. Interpreters are also referred to as translators in this report.

Interpreting: for the purpose of this project refers to the process by which a spoken language is relayed, with the same meaning, in another language. Two common forms of interpretation are simultaneous interpretation where interpretation is delivered nearly instantaneously after the original message. This is the common form of conference interpreting. Consecutive interpretation involves interpretation of segments of a conversation, with a lag between the original message and its interpreted form. This report uses "**Interpreting**" and "***Interpretation*"** interchangeably.

Translation refers to the written conversion on one language into another

Mental Health: The World Health Organisation's (2001a) definition: "A state of well-being In which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (p.1).

Mental Health Practitioner: refers to mental health workers, including Psychiatrists, Psychologists, Psychotherapists, Case Managers, Social Workers, Mental Health Nurses, and Therapists

Mental Health Provider: refers to a service providing mental health services

Mental Health Service User: is a term used to refer to a person who has received or is receiving assessment or treatment in mental health services also referred to as a ***mental health client***. This report uses mental health service user and client and consumer interchangeably.

Mental Illness refers collectively to all mental disorders, which are health conditions characterised by alterations in thinking, mood, or behaviour (or some combination thereof) associated with distress and /or impaired functioning (US Department of Health and Human Services, 2001, p.7)

Mental health problems refer to signs and symptoms of insufficient intensity or duration to meet the criteria for any mental disorder (US Department of Health and Human Services, 2001, p.7). Most people have experienced mental health problems at some point in their life. The experience of feeling low and dispirited in the face of a stressful job is a familiar example.

Primary health refers to essential health care serviced provided to people in their communities and is the first level of contact with the health system.

Secondary mental health services refers to clinical mental services provided by the three Auckland-metro District Health Boards which includes acute inpatient units, community mental services covering a range of acute/crisis services through to outpatient services. It also includes mental health services for child and youth and for the elderly, as well as alcohol and drug addiction services.

Auckland region or Auckland-metro: in this report refers to the districts served by Auckland District Health Board, Counties Manukau District Health Board and Waitemata District Health Board.

List of Acronyms Used

ACMA	Auckland Chinese Medical Association
ADHB	Auckland District Health Board
APHIS	Auckland Public Health Interpreting Service
ARPHS	Auckland Regional Public Health Service
AUT	Auckland University of Technology
CMDHB	Counties Manukau District Health Board
CTO	Compulsory Treatment Order
DHB	District Health Board
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition
ICD-10	International Classification of Disorders
LEP	Limited English Proficient
MH	Mental Health
MSE	Mental status examination
NAATI	National Accreditation Authority for Translators and Interpreters
NDSA	Northern DHB Support Agency
RAS	Refugees As Survivors Centre
WATIS	Waitemata Auckland Translation & Interpreting Service
WDHB	Waitemata District Health Board
WHO	World Health Organisation

9. Appendices

Appendix 1. Terms of Reference for Steering Group

Version 6

Project Title	**Asian Mental Health Interpreter Workforce Development Project**
Prepared By	Sue Lim, Project Manager *Updated: 26 April 2005*
Purpose of the Steering group	
Purpose	The steering group is formed to provide expert advice and governance to this project. The rationale for forming a steering group with expertise in the provision of Mental Health Services under a formal Terms of Reference is to ensure transparency in the (standard) process and recommendations, to ensure rigour and buy-in from the three DHBs in the decision-making process. It is also to ensure that the principles of regional collaboration, within mental health services, as agreed by the region's CEOs and mandated by the NDSA are recognised and adhered to as part of the project process. To this end the Northern Regional Director – Mental Health Services will undertake the role of sponsor for this group. The Steering Group makes decisions based on information and recommendations provided by the sub-group (working group) or the project manager /team.
Representation	Sponsor: Derek Wright – Regional Director Mental Health (Chair) • NDSA representative (Bram Kukler) • Mental Health Managers from Auckland DHBs (max 3) • Asian Mental Health Practitioners (max 3) from Auckland DHBs • Non Asian Mental Health Practitioners (max 3) from Auckland DHBs • Asian Mental Health Practitioners (max 3) from NGOs • Auckland Regional Public Health Coordinators (2) • Representative from Refugees as Survivors (1) • Mental Health Consumer Representatives (2) • Interpreters (2)
Role	§ To be responsible for reviewing information papers for discussion and make recommendations to the regional funding team within the scope of the project § To be accountable for governing this project against planned deliverables and milestones § To be accountable for the delivery of project information to their own organisation (this will include consultation within their own organisation and with stakeholders as appropriate) § To fully represent their organisation within the context of the scope of the steering group § To be accountable for all data validation within a timely manner on behalf of their own organisation § To keep their CEO's/GM's and other key stakeholders fully advised of progress and issues § To be a workstream for feeding back to the Network North Coalition Group.
Principles of conduct	• All members of the team will treat each other with respect and allow all views to be presented. Where a member has a significant disagreement with the position of other members, the other members of the group will make every effort to accommodate or at least fairly represent the dissenting view. • All members of the steering group must act in good faith on issues of information and disclosure and there will be full transparency at all stages of the project. • The members will work together to recognise the key areas where this project would/do benefit from a regionally collaborative approach. • Linkages with the Northern Region Mental Health & Addiction Strategy project will be strong to ensure full alignment of the strategy project.
Functions of the Steering Group	1 To make decisions based on rigorous analysis of information and recommendations provided by the sub-group or project team/manager 2 To ensure that formal decision-making processes and regular feedback on the process of the project are applied and adhered to Sign off of recommendations: • If there is unanimous agreement on recommendations, the agreement will be submitted for sign-off by the Regional Director
Quorum	Ideally each meeting should have, at least, 1 representative from each DHB and 60% of the members present, but it is still the responsibility of DHB representatives to ensure that they attend meetings.
Delegated Attendance	Delegate attendance is the responsibility of the members. If a member has appointed a delegate to attend, the member is expected to ensure the delegate is well-briefed and understands the project to attend on behalf. If the delegate is not able to attend, further delegation is not required.
Secretary	Project Manager
Decision making style	Consensus style where possible Appropriate voting system to be applied if consensus not reached No feedback from members will be assumed as agreed
Meeting Frequency	Meetings will occur monthly.
Minutes & agendas	Minutes in the form of action points will be available within five working days of meetings. They will be distributed to all members. Agenda will be circulated 3 days prior to the meeting. All agenda and agenda items and accompanying papers must be submitted to the Secretary 5 days prior to the meeting.

Appendix 2. Terms of Reference for Working Group

Version 2

Project Title	**Asian Mental Health Interpreter Workforce Development Project**
Prepared By	Sue Lim, Project Manager *Updated: 26 April 2005*
Purpose of the Working Group (Sub-group)	
Purpose	The Sub-Group is formed as a closed group to provide expert advice to the Steering Group of the project on all matters associated with the information requirements to enable the Steering Group to make effective and rigorous informed recommendations. The rationale for forming a Sub-Group with expertise in the provision of Mental Health Services under formal Terms of Reference is to ensure transparency in the (standard) process and recommendations and to ensure rigour in information provided. It is also to ensure that the principles of regional collaboration within mental health services, as agreed by the region's CEOs and mandated by the NDSA are recognised and adhered to as part of the project process. The Sub-Group ensures a rigorous process is applied towards the formation of recommendations to the steering group.
Representation	• Chair: Project Research Advisor (Dr Ratana Walker) • Project Manager: Sue Lim • Project Member: Hien Mack • ADHB: Dr Sanu Pal, Patrick Au • ADHB/CMDHB: Dr Sai Wong • CMDHB: Dr Rajendra Pravagada • WDHB: Patrick Hinchey • ARPHS: Janet Chen and Bonnie Yi • RAS: Nyung Naing and Victoria Camplin-Welch • AUT: Ineke Crezee • Consumer Rep: Anne Ho • Interpreter: Shelley Sha plus 1 more
Role	• To be accountable for reviewing information provided by the project team/manager, actively participating/debating issues • To fully represent their organisation within the context of the scope of the sub-group • To be accountable for the delivery of project information to their own organisation (this will include consultation within their own organisation as appropriate) • To be accountable for all data validation within a timely manner on behalf of their own organisation • To keep their CEO's/GM's and other key stakeholders fully advised of progress and issues
Principles of conduct	Same as Steering Group (ToR) Terms of Reference
Functions of the Working Group	• To debate and make recommendations based on rigorous analysis of information provided by project team/manager • To actively participate and engage in the discussion process to ensure views from all members are considered • To provide feedback on the process of the project to correct the process, to achieve collaboration and transparent process Sign-off of recommendations. If there is unanimous agreement among the working group in its recommendation process
Quorum	Ideally each meeting should have, at least, 1 representative from each DHB and 60% of the members present.
Delegated Attendance	Delegate attendance is the responsibility of the members. If a member has appointed a delegate to attend, the member is expected to ensure the delegate is well briefed and understand the project to attend on behalf. If the delegate is not able to attend, further delegation is not required.
Secretary	Project Manager
Decision making style	Consensus style where possible Appropriate voting system to be applied if consensus not reached No feedback from members on information provided will be assumed as agreed
Meeting Frequency	Meetings will occur before each wrking group meeting Special meetings may be arranged
Minutes & agendas	Minutes in the form of action points will be available within five working days of meetings. They will be distributed to all members Agenda will be circulated 3 days prior to the meeting. All agenda and items and accompanying papers must be to the Secretary 5 days prior to the meeting.