eCALD®

Cross-Cultural Resource for Health Practitioners

Supplementary Resources

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FOREWORD

Waitemata DHB's Asian Health Support Service is proud to present an innovative cross-cultural resource for health practitioners working with culturally and linguistically diverse clients, in the form of an e-Toolkit and a Desktop kit. It is the first of its kind in New Zealand.

One of the key drivers for the resource development is because of requests for resources and references from health practitioners who attended cultural workshops ran by WDHB Asian health support services. Secondly the Health Practitioners Competence Assurance Act 2003 requires cultural competence of medical practitioners.

We are pleased to be able to present a cross-cultural resource to complement the range of eCALD™ courses available on the eCALD™ website www.ecald.com.

We would like to convey our sincere acknowledgements and thanks to the researcher and community members for participating in this research process and everyone involved with the project (as listed overleaf).

Sue Lim
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(2015)

THE PROJECT TEAM

This resource was developed by:

- Victoria Camplin-Welch – Researcher, Cultural Competence Specialist responsible for writing and compiling the e-toolkit and desktop kit resources.
- Sue Lim – Manager Asian Health Support Services WDHB and Project Manager for this resource development for Waitemata DHB, responsible for providing some materials, designing and coordinating the production of the desktop kit.

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- People who offered themselves as consultants for the different cultures: *Dr. Nyuant Naing Thein* for the Burmese, *Judy He, Charles Cui*, *Sue Lim, Mo Yee Poon* and *Ching Sy* for the Chinese, *Sally Han* and *Grace Ryu* for the Koreans, *Hien Mack* for the Vietnamese, *Supreet Cheema* and *Pratima Nand* for the Indians, and *Kuy Be Mathin* for the Cambodians and *Dr. Arif Saeid* for the Afghani, *Elizabeth Alkass* for the Christian Iraqi, *Zoreh Karimi* for the Iranian, *Monica Jok* for the Sudanese, *Dahaba Hagi* for the Somali, *Dawit Arshak* for the Ethiopian and a number of community members for the Burundians and Arabic Iraqi who would like to remain anonymous. Their input provided invaluable current and real perspectives from resettled immigrants on theoretical material. Many spent considerable time in consulting additional community members and leaders, and others gave generously of their time in proofing the information once it had been written up
- The work of *Kemp and Rasbridge* (2004) and Jackson (2006) all of whom have provided the basis for much of the material. Thanks to other researchers and publications and also to *Queensland Health*, Australia whose extensive resources and information for clinicians has been extremely helpful

INTRODUCTION

This resource is in honour of the Great Movement of Cultures across our planet, of people bravely migrating, and some being displaced with much anguish from their homelands to settle in New Zealand. With them they bring new perspectives, traditions and experiences to enrich our rapidly growing multi-cultural society.

This resource is also produced with respect for those health professionals who serve in our health system within this dynamic and demanding context, constantly having to update, integrate and re-frame their world views, traditions and practice to meet the needs of this changing society.

Lastly it is in recognition of the New Zealand Spirit, a vessel able to hold a myriad of possibilities. Rich in its own heritage it is constantly challenged to embrace and support the New.

The aim of this resource is as follows:

1. The first is to enhance awareness around cultural competence issues, what cultural competence means and what it constitutes.
2. The second is to provide information to assist practitioners in developing a relevant set of skills for culturally competent practice. For this purpose we have included a self-assessment for cultural competency development, pre-interview checklists and interview guidelines, communication tips and greetings for each culture, tables comparing various aspects of Asian and Western cultures, and how to work effectively with interpreters (Chapter 1).
3. The third aim is to provide some brief background information on seven Asian cultures that will assist practitioners in their attempts to develop rapport, build relationship and provide an effective and appropriate service (Chapter 2).
4. The fourth aim is to provide general information about Middle Eastern and African cultures and some brief background information on 3 Middle Eastern cultures and 4 African cultures that will assist practitioners in their attempts to develop rapport, build relationship and provide an effective and appropriate service (Chapter 3).

The e-toolkit is an updatable resource. The initial focus is on Asian cultures (included are Chinese, Korean, Indian, Vietnamese, Cambodian, Laotian and Burmese) and Middle Eastern and African cultures (included are Afghani, Burundian, Ethiopian, Iranian, Iraqi, Somalian, and Sudanese), as these are considered the major migrant and refugee population groups outside the dominant New Zealand host cultures. The e-toolkit will be revised from time to time with information on additional cultures as the needs arise, mental health issues, and other refugee and migrant issues.

For ease of reading, references and resources are included at the end of each chapter and section, rather than inserted into the text.

HOW TO USE THIS RESOURCE

1. E-Toolkit resource

It is divided into three chapters:

- **Chapter 1** contains general information about cultural competence, effective communication, and working with interpreters.

- **Chapter 2** covers Asian cultures, with an Introduction providing generalized information, and seven separate Sections on different cultures providing more culture specific information. This information includes background, greetings and communication, health beliefs and practices, family values, tips for practitioners working in practice, health risks, women's and youth health, and spiritual practices.

- **Chapter 3** covers MELAA cultures, with an Introduction providing generalized information on this group. Part I covers Middle Eastern cultures and Part II African cultures. Separate Sections in Part I and II offer more culture specific information which includes background, greetings and communication, health beliefs and practices, family values, tips for practitioners working in practice, health risks, women's and youth health, and spiritual practices.

PLEASE NOTE This toolkit outlines *traditional* practices from each of the cultures. These are more likely to apply to recent migrants. However many CALD clients who have migrated from other countries of resettlement, as well as those of 2nd and 3rd generations in New Zealand may have acculturated to the extent that there are few, if any, noticeable differences from the New Zealand culture. **It is imperative, to avoid stereotyping, that the tools in Chapter I of this resource are used to assess the degree of acculturation of each individual client.**

2. Desktop-Kit

A summary version of this e-Toolkit Resource is available in the form of a desktop kit for purchase. An order form is available on www.ecald.com.

CHAPTER 1: CULTURE

CULTURALLY COMPETENT PRACTICE, EFFECTIVE COMMUNICATION, AND WORKING WITH INTERPRETERS

Culture is defined by the *shared history, values, beliefs and practices of a group,* and not just by ethnicity. Culture affects all aspects of living including behaviour, family structure, child rearing, dress, body image, diet, food, caregivers' roles and spiritual practices. In the context of health care, culture is integral to ideas of what constitute illness and wellness, and what acceptable and effective treatment is.

In addition 'culture' provides people with a way to identify themselves, to make sense of their world, and gives some structure to understanding their thoughts, behaviours and events. For people immigrating to a different country, being able to retain aspects of their culture is vital, particularly if the host culture of the new country is markedly different. When people move from one cultural context to another, one of four processes tend to occur: assimilation, integration, separation or marginalisation (Berry 1997). People may move through the spectrum, experiencing different degrees of each process at different times. Some may stay within a particular process. It is important to ascertain how much your client may have integrated or assimilated before initiating treatment decisions.

Processes occurring when people move from one cultural context to another	
Integration	retaining the beliefs, values and behaviour of their own cultural group as well as adopting many of those of the new cultural group/s
Assimilation	loses own cultural identity by assimilating the values, beliefs and behaviours through constant interaction with the new culture/s
Separation	maintains own culture by avoiding interaction with the new culture/s
Marginalization	loses contact with own cultural group and avoids interaction with the new cultural group

(Berry, 1997)

CULTURAL COMPETENCY

Defining cultural competence

In most countries the *host cultures* (i.e. in New Zealand the Maori, Pacific and Anglo-European based cultures) dominate health care services. However, since New Zealand is an exceptionally fast growing multi-cultural society, services need to be accessible, equitable and appropriate for a markedly diverse population.

To provide such service we need a workforce that is competent to work with culturally and linguistically diverse clients, and who can tailor service delivery to meet health, social, cultural and linguistic needs of these clients.

Cultural competence involves different levels of awareness, knowledge, sensitivity and skills. Terms such as *'cultural awareness'*, *'cultural safety'* and *'cultural clinical competence'* have been used to describe these different levels. Whilst in the past it has been considered sufficient to be sensitive in cultural interactions, expectations and requirements are now that all health care providers practice cultural safety and possess the skills to be considered culturally competent, particularly *within a clinical context*.

Cultural awareness

This requires that a practitioner is aware of their own beliefs, values, expectations and cultural practices, and how these may differ from their CALD (culturally and linguistically diverse) client's. This awareness is necessary in order to recognize and evaluate whether, and how, their own values might impact on their clinical interactions, and on how they influence their own attitude and approach towards healthcare interventions.

Cultural knowledge

This involves knowledge about other cultural practices, and the ability to note key differences between one's own and another's culture. Knowledge, however is not as important as awareness or cultural sensitivity since practitioners cannot be experts in every culture from which they have clients. Understanding that family values and practices, health values and practices, as well as religious and spiritual practices are key points of difference is a useful starting point. Other common cultural variations that can cause misunderstanding include physical contact, expression of emotion, "wordiness", and values and ideas about time. Cultural knowledge is an aspect of competence that grows over time, through experience, research and enquiry.

Cultural sensitivity

Although cultural sensitivity does require *some* knowledge of another culture, it relies more on the ability of the practitioner to develop mutual respect with someone who holds different values and practices. A willingness to enquire, maintain objectivity, have tolerance for diversity, show respect, and to negotiate the process of treatment, will assist enormously in rapport building. The tendency towards *ethnocentrism* (the conviction that ones' own culture is 'normal' or superior) is particularly important in this regard as it prevents us from meeting people on their own cultural ground. Instead there is often an implicit goal to try to get people to conform to mainstream or our own cultural orientation. This has direct implications for healthcare safety and influences the relationship between provider and client and therefore, inevitably, compliance.

Cross-cultural skills

Clinical cultural competence involves skills in clinical assessment, effective communication and rapport building, knowledge of cross-cultural ethics, and working with interpreters.

Cultural safety refers to the outcome of professional education that enables safe service to be defined by those who receive the service.

It is well understood that the therapeutic relationship plays a central role in client compliance and in the successful outcomes of treatment. Given the cultural challenges and barriers to access for CALD clients, it is recommended that practitioners give priority to developing rapport and understanding between the parties. There are guidelines in the individual culture sections that will assist this process, but in general, being interested in the client's perspectives and being willing to negotiate treatment to accommodate as much of the client's needs as possible, will facilitate this process considerably. An increased awareness and understanding of the different health beliefs and expectations about treatments that clients may hold is essential.

Clinically competent skills include:

- **Tolerance** for diversity
- **Sensitivity** to the role of traditional medicine and practices
- Considering how **prescribed interventions might conflict** with a client's beliefs or traditional practices
- Enquiring about the **client's own perspectives and explanations** of their illness
- The willingness and ability to **negotiate** treatment by accommodating the client's framework and expectations (to a clinically safe degree)
- A readiness to **involve family** in interventions and feedback
- **Engaging an interpreter** when necessary and ensuring that a good rapport amongst parties is facilitated when working with an interpreter

Best Practice	Not culturally competent practice
Cultural Relativism The attitude that other ways of doing things are *different* but equally valid Attempt to understand the behavior in its cultural context	**Ethnocentrism** The view that one's culture's way of doing things is the right and natural way, and that all other ways are inferior, unnatural, perhaps even barbaric
Generalization Indicates common trends, but further information needed to ascertain appropriateness of a statement to a particular individual May be inaccurate when applied to specific individuals	**Stereotyping** Belief that a statement is true of all individuals from a particular group

Self-assessment for cultural competence development

It is inevitable that all of us will hold some prejudices, stereotypes, or have beliefs that remain within the shadows of our awareness. It is the consistent attempts to identify and manage these that nurture development in cultural competency and acceptance of diversity. Below are some questions for reflection:

Checklist for ongoing Cultural Competence Development

1. How self-reflective are you about your interactions with clients from other cultures or minority ethnic groups?

2. Do you recognize prejudices you may hold about certain ethnic groups, or their practices and beliefs?

3. Can you identify how *ethnocentric* you might be in your interactions with clients from different cultures?
   - Can you greet people from any other culture in their own language (verbal or non-verbal)?
   - Do you assume that they need to understand how your system works?
   - Do you know anything about where they come from and the circumstances under which they might have migrated?
   - Do you know anything about their traditional health practices and expectations?
   - Are you able to accommodate any of the diversity in your interventions?

4. How does your ethnic identity affect your decisions with clients and others?

5. How often do you attend functions or take part in any activities involving people from minority ethnic groups?

6. Have you read any books/articles or seen any films recently about people from other cultures, particularly minority ethnic cultures?

7. Do you respect client's religious or spiritual beliefs that are different from your own? Are you able to incorporate these comfortably in interventions when appropriate?

8. Have you discussed any cross-cultural issues that might have arisen in your work, with a colleague or supervisor?

9. Have you attended any training or sought education on cross-cultural issues?

10. Have you ever challenged a racist attitude by someone, or realized you might have made/thought one?

11. How much do you value the metaskills of 'compassion', 'neutrality', 'non-judgement', 'acceptance' and 'listening' in your practice?

See Jackson (2006) p. 195, for *Charactersitics of cross-culturally competent mental health practitioners*, and Pack-Brown Williams (2003) p. 136 for a checklist on *Professional development in multicultural mental health* (some of both included in above questions).

COMMUNICATING EFFECTIVELY

"It is much more important to know what sort of patient has a disease, than what sort of disease a patient has" (William Osler, quoted in Carrillo *et a*l)

When conducting a clinical assessment with someone from another culture practitioners are faced with not only the challenge of different levels of host language proficiency, acculturation and socioeconomic status, but more importantly within the health context **different expectations, traditions and experience of health care**. Since client satisfaction and compliance is closely related to the effectiveness of the communication between practitioner and client, not only cultural sensitivity, but particular cross-cultural skills are needed in assessment to ensure adequate understanding between the two.

Core issues that are likely to create misunderstandings across cultures relate to **physical contact, authority, communication styles, gender, sexuality, family, spiritual beliefs,** and **explanatory models of illness and health.**

A 'Pre-interview Checklist' and 'Essentials for communicating' during the interview will assist both rapport building and assessment.

Pre-interview checklist:

- Do you know what *culture* your client is from?
- Do you know what *language and/or dialect* they speak?
- Can you *greet* your client in their language?
- Do you need an *interpreter*? (see Working with Interpreters below)

Essentials for Communicating Clearly during the interview:

- *Explain your role* to your client (different professional roles are not always understood by someone who has come from a different health system)
- *Do not assume* English proficiency
- *Speak clearly* and *slowly*
- *Avoid jargon*
- *Simplify* the form of the sentence or question (e.g. use active not passive statements)
- *Pause* and take time to explore any issues that need clarifying to ensure you are understood before continuing (the assumption that everything is understood could lead to non-compliance)
- *Periodically summarize* and encourage feedback to check understanding
- *Note differences in meanings* of words (e.g. Anglo Europeans use "Yes" as affirmative, whilst in other cultures it can be a form of acknowledgement without indicating consent. Saying "that is correct" or "I understand" may be clearer. Check what your client means)
- Be aware of *client's level of understanding* (need to find the balance between being patronizing or assuming they understand how the health system and treatments work)
- *Respect* others' beliefs and attitudes (don't be afraid to ask how things are done/seen/understood in the client's culture. People often open up if they feel the listener is genuinely interested)
- *Take note of non-verbal language* (people express emotions in different ways, a dissonance between verbal and non-verbal language may also indicate a lack of understanding)
- *Engage interpreters* where there is low English proficiency and utilize their role

as cultural advisors to assist the communication process
- Be sure to *address the client appropriately* (not all cultures regard first names as acceptable in a formal setting)
- Find out whether *eye contact* is acceptable or not
- Find out what kind of *physical touch* and *examination* is expected and acceptable

Cross-cultural assessment

Guidelines for culturally competent assessment:

Important cultural background information:
1. Where was the client born? 2. How long has the client been in this country? 3. What is the client's ethnic affiliation? 4. Who are the client's major support people? 5. What are the client's primary and secondary languages, their reading and writing ability in these? 6. What is the client's religion, its importance in daily life, and current practices? 7. What are their food preferences and prohibitions? 8. Is the client's income adequate to meet their own and their family's needs? 9. What are their health and illness beliefs and practices? 10. What are their customs and beliefs around life events such as births, illness and death?

Adapted from Allotey, et al (1998)

Guidelines for eliciting the client's own explanatory model so that this can be incorporated into the diagnosis and treatment plan:

A BRIEF set of questions to elicit client's own perspective and beliefs about their health: (The CAT, Cultural Awareness Tool)
1. What does your sickness do to you; how does it work? 2. What do you think caused your problem? 3. How bad is your sickness? How long do you expect it to last? 4. Do you have a name for this problem in your language? 5. What is your biggest worry about your sickness? 6. What have you been doing or taking for this problem so far? 7. Who advises you about your health in your culture? 8. What kind of treatment do you think you should receive? 9. What are the most important results you hope to receive from this treatment? 10. Is there anything you would like me (your doctor) to know about your problem?

Adapted from The Cultural Awareness Tool, Multicultural Health Australia, 2002.

Treatment/care and Discharge Considerations:
1. Does client understand your perception of their illness? 2. In the case of serious/terminal illness is it appropriate to speak with a relative first? 3. Does the client understand how the treatment works/ how to take the medicines/can they read the instructions? 4. Does the client understand how the treatment will help him/her? (NB for compliance) 5. Does the client understand how to incorporate the treatment with (possibly) their own existing practices? (Consider dietary and food preferences) 6. Is there place for self-determination of client and family in the treatment/care process? 7. Does the client understand the whole plan? 8. Is follow-up procedure clear? 9. Consider using an interpreter for treatment instruction/discharge if English proficiency is not high or if there is difficulty about compliance

WORKING EFFECTIVELY WITH INTERPRETERS

Working with interpreters is a further challenging factor to the CALD treatment sessions. The presence of a third party has significant influence on rapport potential, and depending on the client-interpreter relationship, can also affect outcome. It is essential to engage trained interpreters when necessary (see below) and to facilitate the process according to guidelines. In New Zealand considerable steps are being taken to ensure that interpreters are professionally trained and practice according to standard guidelines and ethics. There is currently a specialist, Regional Interpreter Training Package for interpreters working in mental health which also includes a component for practitioners. It is a requirement that all interpreters working in the area of mental health attend this training in order to continue working in the field. It is also recommended that practitioners attend the 2 day training component in order to develop the most effective means of working together with interpreters.

Engaging an interpreter

A client may request an interpreter in advance, or you may need to assess whether one is required. If you feel that your client's English ability could restrict either their *understanding of information* provided or *your ability to understand their needs*, then an interpreter is required. (Note that English ability as a second language can deteriorate in situations involving illness, shock, pain or stroke).

To assess the need:
• Ask your client open ended questions that require more than a Yes / No answer • Ask your client to repeat what you have just said in their own words

Using trained or untrained interpreters

Trained interpreters are available from professional Interpreters services in South, West and Central Auckland (See Chapter 4 Additional Resources for contacts and details). The term 'untrained' interpreter refers to family members, friends, support persons, volunteers or staff, or anyone who has not had professional training as an interpreter.

Use a trained interpreter when:

- Client is not accompanied by family / support person / friend, or when one cannot be readily contacted
- Dealing with children
- Client does not wish to use family / friends / support persons or staff
- Client and/or family request an interpreter
- Staff need to determine client's medical history, injury or ailment
- Explanations of confidential / sensitive issues are delivered
- Client and/or family are distressed / emotional
- Client is to undergo invasive procedure / treatment
- Pre-op or post-op instructions are to be given to the client
- Discharge or referral information is to be given to the client
- Managing an entire episode of care
- Client is undergoing therapy / counselling and crisis intervention

An untrained interpreter can be engaged:

- When a client requests or agrees to use family/support person/staff **and there is no conflict of interest**
- When the client and/or family are not in an emotional / traumatised state
- When staff are confident that the use of an untrained interpreter is appropriate
- For communicating simple / non-medical related information
- In emergency situations where insufficient time to obtain a trained interpreter
- In conjunction with a trained telephone interpreter

Identified risks when using untrained interpreters: *(especially children under 20 years old):*

- It can be unsafe from a clinical safety perspective
- It can be culturally inappropriate
- Equity of treatment is not ensured
- Inaccurate interpretation / lower standard (lower English proficiency)
- Bias and distortion (e.g. may censor information obtained)
- No confidentiality or ethical code
- No explanation of cultural differences
- Possible misunderstanding of roles

Interpreters' roles

Policy and guidelines have been developed for interpreters and it is important to note that their roles are threefold ONLY. Their roles are:

1. To act as a ***Conduit*** – to process the spoken language, with meaning, so that an accurate equivalent is provided in the target language, with no omissions, additions or editing. (When language is perceived to be nonsensical, interpreting needs to be literal).
2. To act as ***Clarifier*** – to interpret underlying and metaphorical meanings within the cultural context.
3. To act as ***Cultural Clarifier*** – to provide a necessary framework for the message being interpreted. The interpreter would inform either party about

relevant cultural practices and expectations, ethics and etiquette when there is either apparent or potential misunderstanding, and assist in maintaining a good therapeutic relationship through mutual cultural respect and understanding.

Clinical safety

In the interests of clinical safety it is advisable that interpreters are not left alone with the client/family either before or after the session. (They may require a private place to wait before the session begins).

Since clients often identify strongly with the interpreter for cultural reasons, they may divulge information to the interpreter before or after the session which they do not share with the practitioner. This leaves the client vulnerable and the interpreter holding information they may not be equipped to deal with. For this reason interpreters are not to transport clients. Interpreters are expected to engage with the client/family in a professional capacity only, for the purposes of the health intervention. It is understood that interpreters may know clients from a social context, or may have had contact with them previously, given the small communities to which many CALD clients belong. If there are concerns this can be addressed in the pre-briefing session if necessary. Interpreters are expected to let practitioners know if there is a conflict of interest (see 'Code of Ethics' below).

Pre-and post briefing and structuring sessions

When working with an interpreter it is necessary to make time for a short *pre-briefing session*, and also for a *de-briefing session* after the appointment time. This is important for both the quality of service to the client, and for the benefit of the practitioner and interpreter relationship.

Pre-session briefing when using an interpreter
• Introduce yourself and check ID and confirm Job Number of interpreter • Identify a leader for the session (if more than one health professional) • Arrange seating appropriately to facilitate communication (trained interpreters can guide you on this) • Brief interpreter on purpose and objectives of the session • Obtain cultural background information from the interpreter if necessary, and any cultural etiquette required • Establish mode of interpreting - consecutive or simultaneous • Brief on confidentiality protocol (this also includes not discussing client in the session)
Session structure
• Introduce interpreter and explain your and their role to client (include fact that <u>everything said in the session will be interpreted</u> i.e. no private discussions between parties) • Ensure client of confidentiality with all parties (interpreter also bound by a Code of Ethics) • Establish ground rules of speaking ***through*** the interpreter, not ***to*** (i.e. use 1st person singular) • Expect the interpreter to use the 1st person singular when interpreting • Maintain eye contact with your client (if appropriate) not the interpreter • Direct questions / statements to the client or family, not directly to the interpreter • Do not enter into direct conversation with the interpreter

• Do not ask the interpreter for their opinion (only for cultural clarification) • Pause at regular intervals for the interpreter to assimilate and interpret • Allow interpreter to interpret after every 3-5 sentences • Allow enough time for the interpreter to convey information (it may only take you 3 words to explain but it may take more time for the interpreter to convey the information in their language) • Use short sentences • Check with interpreter about any cultural contexts for information provided by patient (if necessary)
De-briefing after the session
• Summarize session and discuss whether objectives were met (there may be language or cultural reasons if objective were not met) • Clarify diagnostic/treatment issues where necessary • Clarify any cultural issues, interpretation of words or concepts • If the session involved traumatic material, check whether the interpreter has had personal material triggered (considering that many interpreters may have come through similar experiences/cultural context as the client for whom they are interpreting). If so offer some de-briefing • Confirm follow-up procedure/appointments as appropriate • Complete interpreter Job Information Forms as required

Perspectives from different parties:

A client who requires an interpreter, might experience some of the following difficulties:

- 'loss of voice' that occurs through not speaking host language
- restricted access to services because of not having enough information about the services or how to find them
- be confronted with myths, taboos and stigmas about health services, and sometimes with what feels like a hostile and unfamiliar health care system
- institutionalized racism
- racism within the practitioner-client relationship
- disempowerment within the intimacy of the practitioner-client relationship
- a loss of their own traditional interventions and illness models

Interpreters can experience the following difficulties:

- 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
- double role – both professional and community member/friend
- 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 during interpreting in therapeutic contexts. De-briefing is essential and the interpreter needs to ask for this if it is not offered by the clinician.

Accuracy in health care interpreting

Accuracy in interpreting is vital since inaccurate interpreting and information can result in misdiagnoses, and unsafe and ineffective health care. It is useful to be aware of the **7 most commonly committed errors in interpreting:**

- **Omission** (e.g. leaving out part of the sentence/explanation)
- **Addition** (adding their own words to those of the client's)
- **Substitution** (e.g. because the interpreter cannot think what is meant; or does not know an exact synonym, or concept does not exist in Target language or culture
- **Role exchange** (interpreter takes over the session)
- **Condensation** (interpreter summarizes what is said)
- **Closed/open Statements** (interpreter changes closed into open statements and vice versa)
- **Normalization** (strange statements 'normalized' for benefit of practitioner which increases possibility of misdiagnoses)

If you think one of the above errors have occurred, address this directly with the interpreter.

Expected competencies for interpreters

- To understand and adhere to the prescribed roles (see 'Roles' above)
- To be able to do sight translation (i.e. translate documents in sessions such as consent forms, Mental Health Act etc. Written translations are not part of the role)
- To be able to do *simultaneous interpreting* (when interpreter and 2nd party speak simultaneously with the interpreter one or two sentences behind)
- To be able to do *consecutive interpreting* (when interpreter interprets after other party has finished speaking)
- To have some knowledge of mental health within their own culture/community
- To have some knowledge of the mental health system in NZ and basic terminology
- To have knowledge of, and to adhere to the Interpreters' Code of Ethics. These include the following clauses:
    - Accuracy
    - Confidentiality
    - Impartiality
    - No conflict of Interest
    - Professional courtesy
    - Declining work
    - Contractual obligations
    - Self education
    - Standard of Conduct
    - Regular peer supervision (if available)
    - Membership of a professional body (not yet available in New Zealand)

PROVIDING A CULTURALLY RESPONSIVE SERVICE

Responsiveness is about working with clients to provide an effective service that can meet their needs, appropriately and timeously.

Does your practice/team:

- Have *flexibility* in service delivery
- Employ *culturally competent staff*
- Have *clinical cultural staff* in the team
- Have access to *clinical cultural advice* if there is no appropriate staff member on your team
- Include *cultural education* as part of professional development
- Provide staff with *resources* about other culture's beliefs and practices
- *Look at gaps* in service provision
- *Provide information* to your clients in a form that they can understand
- *Have access to translations* in various languages on common illnesses and treatments (see Additional Resources at the end of each culture section)
- *Get feedback* from clients about your service
- *Reflect on practice* after feedback/evaluations
- Use *interpreters*

How can you achieve effectiveness?

- Collect client satisfaction data
- Record data on client outcomes
- Have staff with culturally and linguistically diverse skills to assist clients
- Use interpreter services when necessary

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